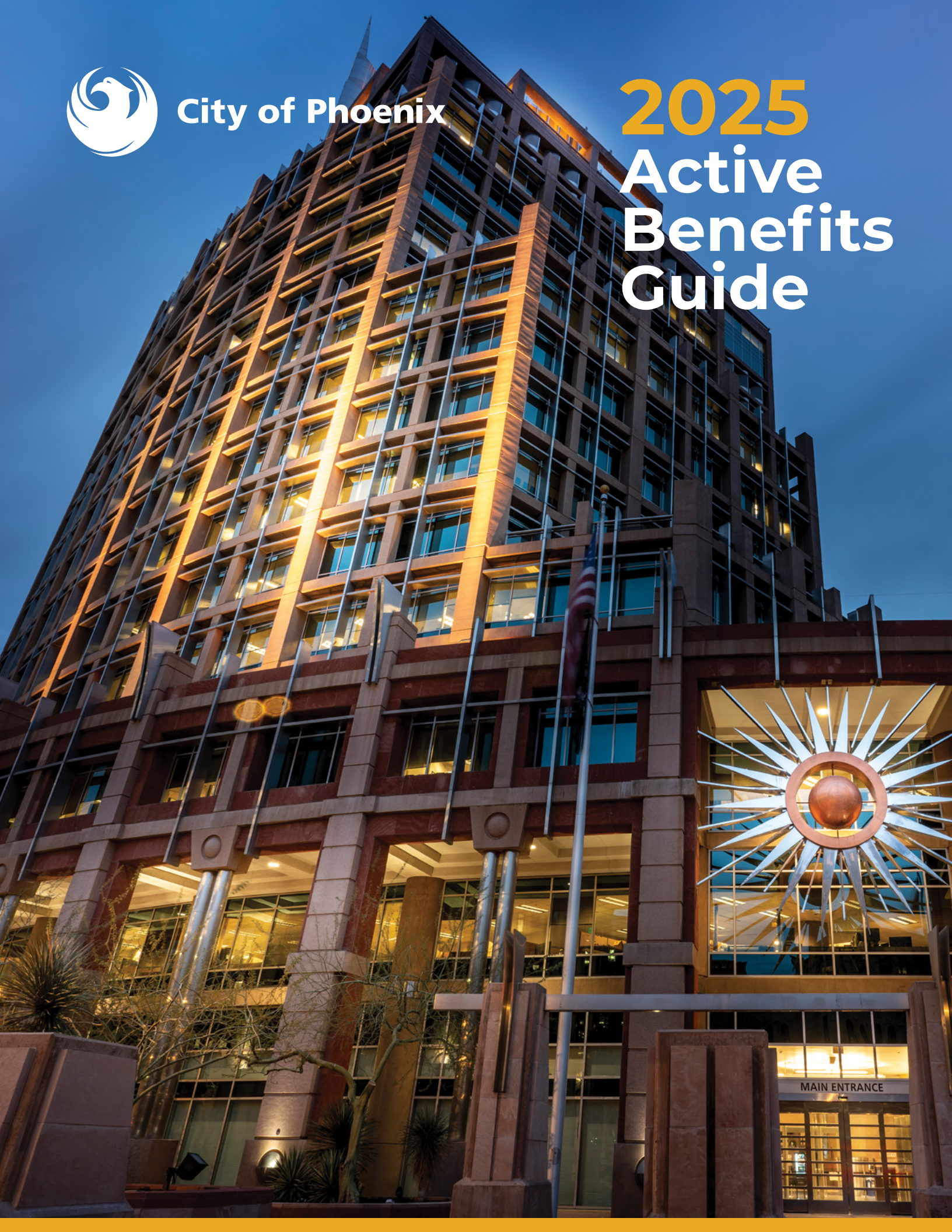
City of Phoenix

2025 Active Benefits Guide



OPEN ENROLLMENT

Open enrollment is **October 11th through November 8th at 11:59 p.m.*** If you have questions about your benefit choices or how to enroll, please call the City's Benefits Office at (602) 262-4777 or send an email to benefits.questions@phoenix.gov. For additional information, visit **phoenix.gov/benefits.**

*Please note that the Benefits Office staff will only be available to answer questions through 5:00 p.m. on November 8th.

