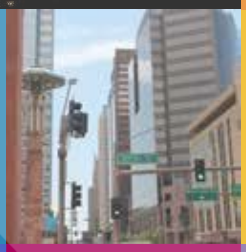

City of Phoenix

2022 EMPLOYEE BENEFITS GUIDE

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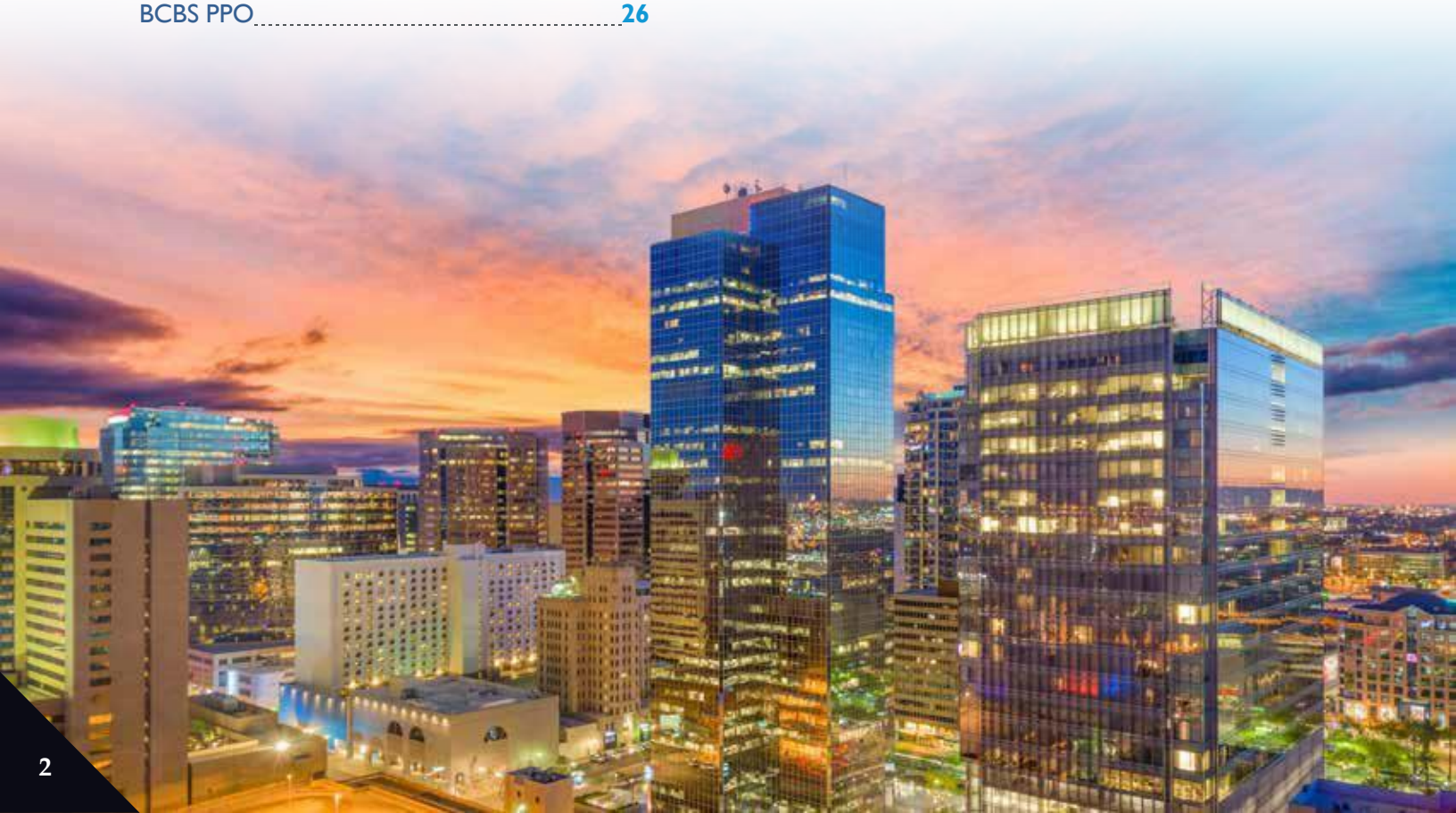

WE'RE GLAD YOU'RE HERE

As a City of Phoenix employee, you are a valuable contributor! Through your efficient delivery of exceptional public services, your work makes our city a great place to live, work, and play. The City is committed to supporting the health and well-being of you and your loved ones by offering an expansive benefits program as a core part of your total compensation.

Our benefits program offers you:

- Three distinct health plans: Saver's Choice Plan, HMO, and PPO
- Three dental plans: Dental PPO, Dental PPO Plus, and a Dental HMO
- A generous Vision Plan
- Health Savings Account when enrolled in the Saver's Choice medical plan
- Flexible Spending Accounts
- 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 2022 Employee Benefits Guide includes important information and updates about these City of Phoenix employee benefits. 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

Open Enrollment for 2022

October 18 through November 12 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**.

Find this guide and additional information at **phoenix.gov/benefits**.

2022 HIGHLIGHTS

The City of Phoenix is pleased to offer a competitive, comprehensive, and well-managed benefits package to you - a valuable employee who, through your efficient delivery of exceptional public services, make our city a great place to live, work, and play! The last few years have been difficult and the City's benefit plans are designed to offer support to you and your family so you can thrive even in days of uncertainty or distress. Here are a few of the highlights of the benefits designed to offer support to you and your family this year:

Mental & Emotional Health Support

It's been a tough year! The City of Phoenix is committed to supporting the mental and emotional health and well-being of you and your family.

The City of Phoenix Employee Assistance Program is a confidential service that focuses on assisting those struggling with personal problems that may be affecting their ability to function at home, work or in the community. EAP counselors focus on supporting employees with resources that set the foundation for the restoration or improvement of emotional and mental wellness.

- Family/Marital Problems
- Anxiety/Emotional Problems
- Stress Management Needs
- Substance/Alcohol Abuse
- Financial Problems
- Death of a Loved One
- Anger Management
- Domestic Violence
- Community Resources
- Eldercare and Caregiving Support

Full-time employees and their immediate family members can receive **12 face-to-face counseling sessions per person, per problem**, plus unlimited access to phone and web-video counseling services.

of our three medical plans: Saver's Choice, Banner | Aetna HMO, and BCBS PPO.

To access mental and emotional health support service, you can call (602)-534-5433 or visit **ComPsych Guidance Resources** (ID = PhoenixEAP)

Employee Healthcare Clinic

It's been a busy year! The City of Phoenix understands that, between adaptations at work and home, you are managing multiple priorities. When life gets busy, it's easy to put seeking medical care on the back burner. Our Employee Healthcare Clinic can help make access to helpful health and well-being resources easy and convenient for you and your family. Enrollment in a city-sponsored medical plan is required.

The Employee Healthcare Clinic is a great place to go when you need a wellness exam, need assistance in managing a chronic condition, or are dealing with an acute illness or injury. The Clinic has a dedicated Physician's Assistant and Part-time Medical Director, and you can establish a Primary Care Provider right in the clinic. For your convenience, there is an on-site laboratory and two in-network pharmacies located nearby.

With a supervisor's permission, you can visit the Clinic during work hours with up to 60 minutes of pay (depending on location and travel time).

High Quality Medical Coverage

It's been a year of an increased awareness about the important role of personal health and well-being for you and your family. Now, more than ever, it's important to stay up to date on preventive care and seek medical help when you need it. In 2022, you can experience the same plans you know and rely on. Most medical plan designs remain unchanged, but include a 7.2% overall rate increase. As the cost of health care continues to rise, rate increases are necessary to ensure sustainability in supporting our employees through high quality medical benefits for years to come. The Dental PPO and Dental PPO Plus plans reflect a 1.6% overall rate increase, but the Dental HMO plan rates remain unchanged.

Coverage through the Banner | Aetna HMO Plan is increasing by 4%, while retaining the advantage of paying no deductibles. HMO plan members will enjoy the added benefit of a decreased out of pocket maximum for both individual and family coverage, compared to last year.

