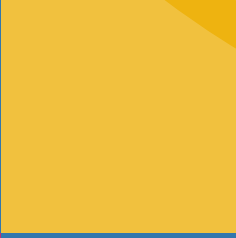




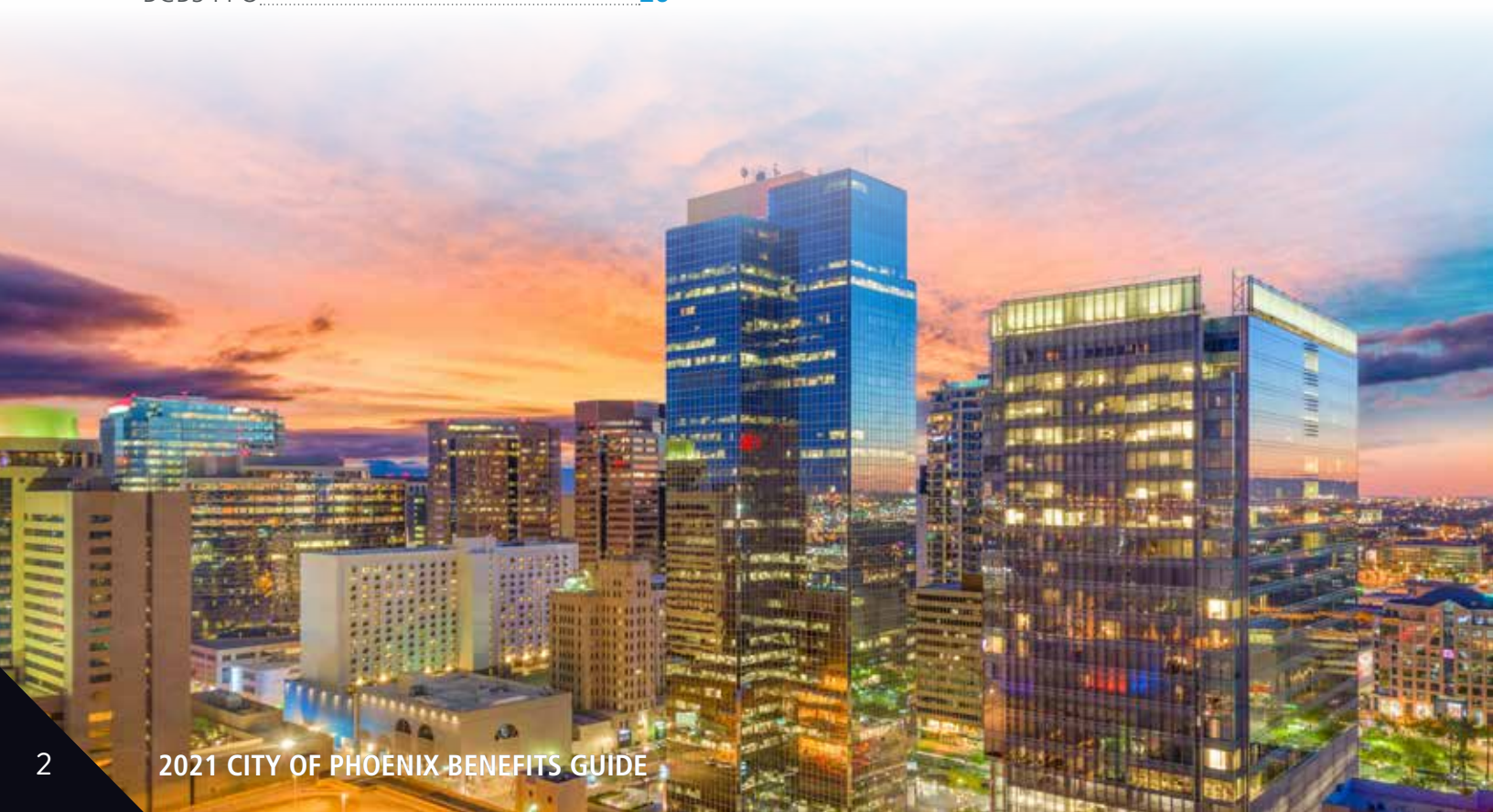
City of Phoenix

# 2021 EMPLOYEE BENEFITS GUIDE



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# WE'RE GLAD YOU'RE HERE

City of Phoenix employees are valuable contributors to the City's success. That is why an expansive benefits program is a core part of your total compensation.

## Our benefits program offers you:

- › Three distinct health plans: Savers Choice Plan, HMO, and PPO
  - Enhanced chiropractic coverage in all health plans
  - Robust mental health benefits
- › Three dental plans: Dental PPO, Dental PPO Plus, and a Dental HMO
- › Health Savings Account when enrolled in the Savers Choice medical plan
- › Flexible Spending Accounts
- › A generous Vision Plan
- › A wellness incentive that can add up to \$60 per month
- › An Employee Assistance Program (EAP) with 12 free counseling visits per incident
- › Two Legal Insurance plans – value and full
- › Qualified domestic partner coverage
- › 401(a), 457(b), and PEHP to help you build your retirement
- › Long Term Disability benefits
- › Employee Loan Program
- › Pet Insurance

This 2021 Employee Benefits Guide includes important information and updates about these City of Phoenix employee benefits.

### Open Enrollment for 2021

**October 19 through  
November 13 at 5:00 p.m.**

If you have questions about your benefit choices or how to enroll, please call the experts in the City's Benefits Office at (602) 262-4777 or send an email to [benefits.questions@phoenix.gov](mailto:benefits.questions@phoenix.gov).

Find this guide and additional information at [phxbenefits.com](http://phxbenefits.com).





# BENEFITS CHANGES FOR 2021

## What's New This Year?

At City of Phoenix, we're committed to providing our employees with a competitive and comprehensive benefits package while managing costs. Striking this balance can translate to increased employee contributions from time-to-time, or adjusted cost-sharing levels in our health plans. While these decisions aren't easy, they allow the City to enhance valued benefits and reinvest in new offerings.

### Medical

- › Employee Contributions: Experience the same plans you know and rely on. Most medical plan designs remain unchanged, but include a 6.0% rate increase.
- › Continued Enhanced Chiropractor Benefits: 36/year.

### Pharmacy Plan

EnvisionRx has a new name – the Pharmacy Benefits provider has rebranded as Elixir. All plan designs remain unchanged, meaning you can receive the same great service, affordable prescriptions, and convenient home delivery – all in one pharmacy. The best part is, there's no action for you to take to continue receiving your prescriptions.

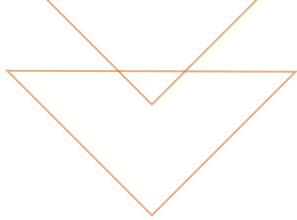
### Health Savings Account (HSA)

The annual employer contribution increased to 75% of the annual calendar deductible, meaning the City will contribute even more into your HSA in 2021! Additionally, the IRS increased annual HSA contribution limits. Along with contributions from the City, you are eligible to contribute up to:

- › \$3,600 for individual coverage only
- › \$7,200 for family coverage

Please note: to elect an HSA, you must be enrolled in the Saver's Choice Plan.





## Life Insurance

Experience the same Optional Life coverage at a decreased premium cost. In 2021, the Optional Life plan designs will remain unchanged, but is now offered at a lower cost.\*

*\*Please note: your premium in the Optional Group Life coverage may change if you reach a new age bracket.*

## Flexible Spending Accounts (FSA)

- › For 2021, the IRS increased the annual health care spending account limit to \$2,750.
- › The City is introducing a new FSA vendor, Connect Your Care (CYC). Our Flexrap accounts will work the same under CYC.

## Pet Insurance

The City is excited to introduce new pet insurance vendor, MetLife! Enrollment begins on January 1, 2021, so you'll be unable to sign up for this benefit until the first day of the New Year. With MetLife Pet Insurance, you can:

- › Use any licensed veterinarian.
- › Receive coverage for your pet's wellness exams, common illnesses, serious conditions, accidents, X-rays, prescriptions, surgery, and more. The plan provides 90% coverage up to \$7,500 annually.\*

- › Get 24/7 assistance with any pet health concern through VetHelpline.
- › Receive a premium discount of up to 10% when you cover multiple pets.

*\*Note: A deductible may apply.*

## TrueConnect Employee Loan Program

TrueConnect is offering loans between \$1,000 - \$5,000 at an APR of 19.99% to help get you resources needed to respond to a financial crisis. TrueConnect's plans are designed to offer employees an easy way to borrow money and outline a responsible plan to pay it back.

## COBRA

Connect Your Care (CYC) will serve as the new COBRA vendor beginning January 1, 2021.

## Buy Up Vision

The City is excited to introduce Davis Vision, the new Buy Up Vision vendor! Davis Vision covers In-Network eye exams, glasses or contacts for \$10 and fully covers single vision lenses, bifocal lenses, and trifocal lenses.





# GREETINGS FROM HCTB CHAIR

The City of Phoenix is committed to providing our employees with a competitive and comprehensive benefits package. While keeping that commitment, it occasionally becomes necessary to make changes to the benefits offered or change the vendors through whom the benefits are provided. The Health Care Trust Board, working with the Health Care Task Force has approved changes to improve the benefits for City of Phoenix employees for 2021. In the upcoming year, you will see both enhancements and vendor changes.

## Enhancements:

- › Increase to HSA Contributions
- › Expanded Chiro benefit

## Vendor Changes:

- › Flexrap
- › Vision
- › Pet Insurance

Open Enrollment for 2021 begins Monday, October 19, 2020 and closes at 5:00 p.m. sharp on Friday, November 13, 2020. Changes you make during this year's Open Enrollment go into effect on January 1, 2021. If you do nothing during Open Enrollment your current coverage will continue through 2021 with the exception of Flexrap (and your HSA Election). IRS requires you to make an election during Open Enrollment if you wish to be enrolled in Flexrap in 2021. Please double-check your current coverage before making the choice to do nothing during Open Enrollment.

If you are a newly hired employee, you have 31 calendar days from your date of hire to enroll in benefits. Please contact the Benefits Office with any questions at (602) 262-4777 or email [benefits.questions@phoenix.gov](mailto:benefits.questions@phoenix.gov).

Will Buividas

Board Chair, Health Care Trust Board

# WHEN TO REVIEW THIS GUIDE

1

When you are hired and are making your new hire benefit elections in the first 31 calendar days of your employment with the City of Phoenix.

2

During Open Enrollment to see what's new before deciding whether to make changes or let your current elections roll forward.

3

Whenever a Life Event occurs – such as marriage, birth, adoption, legal guardianship, divorce, or loss of other group coverage – that may impact your enrollment.

Find this guide and additional information at [phxbenefits.com](http://phxbenefits.com).

*This guide provides highlights of the City of Phoenix employee benefit plans, effective January 1, 2021. Summary plan descriptions, coverage certificates, policies, and contracts prevail.*

## Innovative Features

The City's health plans offer innovative features to save you time and money. For example, you can control costs by using virtual health visits instead of the emergency room when appropriate.

Take advantage of your City benefits program and resources in 2021. Committing to wellness and making smart health care decisions will add up to lower costs for both you and the City.



# 2021 PREMIUM RATES

## Health Plan—Full-Time Employees

A deduction is taken from the first two paychecks of the month for that month's coverage.

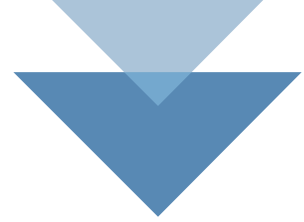
	Saver's Choice Plan with HSA		HMO		PPO	
	Employee	Family	Employee	Family	Employee	Family
Full Premium	\$460.17	\$1,460.83	\$547.95	\$1,739.49	\$595.59	\$1,890.76
City's Portion	\$368.13	\$1,168.66	\$438.36	\$1,391.59	\$476.47	\$1,512.61
Employee's Portion	\$92.03	\$292.17	\$109.59	\$347.90	\$119.12	\$378.15
Paycheck Deduction	\$46.01	\$146.08	\$54.79	\$173.95	\$59.56	\$189.07

## Health Plan—Job Share Employees

A deduction is taken from the first two paychecks of the month for that month's coverage.