OUR BENEFITS PROGRAM INCLUDES

- Three distinct health plans: Saver's Choice, PPO, and HMO
- 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 & buy-up
- Qualified domestic partner coverage
- Post Employment Health Plan (PEHP)
- Employee Loan Program
- Pet Insurance

This 2025 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.

MESSAGE FROM CITY MANAGER

Each year, the City of Phoenix evaluates our Benefits package with the help of the Healthcare Task Force (HCTF) and Healthcare Trust Board (HCTB). Our goal is to provide a sustainable, competitive, and comprehensive benefits package for City of Phoenix employees and their families. Due to rising health care costs, the tough decision was made to implement premium increases and plan design changes in 2025 to improve the sustainability of our Healthcare Trust.

City of Phoenix employees are valuable public servants, your hard work and commitment to our residents does not go unnoticed.

With this year's Open Enrollment, I encourage all city employees to attend the virtual information sessions hosted by our HR Benefits Team to learn more about the changes going in to effect in 2025.

Thank you for all you do for the City of Phoenix!

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WHEN TO REVIEW THIS GUIDE

1

When you are hired and are making your new hire benefit elections. You only have 31 calendar days from your date of hire to make your new hire elections.

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.

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 visiting your PCP in person when appropriate.

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, 2025. Summary plan descriptions, coverage certificates, policies, and contracts prevail.

2025 BENEFIT HIGHLIGHTS

Here are a few highlights of the benefits designed to offer support to you and your family in 2025:

Dental Coverage

Plan Year 2025 Changes:

- HMO Family Plan Monthly Decrease - $0.93 (family)
- PPO Family Plan Monthly Increase - $0.34 (family)
- PPO Plus Plan Monthly Increase - $0.14 (individual), $0.70 (family)
- For PPO and PPO Plus, effective January 1, 2025, In-Network preventive services will be covered at 100%.
- Adult Orthodontia will only be available to those enrolled in the PPO Plus Plan. Adult members utilizing the adult orthodontia in the PPO Plan as of December 31, 2024, will be grandfathered.
- Dental PPO and PPO Plus includes Dental PPO Network Mexico. Visit MyCigna for more information.

Virgin Pulse - Wellness Platform

Virgin Pulse is transitioning to Personify Health. TheFit4Phoenix Program is designed to help employees thrive in every area of health. The City is now offering wellness programs through Virgin Pulse, where employees and their families have access to a wide variety of services and resources through the Virgin Pulse website. The City will continue to offer the wellness incentive administered through Virgin Pulse. Requirements include completion of the Health Assessment and PCP attestation within the same calendar year. **The Wellness Incentive criteria has to be completed by December 15, 2024 to receive the wellness incentive starting in January 2025. You will be unable to complete the wellness incentive from December 16, 2024 through December 31, 2024.**

Employee Healthcare Clinic

The City of Phoenix encourages all employees to make health maintenance a priority. To that end, we offer an Employee Healthcare Clinic designed to 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 your 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

The City is committed to continuing to provide high quality medical coverage through the same plans that you have come to know and rely on!

In 2025, you will see some small modifications in medical plan design along with a 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.

Coming in 2025

Combined Medical and Prescription Drug ID Cards. Updates will be provided on the City's benefits website.

BLUE CROSS BLUE SHIELD PPO PLAN

The PPO plan provides a flexible network that includes out of network coverage. However, it is the highest cost option to include a separate out-of-network deductible and higher copays.

Plan Year 2025 Change:

- Premium Monthly Increases: $13.68 (individual) - $43.44 (family)
- Member Coinsurance for Hospital Emergency Room Increases from 20% to 30%. If admitted, the coinsurance for inpatient hospitalization will be applied.

BANNER | AETNA HMO PLAN

The HMO Plan provides you access to the Banner network.

Plan Year 2025 Changes:

- Premium Monthly Increases: $18.28 (individual) - $58.04 (family)
- Hospital Emergency Room Copay Increases from $250 to $500 (will be waived if admitted)

SAVER'S CHOICE + HSA PLAN

The BCBS Saver's Choice Plan remains the lowest cost option when compared to the PPO and HMO Plan.