Coverage through the BCBS Saver's Choice Plan is increasing by 4%, while retaining the unique features of our high deductible health plan, such as:

- Paying the lowest premium amounts, compared to the other plans
- The ability to work with in-network medical professionals that are part of a large, national network of over 10,000 local physicians and 30 hospitals
- The tax-advantaged Health Savings Account (HSA) that allows you to save and invest money to pay for current and long-term medical/retirement expenses, even after you have left employment with the City
- Generous annual contribution from the city to help fund your HSA account

Coverage through the BCBS PPO Plan is increasing by 13% in order to make the City's medical plan offerings sustainable, given the high costs associated with the PPO plan. Premium affordability is paramount for our employees, and that's why we are working year-round to improve choice and cost-efficient plans. If you are currently enrolled in the PPO plan, we encourage you to consider the following plan options:

- The Saver's Choice Plan gives you the ability to work with in-network medical professionals that are part of the same large, national network as your current BCBS PPO. To find an in-network provider, please visit www.azblue.com. Medical services are offered with no coinsurance paid by you once your deductible has been met. The Saver's Choice Plan gives you access to a Health Savings Account (HSA) that is funded by City contributions and any voluntary contributions made by you. You can use the HSA to pay your deductible costs and any out-of-network qualified healthcare services, as they are not covered by the Saver's Choice Plan. The Saver's Choice HSA is a great way to ensure sustainability of your quality medical care in the future. HSA funds are yours to keep and use, even after you leave City employment. Funds can be used to pay for qualified healthcare expenses in retirement.

- The Banner | Aetna HMO plan is also an affordable choice that features a large, national network of medical professionals. Benefits of the HMO plan include no deductibles and fixed copays.

City HSA Contributions Pro-Rated for New Hires

Effective January 1, 2022, City HSA contributions will be pro-rated monthly for the initial year of coverage for those newly hired or otherwise joining the Saver's Choice plan outside of Open Enrollment.

How will this impact you? If you are enrolled in the Saver's Choice plan for all of 2022, this change will not impact you at all. If you are joining the Saver's Choice at some point after January 1, 2022, either due to being a new hire or experiencing a Qualified Life Event (QLE), the 2022 City HSA contribution will be pro-rated monthly based on the effective date of your enrollment in the Saver's Choice plan. See the chart below for the pro-rated City HSA contribution amounts:

Saver's Choice HSA City Contribution*		
Saver's Choice Plan Effective Date	***Single***	***Family***
January 1	$1,125	$2,250
February 1	$1,031	$2,062
March 1	$938	$1,876
April 1	$844	$1,688
May 1	$750	$1,500
June 1	$656	$1,312
July 1	$563	$1,126
August 1	$469	$938
September 1	$375	$750
October 1	$281	$562
November 1	$188	$376
December 1	$94	$188

*If you go from single to family coverage due to a qualifying life event, the Benefits Office will contact you regarding your City HSA contribution.

GREETINGS FROM HCTB CHAIR

With the departure of Will Buividas as the Health Care Benefits Trust Board Chair, I would just like to take a moment to thank Mr. Buividas for his dedication in helping to provide our employees with competitive and comprehensive benefits and for the improvements and enhancements that occurred during his six-year tenure. I wish him well in his retirement and the new opportunities awaiting him.

The City Manager, Ed Zuercher, recently appointed me to fill Mr. Buividas' vacancy and I will work hard to make sure that City employees continue to have access to the very best benefits and price point possible during my term in this capacity as well as preserving and protecting the balance of the Health Care Benefits Trust Fund. I am a 21-year city employee and had served as the Unit 7 representative on the Health Care Task force since 2006 before this appointment. I hold a bachelor's degree in General Studies with an emphasis in Finance and a master's degree in Public Administration.

The Benefits Office, the Health Care Taskforce and the Health Care Benefits Trust Board will always work together to find the best vendors, products, and services possible for our most important assets, our employees.

The City of Phoenix continues to be a leader in managing the costs associated with benefits. Unfortunately, this also means that premium increases are required nearly annually to maintain a good balance between employee premium (20%), employer premium (80%) and the stabilization of the trust fund from which all claims are paid.

Open Enrollment for 2022 begins Monday, October 18, 2021 and closes at 5:00 p.m. sharp on Friday, November 12, 2021. Changes you make during this year's Open Enrollment go into effect on January 1, 2022. If you do nothing during Open Enrollment your current coverage will continue through 2022 except for Flexrap and your HSA Election. The IRS requires you to make an election during Open Enrollment if you wish to be enrolled in Flexrap in 2022.

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

Regards,

Colleen Ostrander, 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 **phoenix.gov/benefits**

This guide provides highlights of the City of Phoenix employee benefit plans, effective January 1, 2022. 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 2022. Committing to wellness and making smart health care decisions will add up to lower costs for both you and the City.

2022 MONTHLY RATES

Health Plan Premiums —Full-Time Employees

A deduction is taken from the first two paychecks of the month for that month's coverage (24 pay periods).

	Saver's Choice Plan with HSA		HMO		PPO	
	Employee	Family	Employee	Family	Employee	Family
Employee's Premium	$95.71	$303.85	$113.94	$361.71	$134.62	$427.37
Paycheck Deduction	**$47.85**	**$151.92**	**$56.97**	**$180.85**	**$67.31**	**$213.68**
City's Portion	$382.86	$1,215.40	$455.75	$1,446.82	$538.49	$1,709.46
Full Premium	$478.57	$1,519.25	$569.69	$1,808.53	$673.11	$2,136.83

Health Plan Premiums —Job Share Employees

A deduction is taken from the first two paychecks of the month for that month's coverage (24 pay periods).

	Saver's Choice Plan with HSA		HMO		PPO	
	Employee	Family	Employee	Family	Employee	Family
Employee's Premium	$287.14	$911.55	$341.81	$1,085.12	$403.86	$1,282.10
Paycheck Deduction	**$143.56**	**$455.77**	**$170.90**	**$542.55**	**$201.93**	**$641.04**
City's Portion	$191.43	$607.70	$227.88	$723.41	$269.25	$854.73
Full Premium	$478.57	$1,519.25	$569.69	$1,808.53	$673.11	$2,136.83

Dental Premiums—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
Paycheck Deduction	**$0.00**	**$18.82**	**$0.00**	**$35.27**	**$5.28**	**$49.79**
City's Portion	$27.32	$56.48	$51.17	$105.79	$51.17	$105.79
Full Premium	$27.32	$75.30	$51.17	$141.06	$56.45	$155.58

Dental Premiums —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
Paycheck Deduction	**$13.66**	**$47.06**	**$25.58**	**$88.16**	**$30.86**	**$102.68**
City's Portion	$13.66	$28.24	$25.59	$52.90	$25.59	$52.90
Full Premium	$27.32	$75.30	$51.17	$141.06	$56.45	$155.58

Buy-up Vision Plan Premium—All Employees

A deduction is taken from the first two paychecks of the month for that month's coverage (24 pay periods).

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

2022 MONTHLY RATES

Optional Life Insurance Premiums —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 of QDP Age
	2022	2022
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 Premium

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

	Value Plan	Full Plan
	Employee/Family	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

Wellness Programs & Resources

The City recognizes that you, our employee, are our most valuable asset in fulfilling our mission to deliver exceptional and efficient services that make our city great! Through the **Fit4Phoenix Wellness Program**, you can find tools to help you adopt and maintain good health habits to gain and sustain the energy you need to be your best—both at work and at home.

The Fit4Phoenix Program takes a holistic approach, offering programs in the following areas:

- Nutrition programs
- Weight Watchers
- Fitness/Step challenges
- Gym discounts (YMCA & KROC Community Center)
- Work/life balance
- Wellness classes

Wellness Incentive

Incentive Requirements Met By…	Potential Earnings:*
Employee ***or*** Covered Spouse/QDP	$40/month
Employee ***and*** Covered Spouse/QDP	$60/month

*Earnings are paid out bi-weekly and are subject to applicable federal and/or state tax withholdings.