	Saver's Choice Plan with HSA		HMO		PPO	
	Employee	Family	Employee	Family	Employee	Family
Full Premium	\$460.17	\$1,460.83	\$547.95	\$1,739.49	\$595.59	\$1,890.76
City's Portion	\$184.07	\$584.33	\$219.18	\$695.80	\$238.24	\$756.30
Employee's Portion	\$276.10	\$876.50	\$328.77	\$1,043.69	\$357.36	\$1,134.45
Paycheck Deduction	\$138.05	\$438.25	\$164.38	\$521.84	\$178.68	\$568.22





## Dental Rates—Full-Time Employees

One deduction is taken from the first paycheck of the month for that month's coverage.

	Dental HMO		Dental PPO		Dental PPO Plus	
	Employee	Family	Employee	Family	Employee	Family
Full Premium	\$27.32	\$75.30	\$50.38	\$138.87	\$55.57	\$153.17
City's Portion	\$27.32	\$56.48	\$50.38	\$104.15	\$50.38	\$104.15
Paycheck Deduction	\$00.00	\$18.82	\$00.00	\$34.72	\$5.19	\$49.02

## Dental Rates—Job-Share Employees

One deduction is taken from the first paycheck of the month for that month's coverage.

	Dental HMO		Dental PPO		Dental PPO Plus	
	Employee	Family	Employee	Family	Employee	Family
Full Premium	\$27.32	\$75.30	\$50.38	\$138.87	\$55.57	\$153.17
City's Portion	\$13.66	\$28.24	\$25.19	\$52.08	\$25.19	\$52.08
Paycheck Deduction	\$13.66	\$47.06	\$25.19	\$86.79	\$30.38	\$101.09

## Buy-up Vision Plan—All Employees

A deduction is taken from the first two paychecks of the month for that month's coverage.

	Davis Vision Buy-up Vision Plan	
	Employee	Family
Paycheck Deduction	\$5.54	\$13.06



# 2021 PREMIUM RATES

## Optional Life Insurance—Employee, Spouse, or Qualified Domestic Partner (QDP)

One deduction per month is taken from the second paycheck of the month.

	Employee Rate per \$1,000 of Coverage	Spouse or QDP Rate per \$1,000 of Coverage
	Based on Employee Age	Based on Spouse or QDP Age
	2021	2021
Under 25	\$0.057	\$0.043
25 – 29	\$0.064	\$0.051
30 – 34	\$0.080	\$0.068
35 – 39	\$0.088	\$0.077
40 – 44	\$0.095	\$0.085
45 – 49	\$0.137	\$0.132
50 – 54	\$0.211	\$0.196
55 – 59	\$0.340	\$0.366
60 – 64	\$0.527	\$0.561
65 – 69	\$0.997	\$1.080
70+	\$1.606	Not Available

## Optional Life Insurance—Children

One deduction per month is taken from the second paycheck of the month.

	Coverage Amount per Child			
	\$10,000	\$15,000	\$20,000	\$25,000
Monthly Deduction	\$1.00	\$1.50	\$2.00	\$2.50

## Legal Insurance Plan

One deduction is taken from the first paycheck of the month for that month's coverage.

	Value Plan	Full Plan
	Employee/Family	
Monthly Deduction	\$12.00	\$24.40

# Who Sets the Medical Premiums?

For 15 years, the City has self-funded the employee health plans to reduce the cost of group medical coverage. When an employer self-funds its coverage, it sets the annual premium rates based on the group's claims history and projected medical expenses while maintaining an adequate reserve level.

The City of Phoenix Health Care Benefits Trust holds the premium payments made by the City, employees, and retirees. Funds in this trust can only be used for claims and plan administration. Plan administration can include necessary expenses such as leasing provider networks, claims adjudication, the appeals process, drug formulary administration, stop loss coverage, audits, and actuarial services.

Because of self-funding, more than 97% of every premium dollar goes directly to claim expenses.

Banner | Aetna and Blue Cross Blue Shield (BCBS) have been selected in competitive bidding processes to supply the networks we use for doctors, hospitals, labs, and other medical services. Each network provider has a contract in place with Banner | Aetna and/or BCBS. Each contract determines how much is paid for services. Provider contracts are negotiated regularly and subject to change. Providers may apply to join a network at any time and may choose to leave a network when their contract expires. The City does not control the contracts with providers or the decisions made by providers to join or leave a network.

## The Health Care Task Force

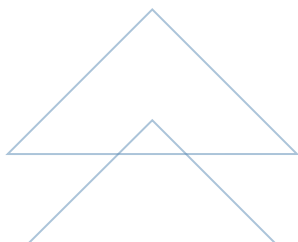
The Health Care Task Force provides input on medical premium rates, copays, plan designs, and wellness programs. The task force is comprised of one representative from each bargaining unit, one representative from middle managers, one executive representative, and one retiree representative. A member of HR Department management chairs the task force.

## The Health Care Benefits Trust Board

The Health Care Benefits Trust Board is charged with financial oversight for the trust that holds premium payments from employees, retirees, and the City. The Board is comprised of four members from the community with relevant benefits and/or financial background and one member representing COPCU (City of Phoenix Coalition of Unions).

## The City's Contribution to Our Medical Premium

The City pays 80% of eligible full-time employee medical premiums, whether enrolled in single or family coverage.





# WELLNESS INCENTIVE

## Save Up to \$720 per year!

- › Receive **\$40 per month** when you or an enrolled spouse/qualified domestic partner qualify.
- › Receive **\$60 per month** when you and your enrolled spouse or qualified domestic partner (QDP) qualify.

## How to Qualify in Plan Year 2021

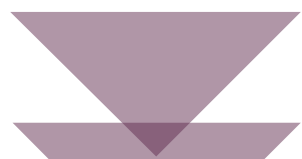
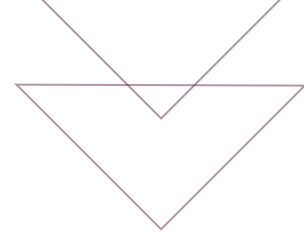
Due to the COVID 19 pandemic impacting the availability of PCP visits for employees and their spouses/ QDPs; we are waiving the PCP requirement to qualify for the wellness incentive benefit in 2021 only. The Health Risk Assessment (HRA) will continue to be required to meet eligibility. If you do not have your biometric data available, please use your most recent available data or your best estimate. The PCP waiver expires December 31, 2021. The PCP visit in addition to completion of the HRA will be required to receive the wellness incentive in 2022.

## Anytime During the Year, During Open Enrollment, Newly Hired, Newly Added Spouse or Qualified Domestic Partner

### Do These Two Things in the Same Calendar Year

1. Get your most recent biometric data, or use your best estimate: height, weight, waist circumference, blood pressure, total cholesterol, HDL cholesterol, and blood glucose from your PCP.
2. Complete the online Health Risk Assessment (HRA) found on your current City medical carrier's website. To do this, you must register on the website and have a User ID and password for [azblue.com](https://www.azblue.com) or [aetna.com/cityofphoenix](https://www.aetna.com/cityofphoenix). A spouse or QDP must have their own User ID and password on the website and log in separately to complete their own HRA.



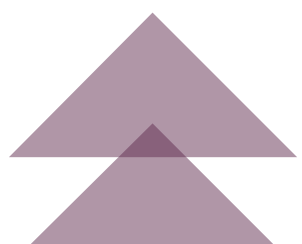


Once you and/or your covered spouse/QDP complete the HRA within the same calendar year, you have qualified for the Wellness Incentive. It will show up on your paycheck about 30 days after completing the HRA. During Open Enrollment, you must complete the HRA by the end of the Open Enrollment period to see the Wellness Incentive in your first paycheck of January 2021. If you miss the deadline, you can still complete your HRA; however, you will not see the incentive on your first paycheck of January 2021.

## The Incentive and Your Paystub

When you qualify, your Wellness Incentive appears on your paystub under "Hours and Earnings," where you can easily view it. There will also be a Year-To-Date incentive total so you can see how long you've been receiving the incentive.

Please contact the benefits office with questions at [benefits.questions@phoenix.gov](mailto:benefits.questions@phoenix.gov).








# ELIGIBILITY

## Eligible Dependents for Medical Insurance

- › Your legally married spouse, which includes a legally married same-sex spouse
- › Your qualified domestic partner (approval process required –  details on page 14)
- › Your children up to age 26 if they are your:
  - Biological children
  - Adopted children or children placed with you for adoption
  - Stepchildren while you are legally married to their parent. When a divorce occurs, stepchildren are no longer eligible
  - Qualified domestic partner's biological children while the qualified domestic partnership is approved and intact
  - Children living with you for whom you have legal custody or court-approved guardianship may be covered until the custody or guardianship expires

*\*All coverages end at the end of the month in which your dependent turns 26 of age.*

*Children enrolled in the City's medical and/or dental plan the day before they turn 26, are primarily supported by you, and are incapable of self-sustaining employment due to permanent disability may be eligible for coverage beyond age 26. An application and medical information must be provided to Banner | Aetna or Blue Cross Blue Shield within 31 calendar days of the child turning age 26. Contact the City's onsite Banner | Aetna or Blue Cross Blue Shield representative for information.*



## Who's Not Eligible?

- › An ex-spouse or former qualified domestic partner is not eligible
- › An ex-spouse or former QDP child(ren) that are not your biological or adopted child(ren)
- › A dependent in active military service is not eligible for coverage
- › A dependent is not eligible for coverage while incarcerated in prison
- › Common law marriage is subject to the City's qualified domestic partner application process
- › An employee's parent or parent-in-law is not eligible for coverage under any circumstance

Employees must remove ineligible dependents within 31 calendar days of the event that makes them ineligible for coverage. For example, within 31 calendar days of divorce, within 31 calendar days of the end of the qualified domestic partnership, or within 31 calendar days of active military service.

When it is discovered that an employee has left an ineligible dependent on their City coverage, all claims incurred and paid while ineligible are totaled together, and the total amount is recovered from the employee through payroll deduction, collections, and other means as available. The employee could face disciplinary action, up to and including termination.





# ELIGIBILITY

## Documentation Requirements for Enrollment

The City of Phoenix Benefits Office requires documentation to establish a dependent's eligibility for coverage. The City has the right to request documentation as often as deemed necessary.

A dependent's coverage will be removed or denied if the employee:

- › Does not provide all documentation requested, and/or
- › Does not respond to the Benefits Office within 14 calendar days of a request for documentation

*Social Security numbers must be provided to the Benefits Office for all family members enrolled in City benefits coverage. This is required for federal reporting under the Patient Protection and Affordable Care Act (ACA).*

## Qualified Domestic Partner (QDP) Coverage

Your domestic partner of the same or opposite sex may be eligible for City medical, dental, vision, and optional life insurance coverage if an application is approved by the City's Benefits Office.

### To Request Coverage:

- › Go to [hr.phoenix.gov](http://hr.phoenix.gov) and click the FORMS icon.
- › Search for "Qualified Domestic Partner Info Sheet" and "Qualified Domestic Partner Application."
- › Contact the City's Benefits Office with questions at [benefits.questions@phoenix.gov](mailto:benefits.questions@phoenix.gov) or (602) 262-4777.





# Enrollment Policies

## When Two City Employees Are Married to Each Other

- › They will have two single coverage elections when there are no children to cover. When there are children to cover, both employees and the children must be enrolled in one family plan. One single and one family election are not allowed.
- › Each employee can have only one type of Optional Life Insurance, either Employee Optional Life Insurance or Spouse Optional Life Insurance. They cannot be covered by both.

## Making Changes Mid-Year

### The 31-Day Rule

Benefit elections can be changed during Open Enrollment each year. Outside of Open Enrollment, you can only change your benefit elections when you experience a Qualified Life Event (QLE). Enrollment changes requested because of a QLE must be submitted to the Benefits Office through eCHRIS Self-Service within 31 calendar days of the event. Please contact the Benefits Office for assistance at [benefits.questions@phoenix.gov](mailto:benefits.questions@phoenix.gov) or (602) 262-4777.