Plan Year 2025 Changes:

- Premium Monthly Increases: $9.52 (individual) - $32.18 (family)
- Member Coinsurance for Hospital Emergency Room Increases from 10% to 20%. If admitted, the coinsurance for inpatient hospitalization will be applied.

elixir → MedImpact

***Elixir is becoming MedImpact** – On February 1st, Elixir was acquired by MedImpact, the nation's largest independent pharmacy benefit and health solutions company.

- Member ID cards will continue to work with no disruption (Rx BIN and Rx PCN will remain the same)
- Customer Care's number will not change: 833-803-4402
- No change to the Pharmacy Network
- Member portals and mobile app will be rebranded but work as before with existing log-in & password.
- Member letters and forms will begin to change to MedImpact colors and logos.
- As additional information becomes available updates will be posted on the benefits website.

Action Required for Saver's Choice + HSA Plan

You are NOT automatically enrolled in an HSA when you elect the Saver's Choice Plan – in order to receive the City's HSA contribution you have to elect HSA, and then you'll receive a free debit card from HealthEquity for your HSA.

Note – If adding a dependent during open enrollment both the elections and applicable dependent verification documentation must be received before the close of open enrollment.

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. Missed premiums will be deducted from your paycheck to satisfy missed premiums.

Eligible Dependents

If eligible for health coverage, you may also cover your eligible dependents, which include but are not limited to:

- Your legal spouse
- Your Qualified Domestic Partner (QDP) (approval process required)
- Your biological or adopted child, up to the month in which they attain age 26
- Your disabled child 26 or older with confirmed disabled dependent certification and recertification by health insurance carrier prior to attaining 26 years of age
- Your stepchildren up to age 26 (so long as you are legally married to their parent)
- Your QDP's biological children up to age 26 (so long as the Qualified Domestic Partnership is approved and intact)
- Children up to age 18 who live with you for whom you have legal custody or court-approved guardianship (until custody / guardianship expires)

Ineligible dependents for health coverage include but are not limited to:

- Your ex-spouse or former Qualified Domestic Partner (QDP)
- Children of your ex-spouse or former QDP that are not your biological or adopted children
- A dependent who is actively serving in the military
- A dependent who is currently incarcerated in prison

Please refer to page 50 for information regarding the audit process.

Part-Time Eligibility

Hourly paid members who have average a minimum of thirty (30) hours weekly in a calendar year shall be entitled to the same benefits as received by regular full-time Unit members. Continuation of participation under these plans will be determined by reviewing the average hours worked in the prior 12-month period every calendar year on October 1st. This qualifying period will be determined for the following benefit year effective January 1st. Regardless of benefits eligibility all part-time employees are eligible for commuter life insurance beginning the date of hire.

Unit 001 Part-Time Eligibility

Hourly paid Unit 1 members who have worked a minimum of fifty (50) hours in each pay period for twenty-six (26) consecutive weeks shall be entitled to the same benefits as received by regular full-time Unit 1 members. Continuation of participation under these plans will be determined by reviewing the average hours worked in the prior 12-month period every calendar year on October 1st. This qualifying period will be determined for the following benefit year effective January 1st.

Unit 001 Part-time employees are allowed an hours reduction of up to two (2) weeks in one pay period in the twenty-six (26) week qualifying period and each period thereafter without impacting their eligibility to participate in the part-time employees' benefit programs.

Moving from Full-time to Part-time will continue benefits eligibility through the end of the Benefit year.

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 phoenix.gov/benefits and click on the Document Library.
- Search for "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

It is the employee's responsibility to remove ineligible dependents within 31 calendar days of the event that makes them ineligible for coverage by contacting the Benefits Office. For example, within 31 calendar days of divorce, within 31 calendar days of the end of the qualified domestic partnership, or within 31 calendar days of entering active military service. Benefits are terminated at the end of the month in which the dependent lost eligibility.