To learn more about the **Fit4Phoenix Wellness Programs and the Wellness Incentive**, visit: https://cityofphoenix.sharepoint.com/sites/hr/benefits/wellness

For questions about wellness programs, email **be.healthy@phoenix.gov**

To earn the incentive:

Step 1: Visit Your Primary Care Provider (PCP). A PCP is a family practice doctor, general practitioner, an internist or an OBY/GYN in your City of Phoenix employee plan network to get your seven pieces of biometric data (HDL cholesterol, total cholesterol, blood glucose, waist circumference, height, weight, and blood pressure)

Step 2: Health Assessment (Real Age Test)

Complete the Real Age Test by visiting the **cityofphoenix.sharecare.com** portal and clicking on "Create an Account." To complete the Real Age Test, you will need both your biometric data and your health insurance ID#. Follow the prompts to complete the Real Age Test. A spouse or QDP must have their own User ID and password on the website and log in separately to complete their own Real Age Test. For more information, call 877-292-1359.

Step 3: Check Your Paystub

Once you and/or your covered spouse/QDP complete the HRA within the **same calendar year**, your wellness incentive will show up on your paycheck (under" Hours and Earnings") about 30 days after your completion of incentive requirements has been reported by insurance carriers. 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 2022. If you miss the deadline, you can still complete your HRA; however, you will not see the incentive on your first paycheck of January 2022.

HEALTH CLINIC

The City of Phoenix understands that, between work and home, you are managing multiple priorities and your life gets busy! Our Employee Health Clinic can help make access to helpful health and well-being resources easy and convenient for you and your family! The Clinic has a dedicated Physician's Assistant and Part-time Medical Director, and you can establish a Primary Care Provider.

Clinic Services:

Wellness
Wellness Exam
Flu Shots
Biometric Screening

Health Management
Hypertension
Diabetes
Hyperlipidemia
Behavioral Health
Medication Management

Acute Illness or Injury
Strep Throat
Flu
Bronchitis
Allergies
Urinary Tract Infections

Personal Injury
Sprains/Strains
Wound Care

Onsite Laboratory

Clinic Details:

Location:
1 N. Central Avenue
Phoenix, AZ 85003
(N.W. Corner of 1st St. & Washington St.)

Hours:
7 a.m. to 6 p.m.
Monday through Friday

To schedule an appointment:
Use the Clockwise App

Where to park:
Use the One N. Central parking structure (visitor spaces on levels B-1 to B-4). Parking ticket validated at Clinic.

What is the cost?
Banner | Aetna HMO members and BCBS PPO members can visit the clinic at no cost. Saver's Choice Plan members will pay a $20 copay until deducible is met. **There is no cost for preventive care.**

For your convenience:
If you need to get a prescription filled, there are two in-network pharmacies (Fry's Grocery Store and CVS) adjacent to the Clinic where you can fill your prescriptions.

For Questions:

Call: (602) 255-7651

Email:
benefits.questions@phoenix.gov

Can I go to the Clinic during work hours?

With a supervisor's permission, employees will be able to attend appointments during work hours with up to 60 minutes of pay (depending on location and travel time). Employees who are based in facilities on the outskirts of the City should talk to their HR representative.

ELIGIBILITY

Eligible Employees

To be eligible for benefits you must be a full-time benefit eligible City employee. Benefits are effective on the 1st of the month following the employee's date of hire. Please see plan documents for specific eligibility requirements for each benefit plan.

Eligible Dependents

DEPENDENT CATEGORY	YES	NO
Your legally married spouse (including same-sex)	X	
Your Qualified Domestic Partner (QDP) (approval process required)	X	
Your ex-spouse or former Qualified Domestic Partner (QDP)		X
Your biological children up to age 26	X	
Your adopted children/children placed with you for adoption up to age 26	X	
Your stepchildren up to age 26 (so long as you are legally married to their parent)	X	
Your QDP's biological children up to age 26 (so long as the qualified domestic partnership is approved and intact)	X	
Children of your ex-spouse or former QDP that are **not** your biological or adopted children		X
Children up to age 26 who live with you for whom you have legal custody or court-approved guardianship (until custody/guardianship expires)	X	
A dependent actively serving in the military		X
A dependent who is currently incarcerated in prison		X
Your parent(s) or parent(s)-in-law		X

Important Information!

Documentation Requirements for Enrolling Dependents

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** 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** or (602) 262-4777.

Removal of Ineligible Dependents

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

Important Note:
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.

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 must be completed through **eChris Self-Service** within 31 days of the qualifying life event. Please contact the Benefits Office for assistance at **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 will 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 Dependent 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

BCBS Saver's Choice w/HSA

May be for you if you like:

- Good medical coverage at the **lowest premium** cost
- Not having to pay coinsurance after your deductible has been met
- Having the flexibility to pay for qualified health care expenses by using **a Health Savings Account (HSA)** all tax free
- To **save and invest money tax-free** that can be used to cover healthcare expenses after you leave the City and can be used for non-medical expenses after the age of 65

Banner | Aetna HMO

May be for you if you like:

- Good medical coverage with **no deductibles**
- Predictable medical expenses **with fixed copays**
- Having the convenience of working with **a Primary Care Physician (PCP)** to coordinate your medical care with specialists
- Lower out-of-pocket maximum costs compared to last year

BCBS PPO

May be for you if you like:

- The option of seeing **out-of-network providers** and don't mind paying extra for it.
- Not having to meet your **deductible** every year. 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

All three plans have these 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

Choosing Your Health Plan – Things to Think About

	Saver's 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	$4,000 for single coverage, $8,000 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 HealthSavings Account	The HMO plan has copays only	The PPO is the only plan with out-of-network coverage

BCBS SAVER'S CHOICE PLAN WITH HSA

The Lowest Health Plan Premium

Key Features of Saver's Choice

Provider Network	Large, national network (same as BCBS PPO) that contains 10,000 local physicians and over 30 hospitals. Coverage is for in-network providers only, except for emergencies.
Lowest Premium Rates (monthly paycheck deduction)	**Individual Coverage:** $95.71/month **Family Coverage**: $303.85/month
Deductible	**Individual Coverage:** $1,500 per calendar year **Family Coverage:** $3,000 per calendar year
Coinsurance	No coinsurance once annual deductible has been met.
Maximum annual out-of-pocket cost	**Individual Coverage:** $1,500 (medical) + prescription copays up to $3,000 after which the Plan pays 100% of health care expenses **Family Coverage:** $3,000 (medical) + prescription copays up to $6,000 after which the Plan pays 100% of health care expenses
Health Savings Account (HSA) funded by City contributions and your voluntary contributions	The City contributes 75% of your annual deductible to your HSA to help your cover your health care expenses. **Individual Coverage Contribution*:** $1,125 **Family Coverage Contribution*:** $2,250

*Effective January 1, 2022, City HSA contributions will be pro-rated monthly for the initial year of coverage for those newly hired or otherwise joining the Saver's Choice plan outside of Open Enrollment

Retiring soon?

Please pay special attention before deciding to enroll in the Saver's Choice Plan (with HSA) if retirement is in your near future. Your enrollment in Medicare and any supplemental Medicare plans impacts how you may invest in and use funds associated with your HSA. Please see **IRS Publication 969** for details.

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

Find a BCBS Provider

- Visit **www.azblue.com**
- Click on "Find a Doctor/Rx"
- Click on the option that best describes you, and follow the prompts

How the Saver's Choice Plan Works

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

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 Saver's Choice Plan or PPO.