Examples of QLEs include:

- › Marriage, divorce, annulment, the death of a spouse
- › Birth, adoption, placement for adoption, legal guardianship, change in legal custody
- › Becoming covered in other group coverage

*Please note newborns are not automatically added to your coverage. You must act by the 31st day to enroll your newborn.*

### Important Information



- The IRS does not recognize a domestic partner as being eligible for the same tax considerations as a legal spouse. Payroll deductions for domestic partner coverage may not be taken from your paycheck on a pre-tax basis. Also, the premium attributed to the domestic partner's coverage may be treated as imputed (additional) income resulting in an increase to the employee's tax liability.
- › A domestic partner and their children are not eligible for the Flexible Spending Account (Flexrap) plans for Health Care or Day Care.
  - › A Health Savings Account (HSA) cannot be used to pay for a domestic partner's or their enrolled children's out-of-pocket health care expenses unless they are recognized as a tax-qualified dependent under applicable state law and the Internal Revenue Code.







# HEALTH PLANS

## Every Plan Offers Generous Coverage and Broad Provider Networks

Savers Choice Plan with HSA • HMO • PPO

### All three plans have these same features

- › Large, national networks of physicians and facilities
- › Pharmacy coverage through Elixir
- › Free in-network preventive care
- › Full-time, designated representatives dedicated to City of Phoenix employees

### The three plans differ on these features

- › Out-of-pocket maximum – the most you pay in a plan year for covered services
- › Annual deductible – the amount you pay out-of-pocket before the plan begins to pay
- › Copays and coinsurance – the amount you pay toward the cost of covered services
- › Virtual Care – your options for online health care





# Choosing Your Health Plan – Things to Think About

	Savers Choice Plan	HMO	PPO
How large is the plan's network?	It is a large local and national network		
Access to Mayo and Phoenix Children's Hospital	Yes		
Am I required to use the plan's network of physicians, facilities, etc.?	Yes, except in the event of an emergency		No, but out-of-network providers can be expensive
Is a referral required to see a specialist?	No		
Is there an annual deductible?	Yes	No	Yes
Is there coinsurance?	No	No	Yes
Are there copays?	Only for prescriptions after the deductible is fulfilled	Yes	For a few services
What is the most I will pay out of pocket per year for in-network prescription drug and medical care?	\$3,000 for single coverage, \$6,000 for family coverage	\$6,600 for single coverage, \$13,200 for family coverage	\$2,400 per person, capped at \$5,700 per family of 3 or more
Will I be enrolled in a tax-free Health Savings Account with this plan?	Yes. The City contributes \$1,125 with single coverage and \$2,250 with family coverage annually	No	No
What makes each plan distinctive?	This is the only plan with a tax-free Health Savings Account	The HMO plan has copays only	The PPO is the only plan with out-of-network coverage




# BCBS SAVERS CHOICE PLAN WITH HSA

## The Lowest Health Plan Premium

### The only plan with a Health Savings Account (HSA)

The Savers Choice Plan is a unique high-deductible health plan:

- › It gives you a large, national network of providers, the same network as the BCBS PPO
- › It is the only plan, per IRS rules, that provides a tax-free HSA
- › The HSA includes an employer contribution, which is currently 75% of the deductible 
- › \$1,500 calendar year deductible for single coverage, \$3,000 calendar year deductible for family coverage
- › No coinsurance once the deductible is met
- › For single coverage: your maximum annual out-of-pocket cost will be \$1,500 plus prescription copays. If your deductible and prescription copays reach \$3,000, the plan will pay 100% of your health care expenses
- › For family coverage: your maximum annual out-of-pocket cost will be \$3,000 plus prescription copays. If your deductible and prescription copays reach \$6,000, the plan will pay 100% of your family's health care expenses

### The Savers Choice Provider Network

The Savers Choice plan coverage is provided through the same large, local and national network of providers as the PPO plan. There are almost 10,000 physicians in the local network and more than 30 hospitals, including Mayo Clinic, Phoenix Children's Hospital, and St. Joseph's Hospital.



#### Important Information

Deductibles include all covered medical expenses including prescription drugs when you use your Elixir pharmacy coverage. The family deductible is one amount, \$3,000, for all covered family member expense to be applied. After the single or family deductible is met, covered medical services received in-network are paid 100% by the plan and prescriptions are subject to copays of \$5, \$30 or \$50 for the remainder of the plan year.

### BCBS of Arizona

(602) 864-4857

[www.azblue.com](http://www.azblue.com)

### Find a BCBS Provider

- › Visit [www.azblue.com](http://www.azblue.com)
- › Click on "Find a Doctor/Rx"
- › Click on the option that best describes you, and follow the prompts

## How the Savers Choice Plan Works



<b>Health Savings Account (HSA)</b>	Set aside tax-free money from your paycheck and receive contributions from the City to help cover your costs now, or in the future.
<b>Deductible</b>	Pay 100% of your medical and prescription costs until you meet the annual deductible.
<b>Coinsurance</b>	There is no coinsurance with the Savers Choice Plan.
<b>Out-of-pocket Maximum</b>	\$3,000 for single coverage (deductible plus Rx copays) \$6,000 for family coverage (deductible plus Rx copays)

- ✓ \$0 copay for PPO members
- ✓ \$20 copay for Savers Choice Plan members

## BlueCare Anywhere Virtual Health Visits

### Online Doctor Visits Through BCBS of Arizona

On-demand health care services through BlueCare Anywhere are available to all employees and dependents enrolled in the BCBS Savers Choice Plan or PPO.

BlueCare Anywhere visits are provided at no cost to PPO plan members and for a \$20 copay per visit for Savers Choice Plan members.

### See a Doctor Anytime, Anywhere

BlueCare Anywhere gives you 24/7 access to U.S. board-certified doctors, counselors, and psychiatrists through your computer or mobile device. Here's how to get started:

- › Enroll online at [BlueCareAnywhereAZ.com](https://www.BlueCareAnywhereAZ.com).
- › Fill out a questionnaire and select your provider type.
- › Savers Choice Plan members pay a \$20 copay. You can use a credit card or your Health Equity HSA debit card.
- › Start your visit or schedule an appointment.
- › Receive a summary of your visit to share with your primary care provider.

In addition to online diagnosis and treatment, your doctor may also order prescriptions for you at the pharmacy of your choice.

### BlueCare Anywhere

[BlueCareAnywhereAZ.com](https://www.BlueCareAnywhereAZ.com)

Mobile App: BlueCare Anywhere APP



# HEALTH SAVINGS ACCOUNT (HSA)

## Part of the Savers Choice Health Plan

### Administered by HealthEquity

You are automatically enrolled in an HSA when you elect the Savers Choice Plan, and you'll receive a free debit card from HealthEquity for your HSA. There is no fee for this account while you are enrolled in the Savers Choice Plan. If you retire, terminate, go on COBRA, or select a different health plan, HealthEquity will deduct a small monthly fee for account administration.

### The Triple Tax Advantage and More

HSAs offer you tax advantages like no other. The City's and your contributions are tax free.

- › You can use your HSA funds to cover qualified medical expenses, plus dental and vision expenses too – tax free. The Triple Tax Advantage means you do not pay federal, state, or Social Security/Medicare tax on the contributions or reimbursements.
- › Unused funds grow and can earn interest over time once your account reaches a certain amount, and the plan offers a variety of investment options. Interest earned on your HSA balance is untaxed.
- › You can save your HSA funds to use for your health care costs when you retire or leave the City. The money is yours to take with you. You can use your HSA as another retirement vehicle. Once you turn 65 years of age, funds may be used for non-medical purposes (regular income taxes apply).

- › If you like the idea of paying less per paycheck and saving tax-free money for future medical expenses or saving for additional income in retirement, consider enrolling in the Savers Choice Plan with the tax-free HSA.

### Eligible Expenses

Use your HSA to pay for medical, prescription drug, dental, vision, and over-the-counter health expenses. For more information, see IRS Publication 969 for qualified health care expenses.

### Who's Eligible for an HSA?

- › Must be enrolled in the BCBS Savers Choice medical plan
- › Cannot be enrolled in other medical coverage, including a spouse's group health plan, Flexible Spending Account, or Medicare
- › Cannot be claimed as a dependent on someone else's tax return
- › You cannot use an HSA to pay for health care expenses incurred by a domestic partner

You should review IRS rules for making HSA contributions if you will turn age 65 during the year. For example, you cannot contribute to an HSA within 6 months of enrolling for Medicare. Contact HealthEquity with questions about eligibility.



## How the HSA Works

- › You must be enrolled in the BCBS Savers Choice Plan with HSA. Per IRS rules, this is the only health plan the City offers with an HSA
- › The current City's contribution to your HSA occurs in a lump sum during your first month of coverage, and during the first month of the plan year (January). The current City contribution is 75% of the annual deductible: \$1,125 for single coverage and \$2,250 for family coverage
- › 2021 contribution limits to an HSA are \$3,600 for single coverage and \$7,200 for family coverage. In addition, there is a \$1,000 additional "catch up" amount for employees 55 or better
- › Your HSA contributions are deducted from your first two paychecks each month on a pre-tax basis.\* You can change this contribution amount using eCHRIS Self-Service
- › HealthEquity administers the City's HSA and provides new enrollees with a debit card at no cost. Use this debit card to pay for out-of-pocket expenses such as copays, coinsurance, and deductibles, or pay online using the HealthEquity website, [www.healthequity.com](http://www.healthequity.com)
- › Money left in your HSA at the end of each year rolls over to the next year, including the City's contribution
- › The HSA account is portable. It stays with you when you resign, retire, or change to a different health plan
- › Employees may contribute to their HSA on a pre-tax basis only while enrolled in the BCBS Savers Choice Plan. If you later switch to the HMO or PPO plan, you can no longer contribute to the HSA

NOTE: Previous elected contribution amount does not roll over for January 2021; if an employee wants to have a contribution on the first paycheck they must make a contribution election during Open Enrollment. You can change your contribution amount at any time throughout the year.

\*In 2021, the City will deduct your HSA contributions over 24 pay periods.

## Contact HealthEquity with Questions

You'll receive a comprehensive welcome packet in the mail from our HSA administrator, HealthEquity, when you enroll in the BCBS Savers Choice Plan. You can manage your HSA account securely online. HealthEquity offers 24-hour customer service phone support and web access to track and manage your funds and provider payments. You are encouraged to attend webinars or view videos about HSAs at [www.healthequity.com/learn/webinars](http://www.healthequity.com/learn/webinars) and [www.healthequity.com/learn/videos](http://www.healthequity.com/learn/videos).

**HealthEquity**

**(877) 582-4793**

**HealthEquity.com**





# BANNER | AETNA HMO

The HMO Health Plan is administered by Banner | Aetna. This is the only health plan without a deductible. If you prefer having predictable health care expenses, consider the HMO plan because it has fixed copays for most services.

With the HMO plan, you can choose to save money by seeing a Primary Care Physician (PCP) who coordinates care with any specialists. Note that services received outside the network are not covered except for emergency services.

## The Banner | Aetna HMO Network

The HMO plan gives you access to a Broad Network that includes a national network of providers, and a local Performance Network that includes:

- › 1,891 primary care physicians
- › 8,632 specialists
- › Access to more than 120 urgent care centers
- › 23 hospitals
- › 12 Banner Health Centers offering primary and specialty care under one roof
- › Phoenix Children's Hospital, through a customized arrangement for the City

You can see providers from both networks seamlessly, but your out-of-pocket costs are lower when you use a provider in the Performance Network.

### Find a Banner | Aetna Provider

Search for in-network Banner | Aetna HMO providers here:

- › Visit the [www.aetna.com/cityofphoenix](http://www.aetna.com/cityofphoenix) website
- › Enter your location and search parameters
- › You can search for HMO providers within the Performance Network (lower copays) or the Broad Network (slightly higher copays)

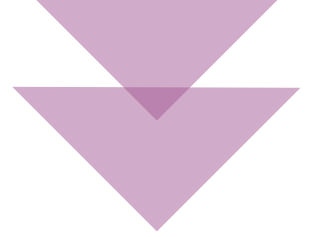
### Additional Resources

A full-time, designated representative from Banner | Aetna works with the City's Benefits Office and focuses full-time on City employee issues. They can be reached at (602) 495-5724 Monday through Friday, 8:30 a.m. – 4:30 p.m.