IMPORTANT NOTE:

Failure to remove a dependent within 31 days, or enrolling an ineligible dependent, constitutes fraud and an intentional misrepresentation of material fact and will result in claims for that dependent being reversed for the period they were not eligible for benefits. The employee or former employee may be financially responsible for all claim costs the City incurred for the dependent while ineligible for coverage. These amounts may be collected through payroll deduction, collections, and any/all other means available, for repayment to the City of Phoenix Healthcare Benefits Trust. Benefits will be terminated on the last day of the month in which the dependent was eligible. Failure to timely notify the Benefits Division of a dependent's loss of eligibility may also impact their ability to access COBRA. In addition, the employee could face disciplinary action, up to and including termination. For more information regarding COBRA, including employee/dependent eligibility, rights, and responsibilities, please see the COBRA legal notice section of the Benefits Guide.

REQUIRED DEPENDENT DOCUMENTATION	
RELATIONSHIP TO EMPLOYEE	**REQUIRED DOCUMENTATION**
Spouse	Marriage Certificate
Qualified Domestic Partner	QDP Application Packet
Qualified Domestic Child	A copy of the birth certificate naming the subscriber's current domestic partner as the parent. For a domestic partner child, you must also provide documentation of your current relationship to your domestic partner as requested above.
Natural Born Child	A copy of the birth certificate naming the subscriber as the parent. When adding a newborn, a document from the birth provider that includes newborn's name, birth date, and name of the parent who is the subscriber, subscriber's spouse or the subscribers qualified domestic partner will be accepted temporarily. The Birth Certificate must be provided within 4 months for continued enrollment.
Step Child	A copy of the birth certificate naming the subscriber's current spouse as the parent and Marriage Certificate.
Adopted Child	A copy of the birth certificate naming the subscriber as the parent.

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.
- Employees and dependents cannot be dually enrolled in a City benefit plan.

Making Changes Mid-Year

Outside of Annual Open Enrollment, you can only change your benefit elections when you experience a Qualified Life Event (QLE) — a chart can be found on the benefits website in the document library

Enrollment changes must be completed through eCHRIS Self-Service within applicable time-frame of the qualifying life event. Coverage changes due to a life event are effective the first of the following month of the date of the life event. Except for birth or adoption of a child which is effective the date of the life event.

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 or losing other group coverage

*Please note newborns are not automatically added to your coverage. Employees have 60 days to add a new born child through the QLE process.

Important Information

Generally, 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, generally, 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. If you have questions about your domestic partner's tax status, contact your financial advisor.

A domestic partner and their children are not eligible for the Flexible Spending Account (FSA) plan for Health Care or Dependent Care. To learn more please contact your financial advisor.

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. To learn more please contact your financial advisor.

City of Phoenix Benefits may conduct periodic audits to verify dependent eligibility in City-sponsored health plans.

The City of Phoenix will provide medical coverage pursuant to a National Medical Support Notice (or Qualified Medical Child Support Order, if the Order complies with the requirements of an NMSN). Unless specified, the default plan for the children identified in the Notice will be the Banner HMO plan.

City Health Savings Account (HSA) Contributions Pro-Rated for New Hires

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 2025, this will not impact you at all. If you are joining the Saver's Choice at some point after January 1, 2025, either due to being a new hire or experiencing a Qualified Life Event (QLE), the 2025 City HSA contribution will be prorated 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	Single to Family Coverage Change Add'l Cont.*
January 1	$1,125	$2,250	N/A
February 1	$1,031	$2,062	$1,031
March 1	$938	$1,876	$938
April 1	$844	$1,688	$844
May 1	$750	$1,500	$750
June 1	$656	$1,312	$656
July 1	$563	$1,126	$563
August 1	$469	$938	$469
September 1	$375	$750	$375
October 1	$281	$562	$281
November 1	$188	$376	$188
December 1	$94	$188	$94

*If you change from single to family coverage due to a qualifying life event, the additional City contribution in the far right column will apply. These coverage changes will be in effect on the 1st of the month if the qualifying event happened on the 1st of the month. If the qualifying event happened after the 1st of the month, then the coverage change will be in effect the on 1st of the month following the qualifying event. To determine the additional City contribution for the change in single to family coverage, refer to the row corresponding to the effective date of the coverage change.