BlueCare Anywhere visits are provided at no cost to PPO plan members and for a $20 copay per visit for Saver's 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**
- Fill out a questionnaire and select your provider type
- Saver's Choice Plan members pay a **$20 copay** which is applied to the annual deductible. 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

Mobile App: BlueCare Anywhere APP

To contact our onsite BCBS representative:

Email: michelle.walker@azblue.com or Michelle.walker@phoenix.gov

Call Michelle: (602) 534-5165

HEALTH SAVINGS ACCOUNT (HSA)

Part of the Saver's Choice Health Plan

Administered by HealthEquity

Benefits of HSAs:

Pay for health care expenses
You can use your HealthEquity debit card to conveniently pay for medical, prescription drug, dental, vision, and over-the-counter expenses. For a list of qualified health care expenses, see **IRS Publication 969.**

Important Note: You cannot use an HSA to pay for health care expenses incurred by a domestic partner.

Enjoy tax savings
When you use your HealthEquity HSA account, you can enjoy tax savings in three ways:

1. Pay for qualified health care expenses tax-free
2. Contribute to your HSA tax-free
3. Earn interest on unused HSA funds tax-free (once HSA reaches a certain amount)

Important Note: Be sure to review IRS rules before making HSA contributions if you will turn 65 during the year.

Take it with you into your future
Money left in your HSA at the end of each year rolls over to the next year, including the City's contribution. 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 also 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).

Enrollment Information

You must be enrolled in the BCBS Saver's Choice medical plan to be eligible for the HSA. You are automatically enrolled in the HSA when you elect the Saver's 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 Saver's 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.

You cannot be enrolled in the HSA if:

- You are enrolled in other non-HSA eligible health coverage, including a spouse's group health plan, Flexible Spending Account (FSA), or Medicare. *Exception: You can enroll in a limited-purpose FSA and an HSA health plan at the same time*
- You are claimed as a dependent on someone else's tax return

Don't Forget!

Your voluntary paycheck contribution amounts do not roll over to the next year. Indicate your desired contribution amount each year at Open Enrollment. You can change your contribution amount at any time throughout the year.

How the HSA Works

Step 1:
Enroll in the BCBS Saver's Choice Plan with HSA. Per IRS rules, this is the only health plan the City offers with an HSA. You will then receive an HSA welcome kit and HSA debit card from HealthEquity.

Step 2:
Activate the debit card. Use the debit card to pay for out-of-pocket expenses such as copays, coinsurance, and deductibles, or pay online at **www.healthequity.com**.

Step 3:
At Open Enrollment time, select the amount of your voluntary contributions to your HSA.* The HSA contribution limits for 2022 are $3,650 for single coverage and $7,300 for family coverage. In addition, there is a $1,000 additional "catch up" amount for employees 55 or older.

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Step 4:
Check your HSA account for the City's contribution given 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. Note that the amount given by the City will be pro-rated monthly for new hires and those otherwise enrolling in the Saver's Choice plan outside of Open Enrollment (for the initial year of coverage).

Step 5: Check your paystub. 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**.

Step 6: Use your HSA account to conveniently pay for qualified health care expenses (see **IRS Publication 969**).

***Important Note:** Employees may contribute to their HSA on a pre-tax basis only while enrolled in the BCBS Saver's Choice Plan. If you later switch to the HMO or PPO plan, you can no longer contribute to the HSA.

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 Saver's 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** and **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.

Key Features of HMO Plan:

Provider Network	National and local network of providers that contains almost 2,000 primary care physicians, over 8,000 specialists, 120 urgent care centers, 23 hospitals (including Phoenix Children's Hospital), and 12 Banner Health Centers offering primary and specialty care under one roof.
Reasonable Premium Rates (monthly paycheck deduction)	**Individual Coverage:** $113.94/month **Family Coverage**: $361.71/month
Deductible	**No Deductibles**
Copays	Fixed copays for most medical services
Maximum annual out-of-pocket cost	**Individual Coverage:** Medical: $1,500 or $2,500 (depending on network) Pharmacy: $1,500 **Family Coverage:** Medical: $3,000 or $5,000 (depending on network) Pharmacy: $3,000

To contact our onsite Banner | Aetna representative:

Email: PerezM5@aetna.com or Magdalena.Perez@phoenix.gov

Call Maggie: (602) 495-5724

Banner | Aetna

(888) 747-7990

www.aetna.com/cityofphoenix

To find a provider:

1. Visit the www.aetna.com/cityofphoenix website
2. Search for HMO providers within the Performance Network (lower copays) or the Broad Network (slightly higher copays)

Banner | aetna™

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

98point6 delivers on-demand diagnosis and treatment from board-certified physicians by secure in-app messaging to include:

- Ordering of prescription drugs and labs
- Outlining care options
- Providing audio and video support
- Referring you to Banner | Aetna HMO network specialists and other resources
- Sending follow-up reminders

✔ $0 Copay

98point6

98point6 mobile app

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.

Key Features of PPO Plan:

Provider Network	Large, national network (same as BCBS Saver's Choice Plan) that contains 10,000 local physicians and 30 hospitals, including Mayo Clinic, Phoenix Children's Hospital, and St. Joseph's Hospital.
Highest Premium Rates (monthly paycheck deduction)	**Individual Coverage:** $134.62/month **Family Coverage**: $427.37/month
Deductible	**In-Network:** Individual: $300/calendar year Family: Capped at $900/year (family of 3 or more) **Out-of-Network:** Individual: $600/calendar year Family: Capped at $1,800/year (family of 3 or more)
Coinsurance	**In-Network:** 20% **Out-of-Network:** 30%
Maximum annual out-of-pocket cost	**In-Network:** **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 **Out-of-Network:** **Medical:** $1,500 per covered member to a maximum of $4,500 per family of 3 or more. **Pharmacy:** Not covered

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 "balanced billing." It is your responsibility topay 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.

BlueCross BlueShield Arizona

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.

To contact our onsite BCBS representative:

Email: michelle.walker@azblue.com or Michelle.walker@phoenix.gov

Call Michelle: (602) 534-5165

BCBS of Arizona

(602) 864-4857

www.azblue.com

Find a BCBS PPO Provider

- Visit **www.azblue.com**.
- Click on "Find a Doctor/Rx."
- Click on the option that best describes you, and follow the prompts.

How the BCBS PPO Works

When you use in-network providers:

Copay	You pay a small fee at the time of service for a few services such as pre-natal care or vision exam.
Deductible	For most services you pay 100% of the contracted costs until you meet the annual per-person deductible.
Coinsurance	After meeting the deductible, you pay 20% (in-network) or 30% (out-of-network) of the contracted costs until you reach $900 out-of-pocket (per person), including the deductible.
Out-of-pocket Maximum	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	Saver's 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%	30%
Calendar Year Out-of-Pocket Maximum for Medical Services	Medical Performance Network Single: $1,500 Family: $3,000 Broad Network Single: $2,500 Family: $5,000 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	Medical $1,500 per covered member to a maximum of $4,500 per family of 3 or more. Pharmacy 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	Saver's Choice Health Plan	PPO	
	In-Network Only	**In-Network Only**	**In-Network**	**Out-of-Network**
Prenatal Office Visits	No charge for office visits Max. co-pay for add'l Maternity tests/services Performance Network $300/year Broad Network $450/year	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: $20		Plan pays 80% of the contracted rate after the calendar yeardeductible 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	Performance Network: $75 Broad Network: $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	One every other year per ear			
Eye Exam with Optometrist Every 12 months	$25	Plan pays 100% of the contracted rate after the calendar year deductible is met.	$25	Not covered
Chiropractic 36 visits max per plan year	36 visits per year	36 visits per year	36 visits per year	
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		$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

To contact our onsite Elixir representative:

Email: **kimbaker@elixirsolutions.com** or **Kim.baker@phoenix.gov**

Call Kim: (602) 534-5370

Save Money!

Order 90-days' worth of medication from one of our three retail pharmacies (CVS, Target, or Fry's) or by mail order through Elixir. (Pay only 2 copays for 3-months' worth of medication!)

Also consider generics: often equally effective as brand-name medications while saving significant money!