**Contact  
Banner | Aetna**

**(888) 747-7990**

**[www.aetna.com/cityofphoenix](http://www.aetna.com/cityofphoenix)**



# 98point6 Virtual Health Visits

## Text-Based Primary Care through Banner | Aetna

On-demand health care services through 98point6 are available to all employees and dependents ages 1+ enrolled in the Banner | Aetna HMO plan. 98point6 visits are provided at no cost to Banner | Aetna HMO plan members.

### No Appointment, No Waiting

98point6 gives you 24/7 access to U.S.-based, board-certified doctors from your phone. Here's how to get started:

1. Download the 98point6 app from your app store
2. Create your account
3. Follow the prompts to start your visit

In addition to text-based diagnosis and treatment, your doctor may also:

- › Order prescription drugs and labs
- › Outline care options
- › Provide audio and video support
- › Refer you to Banner | Aetna HMO network specialists and other resources
- › Send follow-up reminders

✓ \$0 Copay

**98point6**

98point6 mobile app

[98point6.com/cityofphoenix/](https://98point6.com/cityofphoenix/)





# BCBS PPO

The PPO provides in-network and out-of-network coverage. You can see the doctor of your choice, but you will pay more out-of-pocket when you go outside of the network. There are separate deductibles for in-network and out-of-network care, plus coinsurance. Once you reach the deductible, you will pay coinsurance until the out-of-pocket maximum is met. After that, the plan will pay 100% of covered services.

## The PPO Provider Network

The City's PPO coverage is provided through a large local and national network. There are almost 10,000 physicians in the local PPO network and more than 30 hospitals, including Mayo Clinic, Phoenix Children's Hospital, and St. Joseph's Hospital.

### PPO Coverage Highlights

#### In-Network

- › \$300 calendar year deductible per person up to \$900 per family
- › 20% coinsurance on expenses after the deductible is met
- › Preventive care is paid at 100%
- › Medical out-of-pocket maximum – \$900 per person, \$2,700 per family of three or more

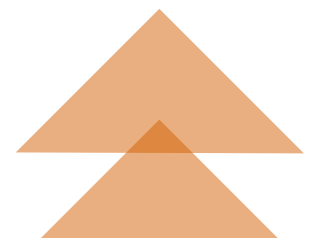
#### Out-of-Network

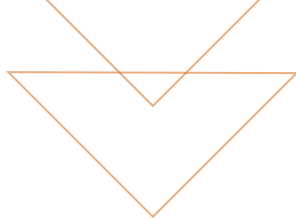
- › \$600 calendar year deductible, per person up to \$1,800 per family
- › 20% coinsurance on expenses after the deductible is met
- › Medical out-of-pocket maximum – \$1,500 per person, \$4,500 per family of three or more
- › Preventive care and vision are not covered out-of-network
- › The out-of-network deductible and coinsurance are tracked separately from the in-network deductible and coinsurance. For example, any amounts you pay for your in-network deductible won't count toward your out-of-network deductible



#### Important Information

When using out-of-network physicians, labs, facilities, etc., you may be billed for the difference between what BCBS pays as the "allowed amount" and what the provider charges. This is called "balance billing." It is your responsibility to pay this difference to the out-of-network provider when billed. This is above and beyond your out-of-pocket costs for the deductible and coinsurance.





## BCBS of Arizona

(602) 864-4857

[www.azblue.com](http://www.azblue.com)

### Find a BCBS PPO Provider

- > Visit [www.azblue.com](http://www.azblue.com).
- > Click on "Find a Doctor/Rx."
- > Click on the option that best describes you, and follow the prompts.



## Deductible Carry Over

If you don't meet your deductible during the calendar year, your expenses applied toward the deductible in the fourth quarter (October through December) carry forward to the following calendar year's deductible.

## About Copays

Copays are used for prescriptions, vision exams, and pre-natal visits. A \$10 copay is also available for primary care physician (PCP) office visits when you visit a Patient-Centered Medical Home (PCMH) physician. Copay charges do not count toward the deductible or coinsurance.

## How the BCBS PPO Works

When you use in-network providers:

<b>Copay</b>	You pay a small fee at the time of service for a few services such as pre-natal care or vision exam.
<b>Deductible</b>	For most services you pay 100% of the contracted costs until you meet the annual per-person deductible.
<b>Coinsurance</b>	After meeting the deductible, you pay 20% of the contracted costs until you reach \$900 out-of-pocket (per person), including the deductible.
<b>Out-of-pocket Maximum</b>	When you've reached \$900 per person or \$2,700 per family of 3 or more, your covered medical services are provided at no cost to you.

*Keep in mind: You pay nothing for in-network preventive care – it's covered in full.*





# HEALTH PLANS AT A GLANCE

	HMO	Savers Choice Health Plan	PPO	
	In-Network Only	In-Network Only	In-Network	Out-of-Network
Networks	Banner   Aetna HMO Broad or Performance	BCBS PPO	BCBS PPO	Not applicable
Local or National Network?	National	National	National	Not applicable
Out-of-Network Coverage?	For emergency services	For emergency services	For emergency services	Yes, with added out-of-pocket costs
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited
Calendar Year Deductible	None	\$1,500 for single \$3,000 for all covered family members combined	\$300 per person per year, capped at \$900 per family of 3 or more	\$600 per person per year, capped at \$1,800 per family of 3 or more
Coinsurance	None	None	20%	20%
Calendar Year Out-of-Pocket Maximum for Medical Services	Medical Performance Network Single: \$3,000 Family: \$6,000 Broad Network Single: \$5,100 Family: \$10,200 Pharmacy Single: \$1,500 Family: \$3,000	Single Coverage \$1,500 plus prescription copays. If your deductible plus prescription copays reach \$3,000, you have reached your maximum out-of-pocket expense.  Family Coverage \$3,000 plus prescription copays. If your deductible plus prescription copays reach \$6,000, you have reached your maximum out-of-pocket expense.	Medical \$900 per covered member, capped at \$2,700 per family of 3 or more Pharmacy \$1,500 per covered member, capped at \$3,000 per family of 2 or more	\$1,500 per covered member to a maximum of \$4,500 per family of 3 or more.  Out of network pharmacy is not covered.
Virtual Health Care Banner   Aetna: 98point6 BCBSAZ: BlueCare Anywhere	\$0	\$20	\$0	N/A
Health Savings Account?	No	Yes	No	No



	HMO	Savers Choice Health Plan	PPO			
	In-Network Only	In-Network Only	In-Network	Out-of-Network		
Prenatal Office Visits	\$30 for the first visit, \$0 thereafter	Plan pays 100% of the contracted rate after the calendar year deductible is met.	\$30 for the first visit, \$0 thereafter	Plan pays 70% of the BCBS allowed amount after the calendar year deductible is met.  The difference between the allowed amount and the billed amount is your responsibility to pay.		
Office Visit, Primary Care	Performance Network PCP: \$10 Broad Network PCP: \$30		You pay: 20% of the contracted rate after the deductible is met. \$0 after the calendar year out-of-pocket maximum is met.			
Office Visit, Specialist	Performance Network: \$30 Broad Network: \$45					
Office Visit, Mental Health	Performance Network: \$10 Broad Network: \$10					
Outpatient Procedure	\$100					
Inpatient Hospitalization	Performance Network: \$100 per admit, max \$300 per year Broad Network: \$150 per admit, max \$450 per year					
Lab and X-rays (Medically necessary)	Covered 100%					
Urgent Care Facility	\$50					
Hospital Emergency Room	\$150					
Physical Therapy, Occupational Therapy	Plan pays 100% with no deductible or copays					
Hearing Aids Max. 1 every other year per ear	90% coverage					
Eye Exam with Optometrist Every 12 months	\$25				\$25	
Chiropractic 30 visits max per plan year	First 36 visits are \$0 copay				\$20 copay	First 36 visits are \$0 copay
Generic Drugs	\$5				Members pay 100% of prescription cost until deductible is met. After that copays of \$5, \$30 and \$50 apply.	\$5
Brand-name Drugs	\$30	\$30				
Non-formulary Drugs	\$50	\$50				
Specialty Drugs	\$50					
Mandatory Mail Order for Maintenance Medication	Yes, with certain retail pharmacies (CVS, Target, and Fry's).		Not applicable			



# PHARMACY BENEFITS

## Elixir

### Drug Tiers

The cost of your prescription drugs under the City's medical plans depends on the tier of the medication:

- › Generic drugs contain the same active ingredients as their brand-name equivalents and meet the same federal standards for safety, but typically cost significantly less.
- › Formulary drugs are brand-name medications that are favored by the prescription plan based on drug effectiveness and cost.
- › Non-formulary drugs are brand-name medications that are not on a prescription plan's formulary based on drug effectiveness and cost. They may still be covered but could require prior authorization and will cost more.

### Maintenance Medication Requirements

- › The City continues to require you to fill maintenance medications using mail order or specific retail locations. Since January 1, 2019, the retail locations available for 90-day fills are CVS, Target, and Fry's.
- › Set up mail order prescriptions by calling Elixir directly or visiting their website.
- › You save by paying only two copays for 90 days of medication when using a 90-day retail pharmacy (CVS, Target, or Fry's) and when using mail order.

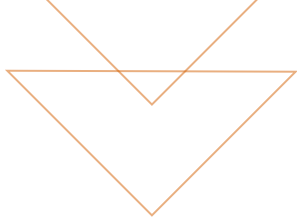
**EnvisionRx is  
now Elixir!**

**Elixir Customer  
Care**

**(833) 803-4402**

**[www.elixirsolutions.com](http://www.elixirsolutions.com)**

**elixir**  
CRAFTED Rx SOLUTIONS



## Have a Question? Need Help?

Contact the City's designated representatives with questions about coverage, claims, and bills. They work with the City Benefits Office and are 100% focused on City employee health plans:

<b>Banner   Aetna</b>	Call Maggie at (602) 495-5724 PerezM5@aetna.com
<b>BlueCross/ BlueShield</b>	Call Michelle at (602) 534-5165 michelle.walker@azblue.com
<b>Elixir</b>	Call Kim at (602) 534-5370 kimbaker@elixirsolutions.com

Contact City staff with questions about eligibility, enrollment, qualified life events (QLEs), premium deductions, retirement coverage, and more:

### **City of Phoenix Benefits Office**

(602) 262-4777  
benefits.questions@phoenix.gov





# BEHAVIORAL HEALTH BENEFITS

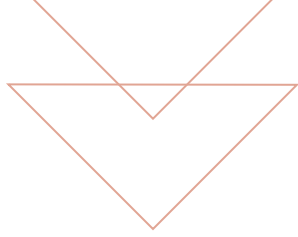
Mental health is as important to well-being as physical health. Your medical plan covers office visits with licensed psychiatrists, psychologists, and counselors as well as outpatient and inpatient programs for certain needs.

## **Banner | Aetna HMO Plan**

Local behavioral health professionals and facilities are available through the HMO's Broad or Performance provider networks. The office visit copay is \$10 for all in-network providers. Pre-certification is required for covered non-emergency inpatient services.







## BCBS PPO Plan

Behavioral health services are available through a national BCBS network and from licensed and accredited out-of-network providers. The City has actively broadened and strengthened this network of providers and facilities. Pre-certification is required for non-emergency inpatient behavioral and mental health admissions. The PPO deductible and coinsurance apply for in-network and qualified out-of-network providers.

## BCBS Savers Choice Plan

Behavioral health services are available through a national BCBS network. There is no out-of-network coverage. Covered services and pre-certification requirements are the same as for the PPO. The Savers Choice deductible applies; you will pay the full contracted rate for services until you reach your annual deductible.

### Exclusions

Exclusions for all plans include but are not limited to non-licensed facilities, group homes, halfway houses, assisted living, wilderness programs, non-emergency inpatient services at non-approved facilities, and residential treatment centers.