2025 Monthly Premium 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		PPO		HMO	
	Employee	Family	Employee	Family	Employee	Family
Employee's Monthly Premium	$129.80	$422.22	$167.34	$531.26	$145.62	$462.30
Paycheck Deduction	$64.90	$211.11	$83.67	$265.63	$72.81	$231.15
City's Monthly Portion	$519.20	$1,688.88	$669.36	$2,125.04	$582.48	$1,849.20
Full Monthly Premium	$649.00	$2,111.10	$836.70	$2,656.30	$728.10	$2,311.50

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). Job Share premiums are 60% employee paid and 40% employer paid.

	SAVER'S CHOICE PLAN WITH HSA		PPO		HMO	
	Employee	Family	Employee	Family	Employee	Family
Employee's Monthly Premium	$389.40	$1,266.66	$502.02	$1,593.78	$436.86	$1,386.90
Paycheck Deduction	$194.70	$633.33	$251.01	$796.89	$218.43	$693.45
City's Monthly Portion	$259.60	$844.44	$334.68	$1,062.52	$291.24	$924.60
Full Monthly Premium	$649.00	$2,111.10	$836.70	$2,656.30	$728.10	$2,311.50

2025 Monthly Premium Rates

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	$17.89	$0.00	$33.10	$14.36	$72.60
City's Monthly Portion	$25.96	$53.67	$48.00	$99.30	$48.00	$99.30
Full Monthly Premium	$25.96	$71.56	$48.00	$132.40	$62.36	$171.90

Dental Premiums – Job Share Employees

One deduction is taken from the first paycheck of the month for that month's coverage. Job Share premiums are 60% employee paid and 40% employer paid.

	DENTAL HMO		DENTAL PPO		DENTAL PPO PLUS	
	Employee	Family	Employee	Family	Employee	Family
Paycheck Deduction	$12.98	$44.73	$24.00	$66.20	$38.36	$105.70
City's Monthly Portion	$12.98	$26.84	$24.00	$66.20	$24.00	$66.20
Full Monthly Premium	$25.96	$71.56	$48.00	$132.40	$62.36	$171.90

Buy-Up Vision 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 BY METLIFE BUY-UP PLAN	
	Employee	Family
Paycheck Deduction	$5.54	$13.06

Take advantage of your City benefits program and resources in 2025. Committing to wellness and making smart health care decisions will add up to lower costs for both you and the City.

2025 Monthly Premium 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 or QDP Age
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	$0.35	$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	BUY-UP PLAN
	Employee / Family	Employee / Family
Monthly Deduction	$11.65	$23.70

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 balance.

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 of Arizona (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

Effective January 1, 2025, Virgin Pulse is becoming Personify Health.

Wellness Programs & Resources

The City wants you to enjoy your work and your life! Good health is an important component of your overall satisfaction at work and at home. Through the **Fit4Phoenix Employee Wellness Program**, you can find tools and resources to help you thrive rather than merely survive the daily challenges that come your way.

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

- Nutrition Programs
- Fitness/Step Challenges
- Gym Discounts
- Health Coaching
- Wellness Classes

INCENTIVE REQUIREMENTS ACHIEVED BY:	POTENTIAL EARNINGS*
Either Employee or Covered Spouse / QDP	$40 per month
Both Employee and Covered Spouse / QDP	$60 per month

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

Wellness 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).

If you leave active City coverage for longer than 30 days, you must create a new account and complete your health assessment and attestation again.

Step 2: Create Account

To create an account or log in visit:

Before January 1st: https://join.virginpulse.com/fit4phoenix [join.virginpulse.com]

Starting January 1st: https://join.personifyhealth.com/fit4phoenix [join.personifyhealth.com]

A Spouse or QDP must create their own account and have their own User ID and password on the website. To create their account the Spouse /QDP would use the employee's ID number with an S at the end. (Example: 000000S)

Step 3: Health Assessment and PCP Visit Attestation

Complete the Health Assessment and PCP Visit Attestation within the same calendar year by visiting the Wellness Incentive portal. To complete both requirements the Health Assessment and PCP Visit Attestation, you will need both you and your spouse/QDP biometric data. For directions on how to complete Step 3, visit the City's wellness website. **NOTE: The Health Assessment, PCP Visit, and PCP Visit Attestation must be completed and submitted in the same calendar year!**

Step 4: Check Your Paystub

Once you and/or your covered spouse/QDP complete the Health Assessment and PCP Attestation 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. **You must complete the two requirements by 12/15/24 to receive the first incentive of the year in 2025.** If you miss the deadline, you will not see the incentive on your first January 2025 paycheck. Your next opportunity to complete the two requirements will be after January 1, 2025.