Elixir Customer Care

(833) 803-4402

www.elixirsolutions.com

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:

Banner | Aetna	Call Maggie at (602) 495-5724 PerezM5@aetna.com
BlueCross/ BlueShield	Call Michelle at (602) 534-5165 michelle.walker@azblue.com
Elixir	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 Saver's 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 Saver's 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

It's been a tough year. The City of Phoenix understands that pandemic living has not been easy and that you and your family may have experienced anxiety, disruption, and grief. The City is committed to supporting the mental and emotional well-being of our employees and their family members. We offer an Employee Assistance Program (EAP) through ComPsych Guidance Services that offers assistance to employees.

Short-term Counseling

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℠, assessments, Q&As, videos, and podcasts for emotional health, fitness, financial and legal issues, and more.
- Search the online elder care and childcare directories.

ComPsych Guidance Resources
(602) 534-5433
guidanceresources.com
Web ID = PhoenixEAP
Mobile App: GuidanceNow®

Need Long-term Counseling?

All three of our medical plans offer behavioral health services. The EAP can provide medical plan participants with in-network referrals so you can get the assistance that you need. For an overview of behavioral health services offered through our medical plans, please page 32.

ComPsych®
GuidanceResources® Worldwide

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.

Traumatic Event Counseling for Officers and Firefighters (ARS 38-673)

Sworn Firefighters and Police Officers who have experienced a traumatic event on duty and need counseling 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** 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

CIGNA DENTAL PLANS

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

Now is the time to get caught up on dental care! The pandemic caused an increase in stress-related dental problems and a decreased utilization of dental care benefits. Preserve your teeth and your smile for years to come!

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 with no annual maximum
- There is no deductible and no out-of-pocket cost for preventive services
- 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 bycalling Cigna Dental at (800) 244-6224 or visit **myCigna.com**
- 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

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 Dental Care Access Plus Network	Cigna Total DPPO Network	Any licensed dentist	Cigna Total DPPO 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	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, please contact your Cigna Dental Representative: Donna Gallifant at Donna.Gallifant@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 (included in Medical Plans)

These benefits are automatically included in your health plan. Vision expenses can be applied to the Saver's Choice plan deductible.

Core Vision Coverage	
Maximum Annual Benefit (Saver's Choice)	$500 maximum for eyewear (glasses and contacts combined)
Exam every 12 months (HMO and PPO)	$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

These additional vision benefits can be purchased through an employee paycheck deduction to provide a low-cost basic eye exam each year along with coverage for eyeglasses and contact lenses.

Vision Care Service	In-Network Benefit	Out-of-Network Reimbursement
Eye Exam, Glasses	$10 Copay	Up to $40
Materials		
Frame Allowance	$175 retail value, including at participating Walmart, Costco and Sam's Club retailers	Up to $50
Single Vision Lenses	Included	Up to $40
Progressive or Bifocal Lenses	Included	Up to $60
Trifocal, Lenticular Lenses	Included	Up to $80

DavisVision™

Davis Vision

(877) 923-2847

[Access Code: 9613]

For more information, or to find an in-network provider, go to:

https://davisvision.com/members/

Vision Care Service	In-Network Benefit	Out-of-Network Reimbursement
Polycarbonate Lenses (adults & children)	Included	N/A
Standard Scratch Resistant Coating	$30 premium	N/A
Standard Tint (all gradients)	Included	N/A
Standard Anti-Reflective Coating	Included	N/A
Transitions	Included	N/A
Contact Lenses		
Elective	$175 allowance	Up to $175
Medically Necessary	Included with prior approval	Up to $250
Standard Contact Lens Fit and Follow Up	Included	N/A
Specialty or First-Time Contact Lens Fit and Follow Up	$60 allowance + 15% discount on overage	N/A
Frequency		
Eye Examination	Once every calendar year	
Lenses, Contact Lenses	Once every calendar year	
Frames	Once every calendar year	
Sunglasses	Free at Prime Eye locations (Limitations apply)	

How much does the Davis Vision Buy-Up Plan cost?

If you sign up for the Vision Buy-Up Plan, you will see a paycheck deduction in the **first two paychecks of each month:**

Employees = $5.54
Family = $13.06

Note: 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

Flexible Spending Accounts (FSAs)

A tax-free way to pay for extra expenses

Medical, childcare, and eldercare costs can contribute to financial stress! Flexible Spending Accounts can help you to save and pay for eligible health care and day care expenses with pre-tax dollars.

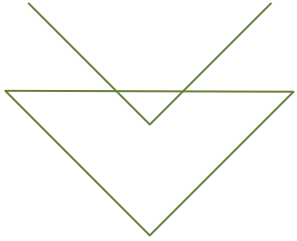
Important Information

Flexrap enrollment does not automatically roll over from one year to the next. Annual re-enrollment is required!

Compare the 3 Types of FSAs Offered:

	Healthcare FSA	Limited Purpose Healthcare FSA	Dependent Care FSA
Who can participate?	Any employee that is ***not*** enrolled in HSA	Employees that ***are enrolled*** in the HSA	All employees
What does it pay for?	Eligible medical, vision, dental expenses, as well as other approved health care expenses Click **here** for a list of eligible expenses	Eligible dental and vision expenses *only* Click **here** for a list of eligible expenses	Eligible day care expenses for children up to age 13 (childcare must be for care while you are working, if married, your spouse also works or attends school full-time) Eligible care expenses for dependent adults Click **here** for a list of eligible expenses
How much can I contribute?*	Up to $2,750*	Up to $2,750*	Up to $5,000 ($2,500 if married and filing separate tax returns)*
When do I enroll?	Every year at Open Enrollment, when newly hired, or when you experience an eligible life event		
How does the FSA impact my paycheck?	**Existing employees:** Annual contribution will be divided into equal deductions over 24 paychecks. Your entire annual contribution amount is available to you after your first contribution. **Newly eligible employees**: Your contributions will be divided over the remaining pay checks through the end of the year, (not more than two paychecks per month).		
What happens if I don't use it?	The Consolidated Appropriations Act of 2021 (the "Act") provides relief for flexible spending accounts ("FSAs"), impacting both health and dependent care FSAs. The City adopted a 12-month grace period that provides employees the flexibility to spend down 2021 funds through December 31, 2022, for eligible expenses incurred through December 31, 2022. All unspent 2021 funds will be forfeited after December 31, 2022. However for the plan year ending in 2022, the grace period will be limited to the first 2 ½ months of the 2023 plan year.		
How do I get reimbursed?	Use your OPTUM Financial/Connect Your Care debit card, or log on to **www.connectyourcare.com** or **www.optum.com/financial**		
IMPORTANT: Why are there two different debit cards?	Starting in 2022, Optum Financial will be moving from VISA to Mastercard to offer enhanced card security. Employees will continue to use their existing cards until they expire or are reported as lost or stolen. FSA participants who have already received a Connect Your Care debit card with an expiration date of 01/24 can continue using that card through 2024.		

***Maximum contribution amounts are subject to change once 2022 contribution limits are announced by the IRS.**



OPTUM Financial | Connect Your Care

Annual enrollment in FSA benefits 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**. Submit your expenses for reimbursement online, by fax, by mail, or via the Optum Financial 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** (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 Optum Financial.

Important Information:

When you file an FSA claim, you may be contacted regarding further information about your expenditure that is needed to process the claim. While this does not happen often, please be aware that being contacted to provide further information does not mean that the claim is ineligible for reimbursement. Simply submit the needed documentation so that your claim can be processed, and you can receive your reimbursement as soon as possible.

Important Information

The IRS has traditionally imposed a "use it or lose it" rule. 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 would be forfeited. The IRS has made an exception for the 2021 plan year, but it is unclear which limits will apply in 2022.

Be sure to review the grace period information on page 39, and 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

Mobile app: Optum Financial

LIFE INSURANCE

Securian – Minnesota Life

You provide for your family and you want to protect them. The City of Phoenix understands that you worry about what would happen to them should something unfortunate happen to you. Because the City is dedicated to the well-being of both you and your family, we offer several insurance benefits to employees to set their minds at ease about their family's financial future.

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.