# EMPLOYEE ASSISTANCE PROGRAM

## ComPsych Guidance Resources

Everyone needs help sometimes. You and your eligible family members receive free and confidential access to licensed counselors through the City's Employee Assistance Program (EAP) provided by ComPsych Guidance Resources. The EAP is available to you no matter what other benefits coverage you elect through the City.

### Clinical Support

Employees and their immediate family members have access to free and confidential support from qualified professionals for:

- › Family and relationship/marital conflicts
- › Problems in the workplace
- › Stress, anxiety, or depression
- › Response to traumatic events
- › Grief and loss
- › Anger management
- › Domestic violence
- › Alcohol and/or drug dependency

**Twelve free counseling sessions are available** per person, per incident. Counseling sessions are provided face-to-face through a large network of local and national providers. Telephonic counseling is available, or counseling can also be accessed via web-video for maximum convenience.

### Elder Care Services

One phone call puts you in touch with a credentialed care manager who specializes in the medical care of older adults. The care manager will come to your loved one's home to learn more about his or her situation and needs. After providing an assessment, the care manager will work with

family members to develop a customized support plan. Together, you can consider housing options, home health services, safety management, health management, social engagement, nutritional counseling, cognitive monitoring, mental health and grief counseling, and more.

### Online Information

- › Mobile access to expert info on thousands of topics including wellness, relationships, work, education, legal, financial, lifestyle, and more.
- › Browse HelpSheets<sup>SM</sup>, assessments, Q&As, videos, and podcasts for emotional health, fitness, financial and legal issues, and more.
- › Search the online elder care and child care directories.

## ComPsych Guidance Resources

(602) 534-5433

[guidanceresources.com](http://guidanceresources.com)

Web ID = PhoenixEAP

Mobile App: [GuidanceResources®](#) Now



## Eligibility for EAP Services

Employee Group	Clinical Support Counseling			Work and Life Services	Eldercare Services
	Face-to-Face	Web Video	Telephonic		
Full-time	12 sessions per incident per eligible family member	Unlimited	Unlimited	Yes	Yes
Part-time	None	Unlimited	Unlimited	Yes	No

## Phoenix Fire Department Employees

If you work in the Phoenix Fire Department in any position, civilian or sworn, you receive EAP services from Public Safety Crisis Solutions (PSCS). The PSCS EAP is administered by the Phoenix Fire Department, not by the City of Phoenix Benefits Office.

### Officer Craig Tiger Act: HB 2502

Sworn Firefighters and Police Officers who have experienced a traumatic event on duty and need counseling as designated by the Officer Craig Tiger Act/HB2502 have a free 36 counseling session benefit available.

If you would like to use this benefit or learn more about the six qualifying categories of traumatic events, please visit [PSCrisisSolutions.com](http://PSCrisisSolutions.com) and click on the navigation bar labeled "Trauma Event Services (TES)." Fill out the appropriate form on that page to initiate this benefit. PSCS can provide this service for all Firefighters and Police Officers and assures you will be seen by a TES specialist within one week.

**Public Safety Crisis Solutions (PSCS)**

(602) 466-9456

[PSCrisisSolutions.com](http://PSCrisisSolutions.com)





# CIGNA DENTAL PLANS

## Choice of 3 Plans: Dental PPO · Dental PPO Plus · Dental HMO



Maintain good dental health through preventive care, including regular checkups. The plan you choose will determine your premium, coverage, and number of dentists in the network.

### PPO Dental Plan

You have a large, national network of dentists to choose from, and using in-network dentists means you pay the lowest out-of-pocket cost for services.

When using an in-network dentist:

- › All services are covered at 80%
- › No deductible for preventive exam, cleaning, and X-rays
- › There is a calendar year \$50 deductible, meaning you pay 100% of the first \$50 of non-preventive covered services
- › The maximum annual benefit per member is \$2,000 per calendar year for general services and a \$4,000 lifetime benefit for orthodontia

You have coverage when using licensed out-of-network dentists, but your out-of-pocket cost may be higher when you use an out-of-network dentist.

### PPO Plus Dental Plan

This is the same Dental PPO plan described above, with these enhancements:

- › The maximum annual benefit per member is \$3,000 per calendar year instead of \$2,000
- › Implant coverage is included with this plan; paid at 80%. **Paid benefits applied to the maximum annual benefit.** Exclusions may apply.

The premium rates for this plan are higher than the PPO Dental Plan.

*Please note: The PPO Plus Plan has a missing tooth limitation (MTL). Please contact Cigna before enrolling for more information.*

### Dental HMO Plan

- › The Dental HMO Plan has the lowest dental plan premiums
- › There is no out-of-network coverage and you have a smaller network of dentists
- › Every person enrolled must choose a primary dentist from the HMO network directory to manage your care. Every person enrolled must have a dentist of record on file with Cigna Dental. Initially, a dentist is assigned, and you can change to a different in-network dentist by calling Cigna Dental at (800) 244-6224 or visit [myCigna.com](http://myCigna.com)
- › There is no deductible and no out-of-pocket cost for preventive services
- › A fee schedule determines the amount you pay for dental treatment

Before choosing this plan, please be sure the dentist(s) you want to use are in the network.

**Cigna Dental**

(800) 244-6224

[myCigna.com](http://myCigna.com)



# Dental Benefits at a Glance

	Dental HMO	Dental PPO		Dental PPO Plus	
	In-network Only	In-network	Out-of-network	In-network	Out-of-network
Dentists	Cigna Care Network	Cigna Core Network	Any licensed dentist	Cigna Core Network	Any licensed dentist
Deductible	None	\$50 per calendar year, maximum \$150 per family Deductible does not apply to preventive services			
Cleanings, exams, X-rays	No charge	Plan pays 80% of covered charges	Plan pays 80% of reasonable and customary charges	Plan pays 80% of covered charges	Plan pays 80% of reasonable and customary charges
Extractions, fillings, crowns, dentures, bridges, root canals, oral surgery	See the HMO Dental Coverage and Fee Schedule				
Implant benefit	None	None		Plan pays 80% of covered charges	
Maximum annual benefit	No maximum for most covered services	Up to \$2,000 per member per calendar year for covered services		Up to \$3,000 per member per calendar year for covered services	
Lifetime orthodontia benefit	See the HMO Dental Coverage and Fee Schedule	\$4,000 per person		\$4,000 per person	

## Cigna Dental Oral Health Integration Program

Even more coverage is available with certain health conditions – contact your Cigna Dental Representative at [linda.sawyer@cigna.com](mailto:linda.sawyer@cigna.com).

	Heart Disease	Stroke	Diabetes	Maternity	Chronic Kidney Disease	Organ Transplants	Head and Neck Cancer Radiation
Periodontal Treatment & Maintenance	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Periodontal Evaluation				Yes			
Oral Evaluation				Yes			
Emergency Palliative Treatment				Yes			
Topical Application of Fluoride or Fluoride Varnish					Yes	Yes	Yes
Sealants					Yes	Yes	Yes
Sealant Repair					Yes	Yes	Yes



# VISION BENEFITS

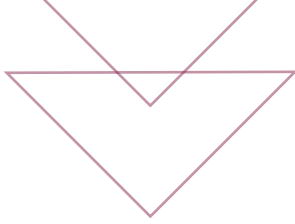
## Core Vision Benefits Through Your Medical Plan

These benefits are automatically included in your health plan. Savers Choice plan members must first meet their annual medical plan deductible before core vision benefits become available. Vision expenses can be applied to the Savers Choice plan deductible.

	Core Vision Coverage
Exam every 12 months	\$25
Frames every 12 months	\$30 credit
Single Vision Lenses every 12 months	\$20 – \$40 credit
Contacts	\$75 credit
Gradient tint; polycarbonate lenses; solid tint; standard anti-reflective coating; standard progressive lenses; standard scratch resistant coating; ultraviolet coating	20% discount may apply
Vision Provider Network	Banner   Aetna HMO: Aetna Vision Network BCBS: Blue Cross Network

## Davis Vision Buy-up Plan

Vision Care Service	In-Network Benefit	Out-of-Network Reimbursement
Eye Exam, Glasses or Contacts	\$10 Copay	Up to \$40
<b>Materials</b>		
Frame Allowance	\$175 retail value, including at participating Walmart, Costco and Sam's Club retailers	Up to \$45
Single Vision Lenses	Included	Up to \$40
Bifocal Lenses	Included	Up to \$60
Trifocal, Lenticular Lenses	Included	Up to \$80
Standard Progressive Lenses	Included	Up to \$60
Premium Progressive Lenses	Included	Up to \$60
Polycarbonate Lenses	Included	Up to \$10



**DavisVision™**

## Davis Vision

(800) 828-9341 [Access Code: 9613]

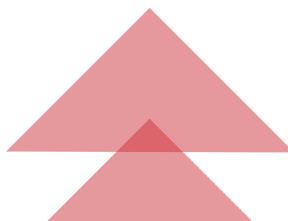
7:00 a.m. to 8:00 p.m. EST

[davisvision.com/members/](http://davisvision.com/members/)

Vision Care Service	In-Network Benefit	Out-of-Network Reimbursement
Standard Scratch Resistant Coating	Included	Up to \$5
Standard Tint	Included	Up to \$4
Standard Anti-Reflective Coating	Included	Up to \$24
Transitions	Included	Up to \$30
All other lens options	Discounted up to 20% off retail	N/A
<b>Contact Lenses</b>		
Elective	\$175 allowance	Up to \$175
Medically Necessary	Included	Up to \$250
Contact Lens Fit and Follow Up	Included	N/A
<b>Frequency</b>		
Eye Examination	Once every 12 months	
Lenses, Contact Lenses	Once every 12 months	
Frame	Once every 12 months	

*\*Please note that coverage is lower at these discount retailers. Don't assume you will have the lowest out-of-pocket cost at these locations.*

**You cannot apply both coverages to the same purchase for glasses or contacts. You can, however, use each coverage separately one time per year.**





# FLEXRAP

## A tax-free way to pay for health care or day care expenses

Flexrap is the City's Flexible Spending Account (FSA) program. FSAs allow you to pay for eligible health care and day care expenses using tax-free dollars, saving up to 25% on your health care and/or day care expenses.



### Important Information

Flexrap enrollment does not automatically roll over from one year to the next.

#### Health Care Account

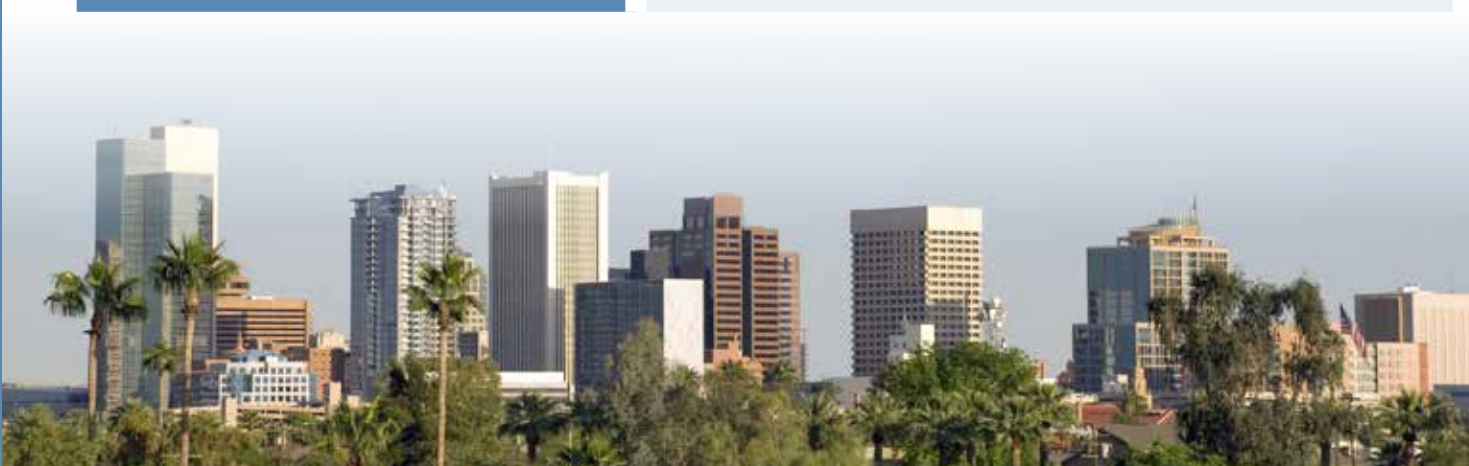
Used to pay for the cost of services not covered by your medical, dental, or vision plan, such as copays, coinsurance, deductibles, prescription expenses, lab exams and tests, contact lenses, and eyeglasses for you and your dependents. IRS Publication 969 lists all the expenses that would be eligible for reimbursement.