IMPORTANT: If you are/were enrolled as a spouse on another employee's City medical plan and then enroll on your own City medical plan, you must contact the benefits office to have your accounts merged, within 30 days of this change.

Fit4Phoenix Employee Wellness Program

To learn more about the Fit4Phoenix Wellness Programs and the Wellness Incentive, visit cityofphoenix.sharepoint.com/sites/hr/benefits/wellness. For questions about wellness programs, email be.healthy@phoenix.gov

Health Clinic

The City of Phoenix understands that working within the "new normal" involves juggling multiple priorities within a busy lifestyle. 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
High Cholesterol
Behavioral Health
Medication Management

ACUTE ILLNESS OR INJURY

Strep Throat
Flu
Bronchitis
Allergies
Gastrointestinal Distress
Urinary Tract Infections
X-Ray

PERSONAL INJURY

Sprains/Strains
Wound Care

ONSITE LABORATORY

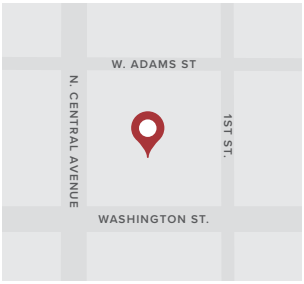
For Questions

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

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

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.

CAN I GO TO THE CLINIC DURING WORK HOURS?

Yes. 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 based in facilities on the outskirts of the City should talk to their HR representative.

Health Plans

Every Plan Offers Generous Coverage and Broad Provider Networks

BCBS SAVER'S CHOICE W/HSA	BCBS PPO	BANNER|AETNA HMO
May be for you if you like:	**May be for you if you like:**	**May be for you if you like:**
Medical coverage at the lowest premium cost	The option of seeing out-of-network providers at a higher cost share	Medical coverage with no deductible
10% additional cost share after you meet your deductible		Medical expenses with fixed copays
Flexibility to pay for qualified health care expenses by using a Health Savings Account (HSA), all tax free, including the City HSA contribution		Having the convenience of working with a Primary Care Physician (PCP) to coordinate your medical care with specialists although referrals are not required
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		No change in out-of-pocket maximum costs compared to last year

ALL THREE PLANS HAVE THESE FEATURES:

- Large, national networks of physicians and facilities
- Pharmacy coverage through Elixir (soon to be MedImpact)
- Free in-network preventive care
- Full-time, designated representatives dedicated to City of Phoenix employees
- Emergency International coverage available when traveling abroad (exclusions may apply). Please contact your designated representative for additional information

TIP: When selecting a plan, you may want to confirm your provider's in-network status but keep in mind that providers may leave and join the network throughout the plan year.

Choosing Your Health Plan – What Makes Each Plan Distinctive?

	SAVER'S CHOICE PLAN	PPO	HMO
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	Yes, except in the event of an emergency
Is a referral required to see a specialist?	No		
Is there an annual deductible?	Yes, $1, 700 for individual coverage and $3,400 for family coverage. Medical and prescription deductible is combined.	Yes, $600 ($1,200 Out-Of-Network) per covered member to a maximum of $1,800 ($3,600 Out-Of-Network) per family	No
Is there coinsurance?	Yes	Yes	Yes, 10% applicable to Home Healthcare and Skilled Nursing
Are there copays?	Only for prescriptions after the deductible is fulfilled	For a few services, including prescriptions	Yes
What is the most I will pay out of pocket per year for covered in-network prescription drug and medical care?	$3,400 for single coverage, and $6,800 for family coverage	Medical Single: $1,200 Family: $3,600 Pharmacy Single: $1,500 Family: $3,000	Medical Performance Network Single: $1,500 Family: $3,000 Broad Network Single: $2,500 Family: $5,000 Pharmacy Single: $1,500 Family: $3,000
Will I be enrolled in a tax-free Health Savings Account with this plan?	Yes. The City contributes $1,125 with single coverage and $2,250 with family coverage annually	No	No
What makes each plan distinctive?	This is the only plan with a tax-free Health Savings Account	The PPO is the only plan with out-of-network coverage	No deductible, fixed copays, and no cost 98point6 virtual health visits