Basic Life Insurance Coverage	
Unit 1	$15,000
Unit 2	The greater of $25,000 or 1x base salary
Unit 3	The greater of $25,000 or 1x base salary
Unit 4	$15,000
Unit 5	1x base salary
Unit 6	1x base salary
Unit 7	The greater of $25,000 or 1x base salary
Unit 8	1.5x base salary
Unit 9	1.5x base salary (up to $500K)
Unit 10	1.75x base salary (up to $500K)

Accelerated Benefit

Basic and Optional Life Insurance includes 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 (continued)	
Unit 11	1.75x base salary (up to $500K)
Unit 12	2x base salary (up to $500K)
Unit 16	1.5x base salary (up to $500K)
Unit 17	1.5x base salary (up to $500K)
Unit 18	1.75x base salary (up to $500K)
Unit 19	1.75x base salary (up to $500K)

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.

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	Employee	Spouse or Qualified Domestic Partner (QDP)	Child(ren)
Optional Life Insurance Amounts Available **NEW EMPLOYEES:** During your first 31 days of employment, you have a ONE TIME OPPORTUNITY to elect up to $150,000 of Optional Life Insurance and/or up to $50,000 for your spouse or QDP without having to provide Evidence of Insurability to the insurance company (Guaranteed Issue).	Increments of $10,000 up to $250,000 Increments of $50,000 from $250,000 to $500,000	Increments of $10,000 up to $300,000 The spouse coverage amount cannot be more than the employee's combined amount of Basic Life Insurance and Optional Life Insurance (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.	Amounts of $10,000, $15,000, $20,000, or $25,000 One election covers all eligible children at one premium rate.
How do I request an increase in coverage or cancel coverage?	Make your request for increase in coverage through eCHRIS Self-Service, our online enrollment system	Make your request for increase in coverage through eCHRIS Self-Service, our online enrollment system	Make your request for increase in coverage through eCHRIS Self-Service, our online enrollment system
When is Evidence of Insurability (Underwriting) Required?	Required for coverage amounts over $150,000 Required for coverage increases of $20,000 for an amount that exceeds $150,000 or more	Not required for those already enrolled for up to $40,000 in spouse or QDP life insurance electing to increase coverage to up to $50,000 Required for all other spouse/QDP coverage requests	Not Required
Do I need to name a beneficiary?	Employee must name a beneficiary	Employee is automatically named as the beneficiary	Employee is automatically named as the beneficiary
When does approved coverage become effective?	First of the month following underwriting approval	First of the month following underwriting approval	First of the month following election
When is coverage reduced or stopped?	Employee coverage is automatically reduced to: 65% at age 70 45% at age 75 30% at age 80	Coverage stops when spouse/QDP reaches age 70	Coverage automatically stops when the child reaches age 26

Submission of Evidence of Insurability (Underwriting)
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 qualified domestic partner (QDP), and eligible children, to call on for a wide variety of legal needs. 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. Network attorney fees are 100% paid in full for most covered matters.

- 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, tax advice and discounted tax preparation assistance
- Legal insurance plans are elected during open enrollment and last for the calendar year

Both legal insurance 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

- $1 million Identity theft insurance
- Full-service identity restoration
- Single-bureau credit monitoring
- Internet surveillance
- Change-of-address monitoring
- Child identity monitoring
- Lost wallet services

ARAG

Legal Insurance

ARAG Legal

(800) 247-4184

ARAGlegal.com/plans

(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** to apply for a loan.

TrueConnect

TrueConnect
(561) 270-5981
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 2022 through MetLife. Benefits include:

- Call MetLIfe to elect a coverage level customized to your needs and **say you are from the City for a 10% rate discount**
- Rates will vary based on elected deductible, benefit maximum, and pet age, breed, and ZIP
- Use any licensed veterinarian or animal hospital
- Up to 100% coverage for ear infections, prescriptions, rashes, poisoning, broken bones, cuts, cancer, diabetes, allergies, X-rays, surgery, and hospitalization
- You may also elect up to 100% coverage for exams, vaccinations, spaying or neutering, and dental care
- Elect pet insurance anytime during the calendar year. Premiums are paid directly to MetLife (premiums are not paycheck deductible)

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

SAVING FOR RETIREMENT

Building Your Future Together

Your investment of time, dedication, and talent is what makes the City of Phoenix a great place to live, work, and play! The City is committed to providing you with opportunities to save for retirement so that you can look forward to a secure and satisfying future once your employment with the City has ended.

The City's Deferred Compensation Board of Trustees (made up of community members, City management, and union representatives) is pleased to offer you five ways to save for your retirement expenses:

Traditional 457(b)

Roth 457(b)

401(a)

Post-Employment Health Plan (PEHP)

Saver's Choice HSA

The Deferred Compensation Plan (DCP) program is administered by the City's HR Department – Benefits Division. These retirement vehicles are in addition to your pension plan.

Nationwide Retirement Solutions 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 available 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
(800) 891-4749

CITY OF PHOENIX
DEFERRED COMPENSATION PLANS
Building your future together

Benefit Category	City Contribution to Your 401(a) Account
	July 12, 2021 - June 30, 2023
001	0.45%
002	3.62%
003	2.36%
004	2.56%
005	4.42%
006	0.05%
007	6.50%
008	1.92%
009, 010, 011, 016, 017, 018, 019	9.0% or $9,500 annually (whichever is greater)

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**. Contribution elections are not made on eCHRIS.

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

Viewing Your DCP Accounts

To manage investments, adjust 457(b) contributions, elect an automatic annual contribution increase *(new feature!)*, or register for workshops, go to **phoenixdcp.com** or email questions to **dcp.benefits@phoenix.gov**.

HOW TO ENROLL IN BENEFITS

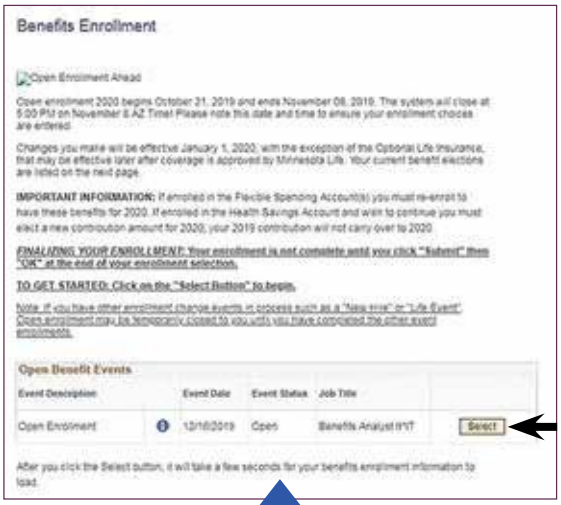
Enroll Online Through eCHRIS Self-Service

1. Logging in:
   - Go to **https://hcmprod.phoenix.gov/psp/hcmprod/** (From a work computer, go to **hr.phoenix.gov**)
   - 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
2. Click on the Benefits tile as shown next to the arrow
3. On the left side of the screen, locate and click on Benefits Enrollment as shown next to the arrow
4. Follow the on-screen prompts to enroll in your benefits for 2022

1

2

3



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CONTACTS

Contact the City of Phoenix Benefits Office if:

- You have a question about benefits eligibility
- You have a question about Open Enrollment
- You have a question about making a change in your benefits enrollment
- You need to elect or update a beneficiary
- You have a question about the Fit4Phoenix Wellness Program or Incentive
- You have an unresolved problem with one of our benefits vendors

Contact our Benefits vendors if:

- You want specific information about services
- You need assistance finding a provider
- You need to order a new benefits ID card
- You need to submit a claim
- You need an update on the status of your claim
- You have a question about your claim
- You need to dispute a claim

City of Phoenix Benefits Office

Visit: www.phoenix.gov/benefits

Email:

For Benefits:
benefits.questions@phoenix.gov
For Wellness:
be.healthy@phoenix.gov
For Deferred Compensation Program:
dcp.benefits@phoenix.gov