#### Limited Purpose Health Care Account

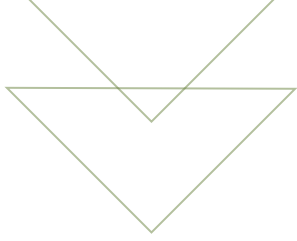
This account is the same as the Health Care Account EXCEPT it is for employees enrolled in the Health Savings Account (HSA). HSA participants cannot be enrolled in the traditional FSA. With this account you can pay for dental and vision expenses, but not medical expenses. Note: you can also pay for dental and vision using your HSA account.

#### Day Care Account

Used to pay for day care expenses associated with caring for a child 12 years old or younger who lives with you or older adults who may be disabled and under your care that are necessary for you or your spouse to work or attend school full-time. You cannot use your Flexrap Health Care FSA to pay for day care expenses.







Annual enrollment is required. You must sign up for Flexrap accounts every year; your prior year elections do not continue into the new plan year.

By enrolling in Flexrap, you can contribute to the Health Care Account, the Day Care Account, or both, with pre-tax dollars deducted in equal amounts from your first two paychecks each month. That means no taxes (federal, state, or Social Security) will be withheld from those contributions.

When you enroll in the Flexrap Health Care Account available through Connect Your Care, you can request a debit card pre-loaded with your annual Flexrap health care contribution. You can be reimbursed using the Connect Your Care online portal, the mobile phone app, or by submitting claims via fax or mail. When you set up direct deposit, your reimbursement will appear in your account within three business days of Connect Your Care receiving your claim and documentation.

Eligible expenses must be incurred in the calendar year for which you are enrolled. When you have a qualifying event such as marriage, birth, adoption, divorce, or a new day care provider, you can make a correlating change to your Flexrap amount when you contact the Benefits Office within 31 calendar days of the event. The annual deadline for submitting claims is March 31st of the next year.

## Expense Reimbursement

Find an alphabetical list of eligible expenses at [www.connectyourcare.com](http://www.connectyourcare.com). Submit your expenses for reimbursement online, by fax, by mail, or via the myCYC mobile app.

Set up direct deposit and select Paperless Notification & Payment Authorization Form to have your reimbursement automatically deposited. A check will be mailed if direct deposit is not established.

Find account information and claim forms at [www.connectyourcare.com](http://www.connectyourcare.com) (choose General FSA Claim Form). You can submit claims without using a claim form when you submit online or via the mobile app. Find the mobile app by searching your app store for myCYC.

### Mobile App

Download the myCYC mobile app to look up information about your Flexrap account and submit claims. No claim form needed, just fill out some information, take a picture of your documentation, and submit. Search in your app store for myCYC.



#### Important Information

There is a “use it or lose it” rule imposed by the IRS. In other words, if you do not spend all the money in your FSA by the deadline, any unused dollars in your account(s) after the deadline will be forfeited. **THERE IS NO ROLLOVER OF FLEXRAP FUNDS** from one year to the next. If it is your first time electing Flexrap, be conservative in your estimate of how much money you’ll spend.

**Connect Your Care**

**877-292-4040**

**[www.connectyourcare.com](http://www.connectyourcare.com)**



# LIFE INSURANCE

## Securian – Minnesota Life

Life insurance and Accidental Death & Dismemberment (AD&D) coverage help protect your loved ones in the event of your death or serious injury. Even if you're single, your beneficiary can use your life insurance benefits for burial expenses and to pay off your debts such as credit cards, loans and mortgage.



### Basic Life and AD&D Coverage

Basic Life Insurance coverage is provided at no cost to you, and you are not required to enroll in any other health and protection program. This coverage is automatic. Please designate a beneficiary using eCHRIS Self-Service.

Basic AD&D matches the Basic Life coverage amount and follows a benefit schedule for dismemberment. It includes additional benefits for Felonious Assault, Bereavement and Trauma Counseling, Inhalation of Smoke or Chemical Substance, Permanent Disfigurement/Critically Burned, Seatbelt, Coma, and Airbag.

### Accelerated Benefit

Basic and Optional Life Insurance include an opportunity to accelerate payment when life expectancy is 12 months or less. Contact the Benefits Office to apply for the accelerated benefit.

Basic Life Insurance Coverage	
Unit 1	\$15,000
Unit 2	The greater of \$25,000 or 1 times base salary
Unit 3	The greater of \$25,000 or 1 times base salary
Unit 4	\$15,000
Unit 5	1 times base salary
Unit 6	1 times base salary
Unit 7	The greater of \$25,000 or 1 times base salary
Unit 8	1.5 times base salary
Middle Managers	1.5 times base salary
Executives	1.75 times base salary

# Occupational AD&D

This amount is determined by your bargaining unit during each contract negotiation period. This coverage is payable when a death or covered accident occurs in the course of performing your job duties. Coverage may apply to inhalation of smoke or chemical substance. This coverage pays in addition to the Basic Life coverage, when applicable. Please refer to the policy for coverage details.

Occupational Insurance Coverage	
Unit 1	\$ 75,000
Unit 2	\$ 75,000
Unit 3	\$ 75,000
Unit 4	\$100,000
Unit 5	\$ 75,000
Unit 6	\$100,000
Unit 7, Unit 8, Middle Managers (General City and Fire), Executives (General City and Fire), Mayor and Council	\$ 75,000
Middle Managers and Executives (Police)	\$100,000
Police Reservists	\$ 25,000

Don't wait until it's too late. Check your life insurance beneficiary every year in eCHRIS to be sure it's accurate and up-to-date. Sign in to eCHRIS Self-Service and click Benefits > Benefits Information Life Insurance Summary.





# LIFE INSURANCE

## Commuter Life Insurance

This coverage pays \$200,000 in the event of death within a two-hour timeframe while commuting to and from your established work location.

## Optional Life Insurance

You can add to your Basic Life coverage by purchasing Optional Term Life Insurance. This coverage is provided at group rates for you, your spouse or qualified domestic partner, and/or children. You pay 100% of the group premium with after-tax earnings through payroll deduction. Similar to an individual life insurance policy, this coverage may be subject to underwriting.

Coverage For	Optional Life Insurance Amounts Available
Employee	Increments of \$10,000 up to \$250,000, and in \$50,000 increments from \$250,000 to \$500,000
Spouse/ Domestic Partner	Increments of \$10,000 up to \$300,000
Child(ren)	Amounts of \$10,000, \$15,000, \$20,000, or \$25,000

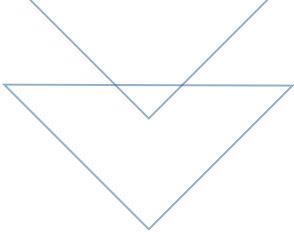


### Important Information for New Employees

During your first 31 calendar days of employment, you have a ONE TIME OPPORTUNITY to elect up to \$150,000 of employee Optional Life insurance, and/or up to \$50,000 of Optional Life insurance for your spouse or qualified domestic partner without having to provide Evidence of Insurability to the insurance company (Guaranteed Issue). Elect coverage through eCHRIS, our online enrollment system.







## Employee Optional Life Insurance Coverage: \$10,000 to \$500,000

If you request an increase through eCHRIS during annual Open Enrollment of more than \$20,000 and/or an amount that exceeds the guaranteed issue amount of \$150,000, you will be required to provide evidence of insurability (underwriting). The underwriting process may take several months and you may be asked for additional information. You must provide this information to the insurance carrier or risk having your application for coverage closed. Once closed, the application cannot be reopened for a year. The approved coverage amount and payroll deductions take effect on the first of the month following underwriting approval.

**Employee coverage is automatically reduced to 65% at age 70, to 45% at age 75, and to 30% at age 80.**

## Spouse or Qualified Domestic Partner (QDP) Coverage: \$10,000 to \$300,000

If you are already enrolled for up to \$40,000 in spouse or QDP life insurance, you may elect up to \$50,000 during Open Enrollment without having to provide evidence of insurability (underwriting). Make your request for increase in coverage through eCHRIS Self-Service, our online enrollment system. All other requests for spouse or QDP coverage are subject to underwriting. The underwriting process may take several months and you may be asked for additional information. You must provide this information to the insurance carrier or risk having your application for coverage closed. Once closed, the application cannot be reopened for a year. The approved coverage amount and payroll deductions take effect on the first of the month following underwriting approval.

**Spouse coverage stops when they reach age**

**70.** The spouse coverage amount cannot be more than the employee's combined amount of Basic Life Insurance and Optional Life Insurance per Arizona State Statute §20-1257. When two City employees are married to each other, one form of Optional Life Insurance may be elected, either employee coverage or spouse coverage, not both.

## Coverage for Children: \$10,000, \$15,000, \$20,000, or \$25,000

No Evidence of Insurability is required for child coverage. Coverage automatically stops when the child reaches age 26. The employee is automatically the beneficiary for child coverage. One election covers all eligible children at one premium rate.

## About the Evidence of Insurability Process

To complete evidence of insurability, go online to [lifebenefits.com/submiteoi](https://lifebenefits.com/submiteoi). The process takes from 10 to 20 minutes to complete. You WILL NOT be able to save your work and return later. Set aside enough time to complete the process at one time.

Have your medical information available to include physician names and addresses, hospitals and clinics where you've been treated, and details regarding diagnosis and treatment.

## Submission of Evidence of Insurability (Underwriting)

[LifeBenefits.com/SubmitEOI](https://LifeBenefits.com/SubmitEOI)

Group Policy # 34390

Access Key: Phoenix



# ADDITIONAL BENEFITS

## Legal Insurance

ARAG provides a national network of attorneys available to you, your spouse or QDP, and eligible children, to call on for a wide variety of legal needs at no cost to you for their time. This includes having a network attorney review or prepare documents, make follow-up calls or write letters on your behalf, provide legal advice and consultation, and representation in court.

- › Value Plan – \$12.00 per month for the most common legal services
- › Buy-up Plan – \$24.40 per month for a wide variety of legal services plus ID theft protection and tax preparation assistance

Both plans offer affordable access to attorneys for legal services such as will preparation, estate planning, and family law.

### Buy-up Plan Includes These ID Theft Services

- › Identity theft services
- › Full-service identity restoration
- › Single-bureau credit monitoring
- › Internet surveillance
- › Change of address monitoring
- › Child identity monitoring
- › Lost wallet services



Legal Insurance

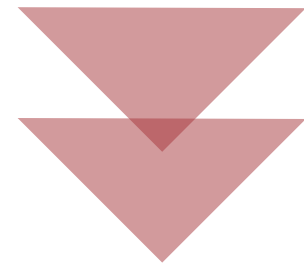
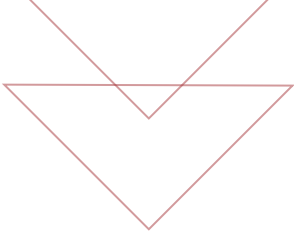
### ARAG Legal

(800) 247-4184

[araglegalcenter.com](http://araglegalcenter.com)

(access code: 16922phx)





## TrueConnect Employee Loan Program

Establish or rebuild your credit by repaying a safe, regulated bank loan through payroll deductions. TrueConnect provides loans from \$1,000 to \$5,000 with no credit check. Loans are offered with an APR of 19.99% and are intended to cover immediate cash needs when other resources are not available. You can apply online, and there are no fees or pre-payment penalties to worry about. Go to [TrueConnectloan.com](https://TrueConnectloan.com) to apply for a loan.