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: $129.80/month Family Coverage: $422.22/month
Deductible	Individual Coverage: $1,700 per calendar year Family Coverage: $3,400 per calendar year
Coinsurance	10% coinsurance (or 20% coinsurance for hospital emergency room*) once annual deductible has been met.
Maximum annual out-of-pocket cost	Individual Coverage: $3,400 (deductible plus Rx copays) Family Coverage: $6,800 (deductible plus Rx copays)
Health Savings Account (HSA) funded by City contributions and your voluntary contributions	The City contributes 66% 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

*If admitted, the coinsurance for inpatient hospitalization will be applied.

**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.

Important Information and 2025 Plan changes

Deductibles include all covered medical expenses including prescription drugs, when you use your Elixir pharmacy coverage. The family deductible is one amount of $3,400, and all covered family member expenses will be applied. **Notes about Saver's Choice:** *After the deductible is met*, covered medical services received in-network are paid at **90%** (or 80% for hospital emergency room, if admitted, the coinsurance for inpatient hospitalization will be applied) by the plan, and prescriptions are subject to copays of $10, $40, $80, or $100 for the remainder of the year until the maximum out-of-pocket limit is reached. For family coverage, the out of-pocket limit is one amount, $6,800, and all covered family member expenses will be applied.

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.

BCBS of Arizona

(602) 864-4857

azblue.com

Find a BCBS Provider

- Visit azblue.com
- Click Find Care/Find Doctor
- Click the option that best describes you, and follow the prompts

BlueCross BlueShield Arizona

How the Saver's Choice Plan Works

BlueCross BlueShield Arizona

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 a 10% coinsurance (or 20% coinsurance for hospital emergency room*) payment for services incurred after the deductible has been met.
Out-of-Pocket Maximum	$3,400 for single coverage (deductible plus Rx copays); $6,800 for family coverage (deductible plus Rx copays)

*If admitted, the coinsurance for inpatient hospitalization will be applied.

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.

BLUE CROSS BLUE SHIELD PPO PLAN

BlueCare Anywhere visits are available at no cost to the PPO plan members.

SAVER'S CHOICE + HSA PLAN

BlueCare Anywhere visits have a $20 copay per visit until the deductible is met, and then is available at 10% coinsurance to 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.

To contact our designated BCBS representative:

To contact our designated BCBS representative, see the Benefits website for current contact information (www.phoenix.gov/benefits)

Health Savings Account

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.

BENEFITS OF HSAS: ENJOY TAX SAVINGS

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

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

Important Note: You may not contribute to a HSA when you are enrolled in Medicare. Please note that if you have to (or choose to) enroll in Medicare Part A, the coverage is retroactive for up to 6 months, but no earlier than your eligibility date. Because of this, you should plan to stop HSA contributions around 6 months before enrolling in Medicare.

If you continue to contribute to your HSA after you enroll in Medicare, there may be potential tax penalties depending on your situation. One such penalty may include a 10% income tax penalty on the amount of funds you have contributed. The City of Phoenix does not provide tax or legal advice. You should consult with your own tax or accounting advisor for specific situation.

Important Note about Customer Identification Program (CIP) Failure: If you fail to meet CIP requirements within 60 days or the end of the calendar year, whichever is sooner, HSA contributions will be returned to the city. If CIP is not verified within the same calendar year, employer contribution funds will be forfeited for that year.

BENEFITS OF HSAS: 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 NOT automatically enrolled in the HSA when you elect the Saver's Choice Plan — in order to receive the employee HSA seed you have to elect HSA, and then you'll receive a free debit card from HealthEquity for your HSA.

You have until December 1, 2025, to enroll in the HSA for this plan year. If you do not enroll in the HSA by December 1, 2025, you will not receive the employer contribution for the 2025 plan year.