Call: (602) 262-4777

Benefits Vendor	Contact Information	
Banner | Aetna	**www.aetna.com/cityofphoenix**	
	24-Hour Customer Service Line: (855) 220-6506	
	Maggie Perez Onsite Representative (602) 495-5724 **Magdalena.Perez@phoenix.gov** or **Perezm5@aetna.com**	
98point6 Virtual Health Visits through Banner | Aetna	**98point6.com/cityofphoenix/** App: 98point6	
Blue Cross Blue Shield of Arizona	**azblue.com** Registration questions and password reset: (602) 864-4844	
	24-Hour Nurse On-call: (866) 422-2729	
	Esteban Romero Designated Representative (602) 534-5165 **Esteban.Romero@phoenix.gov** or **Esteban.Romero@azblue.com**	Member Services: (602) 864-4857

Benefits Vendor	Contact Information
BlueCare Anywhere Virtual Health Visits throughBCBS of Arizona	**BlueCareAnywhereAZ.com** App: BlueCare Anywhere APP
HealthEquity Health Savings Account (HSA) for Saver's Choice Health Plan (HDHP)	**healthequity.com/phoenix** Member Services: (877) 582-4793
Elixir Pharmacy Benefits	**phxrx.envisionrx.com** Preview code: PHXRX. No registration necessary.
	Designated Representative Kimberly Baker (602) 534-5370 **Kim.Baker@phoenix.gov** or **Kibaker@elixirsolutions.com** Elixir Customer Service: (833) 803-4402 (24-hour assistance)
ComPsych Guidance Resources Employee Assistance Program (EAP) Elder Care Services	**guidanceresources.com** Web ID: PhoenixEAP App: GuidanceNow® Member Services: (602) 534-5433
DCP Program 457b/401a/PEHP	**dcp.benefits@phoenix.gov**
Nationwide Retirement Solutions	**phoenixdcp.com** Phoenix Nationwide Office: (602)-266-2733
Cigna Dental Benefits	**mycigna.com** (800) 244-6224 Registration questions and password reset: (800) 853-2713 Cigna Dental Representative: **Donna.Gallifant@cigna.com**
Davis Vision Vision Buy-up Plan	**DavisVision.com/members/** (800) 999-5431 (access code 9613)
OPTUM | Connect Your Care Flexrap and COBRA	**connectyourcare.com** Member Services: (877) 292-4040
Minnesota Life Life Insurance Plan	**lifebenefits.com/submiteoi** Group Policy Number: 34390 Access Key: Phoenix (800) 872-2214
ARAG Legal Insurance Plan	**araglegalcenter.com** Access Code: 16922phx Member Services: (800) 247-4184
MetLife Pet Insurance Plan	(800) GET-MET8 (800) 438-6388 **https://benefits.petinsurance.com/city-of-phoenix**

Legal Notices

NOTICE OF SPECIAL ENROLLMENT RIGHTS FOR HEALTH PLAN COVERAGE

If you are declining enrollment in the City of Phoenix health plan for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward you or your dependents' other coverage). However, you must request enrollment within 31 calendar days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). 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 dependents. However, you must request enrollment within 31 calendar days after the marriage, birth, adoption, or placement for adoption. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance. To request special enrollment or obtain more information, contact the City of Phoenix Benefits Office at benefits.questions@phoenix.gov or (602) 262-4777.

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. Therefore, deductibles and coinsurance listed in this Guide (and/or your health plan's summary plan description) apply. If you would like more information on WHCRA benefits, contact your plan administrator at benefit.questions@phoenix.gov or (602) 262-4777.

NEWBORN'S AND MOTHER'S HEALTH PROTECTION ACT

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).

CITY OF PHOENIX HIPAA PRIVACY NOTICE

This notice describes the privacy practices of these plans: **The City of Phoenix Employee Medical, Dental, and Prescription Drug Plans.** This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice - you can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures
How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services
We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.
Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

For more information on the Plan's privacy policies or your rights under HIPAA

Please contact:

HIPAA Privacy Officer in the Benefits Office
251 W Washington Street, 7th FL
Phoenix, AZ 85003

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 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 and the results from your biometric screening 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.

General notice of your rights: Group health continuation coverage under COBRA

On April 7, 1986, a federal law called COBRA was enacted (Public Law 99-272, Title X), requiring that most employers sponsoring group health plans offer employees and their families (qualified beneficiary/ies) the opportunity for a temporary extension of health coverage at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights as a qualified beneficiary and obligations under COBRA. Both you and your spouse, if applicable, should take the time to read this notice carefully. This notice does not fully describe COBRA or other rights under the City of Phoenix group health plan ("group health plan"). For additional information you should review the Group Health Plan's "summary plan description" or contact the City of Phoenix Plan Administrator at (602) 262-4777. Also, you may visit the Department of Labor website (www.dol.gov) for more information on COBRA. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

Qualifying events

If you are an employee of the City of Phoenix covered by the group health plan, you have a right to choose COBRA if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).
If you are the spouse of an employee covered by the group health plan, you have the right to choose COBRA for yourself if you lose group health coverage under the group health plan for any of the following reasons:

1. The death of your spouse;
2. A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment with the City of Phoenix;
3. Divorce or legal separation from your spouse; or
4. Your spouse becomes entitled to Medicare.

In the case of a dependent child of an employee covered by the group health plan, he or she has the right to choose COBRA if the group health plan is lost for any of the following reasons:

1. The death of the employee;
2. A termination of the employee's employment (for reasons other than gross misconduct) or reduction in the employee's hours of employment with the City of Phoenix;
3. The employee's divorce or legal separation;
4. The employee became entitled to Medicare prior to his/her qualifying event; or
5. The dependent child ceases to be a dependent child under the Group Health Plan.

Sometimes, filing a bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the City of Phoenix and that bankruptcy results in the loss of coverage of any retired employee under the group health plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the group health plan.

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 30-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.

Coverage provided

Under COBRA, the employee or a family member has the responsibility to inform the City of Phoenix plan administrator of a divorce, legal separation, or a child losing dependent status under the group health plan within 60 days of the date of the event. The City of Phoenix has the responsibility to notify the administrator of the employee's death, termination, and reduction in hours of employment or Medicare entitlement. When the administrator is notified that one of these events has happened, the administrator will in turn notify you that you have the right to choose COBRA. Under COBRA, you have at least 60 days from the later of the date you would lose coverage because of one of the qualifying events described above or the date of notification of your rights under COBRA, whichever is later, to inform the City of Phoenix plan administrator that you want to continue coverage under COBRA.

If you elect COBRA, the City of Phoenix is required to give you and your covered dependents, if any, coverage that is identical to the coverage provided under the plan to similarly situated employees or family members. Under COBRA, you may have to pay all or part of the premium for your continuation coverage. If you do not choose COBRA on a timely basis, your group health insurance coverage will end.

Period of coverage

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.

COBRA requires that you be afforded the opportunity to maintain coverage for 36 months unless you lost group health coverage because of a termination of employment or reduction in hours. In that case, the required COBRA period is 18 months. Also, if you or your spouse gives birth to or adopts a child while on COBRA, you will be allowed to change your coverage status to include the child. The 18-month period may be extended to 29 months if an individual is determined by the Social Security Administration (SSA) to be disabled (for Social Security purposes) as of the termination or reduction in hours of employment or within 60 days thereafter. To benefit from this extension, a qualified beneficiary must notify the City of Phoenix plan administrator of that determination within 60 days of the SSA notification date and prior to the 18-month COBRA eligibility end date. The affected individual must also notify the City of Phoenix plan administrator within 30 days of any final determination that the individual is no longer disabled. If the original event causing the loss of coverage was a termination (other than for gross misconduct) or a reduction in hours, another extension of the 18-month continuation period may occur, if during the 18 months of COBRA coverage, a qualified beneficiary experiences certain secondary qualifying events:

1. Divorce or legal separation
2. Death
3. Medicare entitlement
4. Dependent child ceasing to be a dependent

If a second qualifying event does take place, COBRA provides that the qualified beneficiary may be eligible to extend COBRA up to 36 months from the date of the original qualifying event. If a second qualifying event occurs, it is the qualified beneficiary's responsibility to inform the City of Phoenix Plan Administrator within 60 days of the event. In no event, however, will COBRA last beyond three years from the date of the event that originally made the qualified beneficiary eligible for COBRA.