### TrueConnect

(561) 270-5981

[TrueConnectloan.com](https://TrueConnectloan.com)

### MetLife

### Pet Insurance

(800) GET-MET8

(800) 438-6388

## Pet Insurance

The City is excited to announce that Pet insurance will continue to be offered for the plan year 2021 through MetLife. Benefits include:

- › Use any licensed veterinarian
- › Receive coverage for your pet's wellness exams, common illnesses, serious conditions, accidents, X-rays, prescriptions, surgery, and more.\* The plan provides 90% coverage up to \$7,500 annually. Note: A deductible may apply
- › Get 24/7 assistance with any pet health concern through VetHelpline
- › Receive a premium discount of up to 10% when you cover multiple pets
- › Enroll anytime beginning January 1, 2021 by calling (800) GET-MET8

*\* Exclusions include pre-existing conditions, elective procedures, and congenital or developmental conditions.*





# SAVING FOR RETIREMENT

## Building Your Future Together

The City of Phoenix does a lot to help you meet your retirement goals. The City's Deferred Compensation Plans (DCPs) have a combined balance of \$2.2 billion and are governed by an engaged Board of Trustees with representation from the community, City management, and union representatives. The DCP Board assures employees that the program has responsible investment options, low fees, and efficient administration. The Deferred Compensation Program is comprised of:

- › 401(a)
- › Roth 457(b)
- › Traditional 457(b)
- › Post Employment Health Plan (PEHP)

The Deferred Compensation Program is administered by the City's HR Department – Benefits Division.

Nationwide Retirement Services is the record-keeper for the DCP Program. They provide the platform and services to help you build your financial future. The Program has many services which are provided at no additional cost to employees. You can utilize:

- › Local Nationwide representatives
- › Retirement Planning Specialist (certified financial planner)
- › Free online investing advice tool
- › Retirement tracking tool – My Interactive Retirement Planner
- › Evolving workshops and webinars

Nationwide is there to assist you with setting up your online account, loan request, signing up for workshops/webinars, and so much more.

### The 401(a) Plan

All benefits-eligible employees receive a City contribution to their 401(a) account each pay period. The City contribution percentage is negotiated with each bargaining unit each contract period. City contributions are renegotiated every two years. City contribution percentages are:

New employees! You have a one-time opportunity during your first 31 calendar days of employment to choose to make an ongoing, irrevocable contribution from your paychecks to the 401(a).

**Nationwide  
Retirement  
Solutions**  
[phoenixdcp.com](http://phoenixdcp.com)  
(800) 891-4749



Benefit Category	City Contribution to Your 401(a) Account
	July 1, 2020 - June 30, 2021
001	0.45%
002	3.62%
003	1.61%
004	2.56%
005	4.42%
006	0.05%
007	6.50%
008	1.28%
009, 010, 011, 016, 017, 018, 019	8.50%

## The 457(b) Plan

The City does not contribute to the 457(b) Plan, but you can choose to contribute a percentage or dollar amount from your paychecks anytime. The traditional 457(b) Plan allows for loans and emergency withdrawals, subject to IRS Code.

Benefits of a traditional 457(b):

- › Contributions are pre-tax, lowering your taxable income for the year you contribute
- › No age limitation or penalties when you start making withdrawals (regular taxes apply)

## The Roth 457(b) Plan

With a Roth 457(b), you pay taxes upfront when you make contributions into the plan. Then your money grows tax-free, and you'll also enjoy tax-free withdrawals – as long as:

- › You're at least 59½, and
- › You do not take withdrawals from your Roth account for at least 5 years after making your first contribution to the plan

A Roth 457(b) might be right for you if you:

- › Think that taxes will increase before you retire, and you want to take advantage of potential tax-free withdrawals
- › Expect to be in a higher tax bracket when you retire
- › Still have many years until retirement

Build that safety net now – you can access it during and after your employment with the City of Phoenix. As a new hire, your contributions are automatically defaulted to an American Funds Target Retirement Date Fund that correlates to your 65th birthday.

To enroll in the 457(b) or change your contribution amount, login in to your account at [phoenixdcp.com](http://phoenixdcp.com). Contribution elections are not made on eCHRIS.

(The Saver's Choice Health Saving Account may be used as another retirement savings vehicle, learn more on page 22 of this guide.)

## Post Employment Health Plan (PEHP)

Since 2007 the City has provided a \$150 per month contribution to a PEHP account when an eligible employee elects to enroll in a City-sponsored employee health plan. Eligible employees are those who:

- › Were hired as of August 1, 2007, or later
- › Were more than 15 years away from pension eligibility as of August 1, 2007

A variety of investment options are available for PEHP funds. As a new hire, your contributions are automatically defaulted to an American Funds Target Retirement Date Fund that correlates to your 65th birthday. Employees cannot contribute to their PEHP account.

Employees enrolled as a dependent of another City employee are not eligible for PEHP, nor when enrolled under COBRA.

The Saver's Choice Health Savings Accounts is another vehicle to help you save for future medical costs. Learn more on page 22 of this guide.

## Viewing Your DCP Accounts

- › Manage investments
- › Adjust your 457(b) contributions
- › Register for workshops and classes

View your DCP accounts online at [phoenixdcp.com](http://phoenixdcp.com).

Email any of your questions about the DCP Program to [dcp.benefits@phoenix.gov](mailto:dcp.benefits@phoenix.gov).



# HOW TO ENROLL IN BENEFITS

## Enroll Online Through eCHRIS Self-Service

1. Logging in:

- Go to <https://hcmprod.phoenix.gov/psp/hcmprod/> (From a work computer, go to [hr.phoenix.gov](http://hr.phoenix.gov))
- Enter your six-digit employee ID number for your User ID
- If you don't have a current password, please call the Help Desk, open weekdays from 7 a.m. to 5 p.m., at (602) 534-4357 to request a reset



1

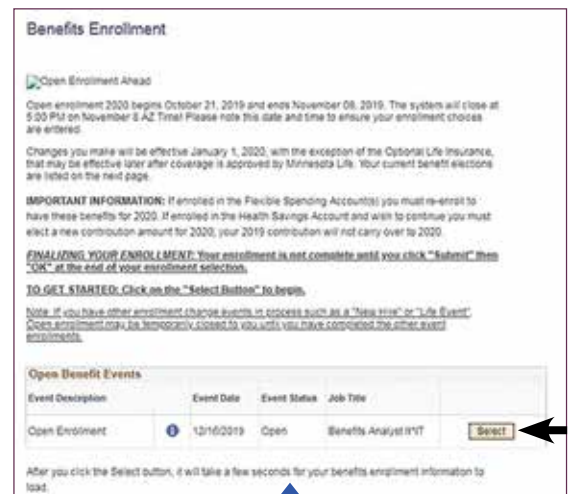
- Click on the Benefits "tile" as shown next to the arrow
- Go to the menu bar and click on Benefits Enrollment as shown next to the arrow
- Follow the on-screen prompts to enroll in your benefits for 2021



2



3



4

# Legal Notices

## NOTICE OF SPECIAL ENROLLMENT RIGHTS FOR HEALTH PLAN COVERAGE

As you know, if you have declined enrollment in City of Phoenix's health plan for you or your dependents (including your spouse) because of other health insurance coverage, you or your dependents may be able to enroll in some coverages under this plan without waiting for the next open enrollment period, provided that you request enrollment within 31 calendar days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible dependents, provided that you request enrollment within 31 calendar days after the marriage, birth, adoption or placement for adoption.

The City of Phoenix will also allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these enrollment opportunities, you will have 60 days – instead of 31 – from the date of the Medicaid/CHIP eligibility change to request enrollment in the City of Phoenix group health plan. Note that this new 60-day extension doesn't apply to enrollment opportunities other than due to the Medicaid/CHIP eligibility change.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

## WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator.

## NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator.

## PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit [www.healthcare.gov](http://www.healthcare.gov).

If you or your dependents are already enrolled in Medicaid or CHIP, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or [www.insurekidsnow.gov](http://www.insurekidsnow.gov) to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

If you have questions about enrolling in your employer plan, contact the Department of Labor at [www.askebsa.dol.gov](http://www.askebsa.dol.gov) or call **1-866-444-EBSA (3272)**.



To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor  
Employee Benefits Security Administration  
[www.dol.gov/agencies/ebsa](http://www.dol.gov/agencies/ebsa)  
**1-866-444-EBSA (3272)**

U.S. Department of Health and Human Services  
Centers for Medicare & Medicaid Services  
[www.cms.hhs.gov](http://www.cms.hhs.gov)  
**1-877-267-2323**, Menu Option 4, Ext. 61565

## CITY OF PHOENIX HIPAA PRIVACY NOTICE

Please carefully review this notice. It describes how medical information about you may be used and disclosed and how you can get access to this information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by the City of Phoenix health plans. This information, known as protected health information, includes almost all individually identifiable health information held by a plan — whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of these plans: **The City of Phoenix Employee Medical, Dental, and Prescription Drug Plans.** The plans covered by this notice may share health information with each other to carry out treatment, payment, or health care operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

### THE PLAN'S DUTIES WITH RESPECT TO HEALTH INFORMATION ABOUT YOU

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important to note that these rules apply to the Plan, not the City of Phoenix as an employer — that's the way the HIPAA rules work. Different policies may apply to other City of Phoenix programs or to data unrelated to the Plan.

### HOW THE PLAN MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

- **Treatment** includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.

- **Payment** includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include determining eligibility, reviewing services for medical necessity or appropriateness, engaging in utilization management activities, claims management, and billing; as well as performing “behind the scenes” plan functions, such as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.
- **Health care operations** include activities by this Plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include evaluating vendors; engaging in credentialing, training, and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses PHI for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes.

### HOW THE PLAN MAY SHARE YOUR HEALTH INFORMATION WITH CITY OF PHOENIX

The Plan, or its health insurer or HMO, may disclose your health information without your written authorization to the City of Phoenix for plan administration purposes. The City of Phoenix may need your health information to administer benefits under the Plan. The City of Phoenix agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. Employee of the City of Phoenix who have been identified as performing plan administration functions are the only City of Phoenix employees who will have access to your health information for plan administration functions.

Here's how additional information may be shared between the Plan and the City of Phoenix, as allowed under the HIPAA rules:

- The Plan, or its insurer or HMO, may disclose “summary health information” to the City of Phoenix, if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.

- The Plan, or its insurer or HMO, may disclose to the City of Phoenix information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option or HMO offered by the Plan.

In addition, you should know that the City of Phoenix cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by the City of Phoenix from other sources — for example, under the Family and Medical Leave Act, Americans with Disabilities Act, or workers’ compensation programs — is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

**OTHER ALLOWABLE USES OR DISCLOSURES OF YOUR HEALTH INFORMATION**

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You’ll generally be given the chance to agree or object to these disclosures (although exceptions may be made — for example, if you’re not present or if you’re incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

Workers’ compensation	Disclosures to workers’ compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody

Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protective services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you’ll be notified of the Plan’s disclosure if informing you won’t put you at further risk)
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
Law enforcement purposes	Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosures about a death that may have resulted from criminal conduct; and disclosures to provide evidence of criminal conduct on the Plan’s premises
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties.
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death
Research purposes	Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project

Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
HHS investigations	Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule

Except as described in this notice, other uses and disclosures will be made only with your written authorization. For example, in most cases, the Plan will obtain your authorization before it communicates with you about products or programs if the Plan is being paid to make those communications. If we keep psychotherapy notes in our records, we will obtain your authorization in some cases before we release those records. The Plan will never sell your health information unless you have authorized us to do so. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use, or disclosure of your unsecured health information as required by law.

The Plan will notify you if it becomes aware that there has been a loss of your health information in a manner that could compromise the privacy of your health information.

## YOUR INDIVIDUAL RIGHTS

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the table at the end of this notice for information on how to submit requests.

### Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

An entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health care item or service not be disclosed to the Plan for purposes of payment or health care operations if you have paid out of pocket and in full for the item or service.

### Right to receive confidential communications of your health information

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

### Right to inspect and copy your health information

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances, you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 calendar days of receipt of your request (60 days if the health information is not accessible on site), the Plan will provide you with one of these responses:

- The access or copies you requested
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed where to direct your request.