Alternate recipients under QMCSOs

A child of the covered employee who is receiving benefits under the plan pursuant to a qualified medical child support order (QMCSO) received by the City of Phoenix during the covered employee's period of employment with the City of Phoenix is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

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.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the initial enrollment period for Medicare Part A or B, you have an 8-month special enrollment period[1] to sign up, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare Part B and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and then enroll in Medicare Part A or B before the COBRA continuation coverage ends, the plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA will pay second. Certain COBRA continuation coverage plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit https://www.medicare.gov/medicare-and-you. [1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods. These rules are different for people with End Stage Renal Disease (ESRD).

Plan contact information

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. (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.

To ensure that all covered individuals receive information properly and timely, it is important that you notify the City of Phoenix of any change in dependent status or any address change of any family member as soon as possible. Failure on your part to notify the City of Phoenix of any changes may result in delayed notification or loss of continuation of coverage options.

If you have any questions about COBRA, please contact our customer care center at (855) 687-2021.

ATENCIÓN: Los Servicios de asistencia lingüística están su disposición, sin cargo alguno. Llame al 855-687-2021.

How to elect COBRA coverage

Under COBRA, you have a limited number of days to elect continuation coverage. Your election window is determined by the plan and is calculated from the date your coverage under the plan is lost because of the event described above or the date of this notice of your election rights, whichever is later. To elect COBRA coverage, complete and submit the election form to Optum FinancialTEST no later than the election period end date ("last day to elect") listed on the COBRA election form. You can also elect online through the member portal. Online election is available until 11:59 PM Central Time on the last day to elect listed on your COBRA continuation election form. Electing online is a safe, fast, and secure way to ensure your elections are processed. COBRA gives you the right to elect coverage independently, you, your spouse or dependent child(ren), if any, may elect single coverage and not include those individuals who do not wish to continue coverage.

Alternatives to COBRA coverage

You also have an alternative to group-based COBRA continuation coverage. You may instead choose to purchase a plan through HealthCompare, an Optum Financial partner. With HealthCompare, you may search and compare quotes for coverage options from many different health insurance companies in your area. HealthCompare offers live customer support available at (844) 961-9514 if you have questions about your coverage options.
In addition to COBRA coverage, other health coverage options may be available to you, such as coverage through the Health Insurance Marketplace at www.healthcare.gov or 1-800-318-2596. You may also be eligible to enroll in coverage through Medicaid or another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage.

When can I enroll in Marketplace coverage?

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. After 60 days your special enrollment period will end and you may not be able to enroll, so you should act right away. In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage. To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the initial enrollment period for Medicare Part A or B, you have an 8-month special enrollment period[1] to sign up, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare Part B and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and then enroll in Medicare Part A or B before the COBRA continuation coverage ends, the plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.
If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA will pay second. Certain COBRA continuation coverage plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit www.medicare.gov/medicare-and-you.
[1] www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods. These rules are different for people with End Stage Renal Disease (ESRD).

Payment of COBRA coverage premiums

The current amount of this premium and the due date for payment are explained in the COBRA election form. The premium may change in the future. We have used the information supplied by the City of Phoenix to calculate your maximum continuation period under the plan(s) you were covered prior to your qualifying event.

Length of COBRA coverage period

If you and your spouse or dependent child(ren), if any, elect coverage, it can last for a maximum continuation period ("last day of COBRA") described in the enclosed COBRA election form beginning on the date of your qualifying event, or loss of coverage, whichever is later. The first day of COBRA coverage will be determined by the plan. The continuation period may be extended for the following reasons:

1. Death of employee, divorce, legal separation or change in dependent status

If these events occur during the original maximum continuation period of COBRA coverage, the period of coverage for your spouse and dependent child(ren), if any, may be extended. These events extend the original maximum continuation period of COBRA coverage only if they would have caused your spouse or dependent child(ren), if any, to lose coverage under the plan if the original qualifying event had not occurred. Note that to receive this extension, you and/or your spouse and dependent child(ren), must notify Optum FinancialTEST within 60 days of the occurrence of these events.

2. Medicare entitlement of employee

If you became entitled to Medicare BEFORE your qualifying event, COBRA laws allow you to remain eligible for up to 18 months of COBRA coverage. However, your spouse and dependent child(ren), if any, may receive extended COBRA coverage for up to the greater of either: (a) 36 months from the date of your Medicare entitlement; or (b) 18 months from the date of your qualifying event, or loss of coverage, whichever is later. If you elect COBRA based on another qualifying event and become entitled to Medicare AFTER your qualifying event but within the original maximum continuation period of your qualifying event, your spouse and dependent child(ren), if any, may receive an additional 18 months of COBRA coverage if Medicare entitlement would have caused a loss of coverage under the plan in absence of the first qualifying event. Note that a person generally has become entitled to Medicare when he or she has applied for Social Security income payments or has filed an application for benefits under Part A or Part B of Medicare.

3. Disability determination

If it is determined that you and/or your spouse or dependent child(ren), if any, were determined to be disabled (by the Social Security Administration) during the first 60 days of COBRA coverage and you are still disabled at the end of your original maximum continuation period of coverage, the original maximum continuation period may be extended for an additional 11 months for all individuals covered under COBRA coverage from the date of the qualifying event. This extension only applies if Optum FinancialTEST is notified within 60 days of a disability determination and before the end of the original maximum continuation period. Federal law requires that you notify Optum FinancialTEST of a determination by the Social Security Administration that you, your spouse, or dependent child(ren) are no longer disabled within 30 days of such a determination.

4. Bankruptcy filing

If the employer files for bankruptcy reorganization and retiree health coverage is lost within one year before or after the bankruptcy filing, COBRA coverage could continue until the death of a retiree (or a surviving spouse of a deceased retiree) or for 36 months from the retiree's death (after the bankruptcy filing) in the case of the spouse and dependent child(ren).

Newborns and adoptees

A child who is born to or placed for adoption with you during a period of COBRA coverage will be eligible to become covered under the plan. In accordance with the terms of the City of Phoenix group health benefits plan and the requirements of Federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to the COBRA administrator Optum FinancialTEST of the birth or adoption.

Early termination of COBRA coverage

COBRA coverage may terminate early if:

(1) The required premium payment is not paid when due.

(2) After the date of your COBRA election, you and your spouse or dependent child(ren), if any, become covered under another group health plan.

(3) After the date of your COBRA election, you, your spouse, or dependent child(ren), if any, become entitled to Medicare benefits.

(4) All of the City of Phoenix group health plans are terminated.

(5) If coverage is extended an additional 11 months due to disability, a determination that the individual is no longer disabled.

(6) COBRA coverage may also be terminated for any reason the plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud).

Continuation coverage under COBRA is provided subject to your eligibility. The plan reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible for coverage. To be sure that you, your spouse, and your dependent child(ren), if any, receive the necessary information concerning your rights, you should keep Optum FinancialTEST informed of any address changes.

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." If you terminate COBRA continuation early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period and may be without health coverage in the interim. When you've exhausted COBRA continuation and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period even if the Marketplace open enrollment has ended. If you sign up for Marketplace coverage instead of COBRA, you cannot switch to COBRA continuation coverage.

This notice doesn't fully describe continuation coverage or other rights under the plan. More information about continuation coverage and your rights under the plan is available in your summary plan description or from the plan administrator. If you have questions about the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, please contact our Customer Care Center at (855) 687-2021.

ATENCIÓN: Los Servicios de asistencia lingüística están su disposición, sin cargo alguno. Llame al 855-687-2021.

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, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa%20 or call their toll-free number at 1-866-444-3272.

This notice is a summary of your COBRA rights. For answers to specific questions, please contact our customer care center at (855) 687-2021.

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City of Phoenix

Human Resources Department
251 W. Washington St.
Phoenix AZ 85003

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