If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous, and specific. Any charge that is assessed to you for these copies must be reasonable and based on the Plan's cost.

#### **Right to amend your health information that is inaccurate or incomplete**

With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will take one of these actions:

- Make the amendment as requested
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

#### **Right to receive an accounting of disclosures of your health information**

You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an "accounting of disclosures." You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made in any of these circumstances:

- For treatment, payment, or health care operations
- To you about your own health information
- Incidental to other permitted or required disclosures
- Where authorization was provided
- To family members or friends involved in your care (where disclosure is permitted without authorization)
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances
- As part of a "limited data set" (health information that excludes certain identifying information)

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more calendar days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

#### **Right to obtain a paper copy of this notice from the Plan upon request**

You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

#### **CHANGES TO THE INFORMATION IN THIS NOTICE**

The Plan must abide by the terms of the privacy notice currently in effect. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised privacy notice.



## COMPLAINTS

If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of Health and Human Services. You won't be retaliated against for filing a complaint. To file a complaint, file a written complaint with the HIPAA Privacy Officer in the Benefits Office at 251 W Washington Street, 7th FL, Phoenix, AZ 85003.

## CONTACT

For more information on the Plan's privacy policies or your rights under HIPAA, contact the Benefits Office at (602) 262-4777.

## NOTICE REGARDING WELLNESS PROGRAM

**Fit4Phoenix** is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to visit your Primary Care Physician (PCP). You are not required to complete the HRA or to visit your PCP.

However, employees who choose to participate in the wellness program will receive an incentive of \$40 or \$60 per month for completing the HRA and visiting their PCP. If the employee or covered spouse (or qualified domestic partner) do this, the incentive is \$40. If the employee and covered spouse (or qualified domestic partner) do this the incentive is \$60. Although you are not required to complete the HRA or complete a PCP visit, only employees who do so will receive the incentive.

Additional incentives may be available for employees who participate in certain health-related activities or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the **Wellness Coordinator, at (602) 262-4777**.

The information from your HRA will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as onsite preventive care, health coaching, webinars or classes. You also are encouraged to share your results or concerns with your own doctor.

## PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and the City of Phoenix may use aggregate information it collects to design a program based on identified health risks in the workplace, Fit4Phoenix will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Deputy Human Resources Director of Benefits and Wellness at (602) 262-4777.

## GINA SPOUSAL NOTICE AND AUTHORIZATION FOR WELLNESS PROGRAM (FOR WELLNESS PLANS THAT ALLOW SPOUSES OR DOMESTIC PARTNERS TO PARTICIPATE IN DISABILITY-RELATED INQUIRIES OR MEDICAL EXAMINATIONS)

You are receiving this Notice and Authorization because the City of Phoenix is making a voluntary wellness program available to you as the spouse (or qualified domestic partner) of an employee. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve health or prevent disease, including the Americans with Disabilities Act of 1990

(ADA), the Genetic Information Nondiscrimination Act of 2008 (GINA), and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as applicable, among others. Your spouse (or qualified domestic partner) who is an employee of the City of Phoenix will receive a separate Notice regarding the wellness program.

Federal law requires that you provide knowing, written, and voluntary authorization prior to the City of Phoenix's wellness program (Fit4Phoenix) collecting your genetic information, which includes information about your current or past health status. By signing this Notice and Authorization, you are agreeing that you have read and understood it and that you are knowingly and voluntarily providing information about the manifestation of your diseases and certain other conditions – considered genetic information – as part of the wellness program. This may include a medical questionnaire that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You may also be asked to visit your Primary Care Physician (PCP). If you are unable to participate in any of the health-related activities, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting **the Wellness Coordinator at (602) 262-4777**.

**You are not required to complete the questionnaire or the PCP Visit. You are not required to provide genetic information; however, if you choose not to provide information regarding your own health status, you may not qualify for the full amount of wellness incentives (\$40 or \$60 per month). The wellness program cannot offer you a wellness incentive in return for you providing your own genetic information, including your family medical history, results of your genetic tests, or information about your children's health status or genetic information. Regardless, you and/or your spouse (or qualified domestic partner) will not be denied access to the City of Phoenix's health plan (or any package of health plan benefits), or subjected to the City of Phoenix discrimination or retaliation if you choose not to participate in the wellness program.**

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The genetic information that you provide will be used to offer you services through the wellness program, such as onsite preventive care, health coaching, webinars or classes. You also are encouraged to share your results or concerns with your own doctor.

We are required by law to maintain the privacy and security of your individually identifiable genetic or medical information. Although the wellness program and the City of Phoenix

may use aggregate information it collects to design a program based on identified health risks, Fit4Phoenix will never disclose any of your individually identifiable genetic or medical information either publicly or to the City of Phoenix, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as permitted by law. Genetic or medical information that personally identifies you that is provided in connection with the wellness program will not be provided to the City of Phoenix, including your spouse's or domestic partner's supervisors or managers and may never be used to make decisions regarding your spouse's (or qualified domestic partner's) employment.

Here is a summary of how we will protect your confidentiality and restrict disclosure of your information:

- The City of Phoenix will retain all enrollment and incentive eligibility materials. Information stored electronically will be protected, and no information you provide as part of the wellness program will be used in making any employment decision.
- Appropriate precautions will be taken to avoid any data breach. If a data breach occurs involving your information, you will be notified.
- Your individually identifiable genetic or medical information will be provided only to you (or a family member whom you authorize) and licensed health care professionals and staff involved in providing services under the wellness program. Your individually identifiable genetic or medical information will not be accessible to managers, supervisors, or others who make employment decisions for your spouse (or qualified domestic partner), or to anyone else in their workplace except as permitted by law. Your individually identifiable genetic or medical information will not be disclosed to the City of Phoenix except in aggregate terms that do not disclose the identity of specific individuals. That aggregate information will be treated as a confidential medical record.
- Your information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted or required by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements.

This Notice and Authorization does not restrict any rights you may have under the Americans with Disabilities Act or the Health Insurance Portability and Accountability Act (HIPAA). If the wellness program provides (directly, through reimbursement, or otherwise) medical care (including genetic counseling) the program may constitute a group health plan subject to HIPAA's privacy rules and you will receive a separate HIPAA privacy notice. If you have questions or concerns regarding this Notice and Authorization, or about protections against discrimination and retaliation, please contact Deputy Human Resources Director of Benefits and Wellness at (602) 262-4777.



## CONTINUATION COVERAGE RIGHTS UNDER COBRA INTRODUCTION

You're getting this notice because you may soon gain coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan.

**This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.**

When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

**You may have other options available to you when you lose group health coverage.** For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 31 calendar day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

## WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

## WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

**For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: the City of Phoenix Benefits Office at (602) 262-4777 or [benefits.questions@phoenix.gov](mailto:benefits.questions@phoenix.gov).**

## HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

### DISABILITY EXTENSION OF 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. Notify the City of Phoenix Benefits Office at (602) 262-4777 or [benefits.questions@phoenix.gov](mailto:benefits.questions@phoenix.gov).

### SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

## ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at [www.healthcare.gov](http://www.healthcare.gov).

## IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit [www.healthcare.gov](http://www.healthcare.gov).

## KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

## PLAN CONTACT INFORMATION

City of Phoenix  
Human Resources Department Benefits Office  
Attention: Benefits Supervisor  
251 W. Washington Street  
Phoenix, AZ 85003  
(602) 262-4777  
[Benefits.questions@phoenix.gov](mailto:Benefits.questions@phoenix.gov)



# NOTES

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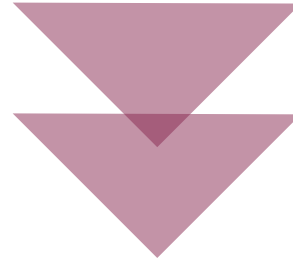
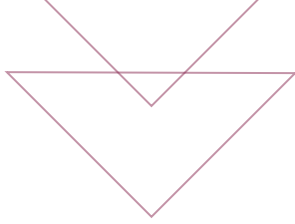
This guide highlights the main features of the City of Phoenix Employee Benefits Program. It does not include all plan rules, details, limitations, and exclusions. Please keep in mind that summary plan descriptions, coverage certificates, policies, contracts, and similar documents prevail when questions of coverage arise. City of Phoenix reserves the right to change or discontinue its employee benefits plans at any time.



# CONTACTS

City of Phoenix Benefits Office	Benefits Office: (602) 262-4777	
	<a href="mailto:benefits.questions@phoenix.gov">benefits.questions@phoenix.gov</a>	<a href="mailto:be.healthy@phoenix.gov">be.healthy@phoenix.gov</a>
Banner   Aetna	<a href="http://www.aetna.com/cityofphoenix">www.aetna.com/cityofphoenix</a>	
	24-Hour Health Information Line: (888) 747-7990	
	Maggie Perez Designated Representative (602) 495-5724 <a href="mailto:magdalena.perez@phoenix.gov">magdalena.perez@phoenix.gov</a> or <a href="mailto:perezm5@aetna.com">perezm5@aetna.com</a>	
98point6 Virtual Health Visits through Banner   Aetna	<a href="http://98point6.com/cityofphoenix/">98point6.com/cityofphoenix/</a> App: 98point6	
Blue Cross Blue Shield of Arizona	<a href="http://azblue.com">azblue.com</a>	
	Registration questions and password reset: (602) 864-4844	
	24-Hour Nurse On-call: (866) 422-2729	
	Michelle Walker Designated Representative (602) 534-5165 <a href="mailto:michelle.walker@phoenix.gov">michelle.walker@phoenix.gov</a> or <a href="mailto:michelle.walker@azblue.com">michelle.walker@azblue.com</a>	Member Services (602) 864-4857
BlueCare Anywhere Virtual Health Visits through BCBS of Arizona	<a href="http://BlueCareAnywhereAZ.com">BlueCareAnywhereAZ.com</a> App: BlueCare Anywhere APP	
HealthEquity Health Savings Account (HSA) for Savers Choice Health Plan (HDHP)	<a href="http://healthequity.com/phoenix">healthequity.com/phoenix</a>	
	Member Services: (877) 582-4793	
Elixir Pharmacy Benefits	<a href="http://phrx.envisionrx.com">phrx.envisionrx.com</a>	
	Preview code: PHRX. No registration necessary.  Designated Representative Kimberly Baker (602) 534-5370 <a href="mailto:kim.baker@phoenix.gov">kim.baker@phoenix.gov</a> Elixir Customer Service: (833) 803-4402 (24-hour assistance)	
ComPsych Guidance Resources Employee Assistance Program (EAP)	<a href="http://guidanceresources.com">guidanceresources.com</a> Web ID: PhoenixEAP App: GuidanceResources Now	
	Member Services: (602) 534-5433	





DCP Program 457b/401a/PEHP	<a href="mailto:dcp.benefits@phoenix.gov">dcp.benefits@phoenix.gov</a>
Nationwide Retirement Solutions	<a href="http://phoenixdcp.com">phoenixdcp.com</a> (800) 891-4749
Cigna Dental Benefits	<a href="http://mycigna.com">mycigna.com</a> (800) 244-6224 Registration questions and password reset: (800) 853-2713 Cigna Dental Representative: <a href="mailto:linda.sawyer@cigna.com">linda.sawyer@cigna.com</a>
Davis Vision Vision Buy-up Plan	<a href="http://DavisVision.com/members/">DavisVision.com/members/</a> (877) 923-2847 (access code 9613)
Connect Your Care Flexrap and COBRA	<a href="http://connectyourcare.com">connectyourcare.com</a> Member Services: (877) 292-4040
Minnesota Life Life Insurance Plan	<a href="http://lifebenefits.com/submiteoi">lifebenefits.com/submiteoi</a> Group Policy Number: 34390 Access Key: Phoenix (800) 872-2214
ARAG Legal Insurance Plan	<a href="http://araglegalcenter.com">araglegalcenter.com</a> Access Code: 16922phx Member Services: (800) 247-4184
MetLife Pet Insurance Plan	(800) GET-MET8 (800) 438-6388





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