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. Any FSA elections while electing an HSA will automatically be converted to a Limited Purpose FSA. (see page 41 for more information regarding FSAs)
- You are claimed as a dependent on someone else's tax return

Don't Forget!

Your HSA pre-tax paycheck election amount must be elected each year. For instructions on how to enroll, visit our website at phoenix.gov/benefits or click this link. Indicate your desired contribution amount each year at Open Enrollment. You can change your contribution amount at any time throughout the year.

How the Health Savings Account 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: myhealthequity.com.

Step 3:

At Open Enrollment time, select the amount of your voluntary contributions to your HSA.* The HSA contribution limits for 2025 (including the City's annual HSA contribution) are $4,300 for single coverage and $8,550 for family coverage. In addition, there is a $1,000 additional "catch up" amount for employees 55 or older.

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 66% 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 or save your HSA dollars to pay for expense in future years. Your money never expires (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.

HealthEquity®

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 healthequity.com/learn/webinars and healthequity.com/learn/videos.

HEALTH EQUITY

Qualified Medical Expense List • **(877) 582-4793** • HealthEquity.com

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.

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 to pay this difference to the out-of-network provider when billed. This is above and beyond your out-of-pocket costs for the deductible and coinsurance.

BlueCross BlueShield Arizona

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.
Highest Premium Rates (monthly paycheck deduction)	Individual Coverage: $167.34/month Family Coverage: $531.26/month
Deductible	In-Network: Individual: $600/calendar year Family: $600 per covered member to a maximum of $1,800 per family Out-of-Network: Individual: $1,200/calendar year Family: $1,200 per covered member to a maximum of $3,600 per family
Coinsurance	In-Network: 20% Out-of-Network: 30% 30% for hospital emergency room*
Maximum Annual Out-of-Pocket Cost	In-Network: Medical: $1,200 per covered member to a maximum of $3,600 per family Pharmacy: $1,500 per covered member to a maximum of $3,000 per family Out-of-Network: Medical $2,000 per covered member to a maximum of $6,000 per family Pharmacy: Not covered

*If admitted, the coinsurance for inpatient hospitalization will be applied.

BCBS PPO

Important Information

You must pay all medical costs up to the deductible amount before coverage begins. If you have family coverage, each member has a deductible up until the individual (or family) deductible is met. Once the member (or family) deductible is met (and unless a copay, fee, or other percentage applies), the member will pay a coinsurance percentage until the member (or family) out-of-pocket limit is reached. The out-of-pocket limit is the most you could pay for medical and prescription drug cost in one year.

BlueCross BlueShield Arizona

How the BCBS PPO Works When using 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% (30% for hospital emergency room*) of the contracted costs until you reach the out-of-pocket maximum.
Out-of-Pocket Maximum	When you've reached $1,200 per covered member to a maximum of $3,600 per family for medical expenses and $1,500 per member to a maximum of $3,000 per family for prescription copays, your covered medical and prescription drug services are provided at no further cost to you.

*If admitted, the coinsurance for inpatient hospitalization will be applied.

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

To contact our designated BCBS representative:

To contact our designated BCBS representative, see the Benefits website for current contact information (**www.phoenix.gov/benefits**)

BCBS OF ARIZONA

(602) 864-4857 • azblue.com

FIND A BCBS PPO PROVIDER

- Visit azblue.com
- Click Find Care/Find Doctor
- Click the option that best describes you, and follow the prompts

Banner | Aetna HMO

The HMO Health Plan is administered by Banner | Aetna. If you prefer having budget-friendly health care expenses, consider the HMO plan. With the HMO plan, you can choose to save money by seeing a Primary Care Physician (PCP) within the Performance Network (Tier 1). 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. No Out-of-network coverage
Reasonable Premium Rates (monthly paycheck deduction)	Individual Coverage: $145.62/month Family Coverage: $462.30/month
Deductible	None
Coinsurance	10% applies to Home Healthcare and Skilled Nursing received from a Broad network provider.
Maximum Annual Out-of-Pocket Cost	Individual Coverage: Medical: $1,500 or $2,500 (depending on network) Pharmacy: $1,500 Family Coverage: Medical: $2,500 or $5,000 (depending on network) Pharmacy: $3,000

Banner | aetna

To Contact Banner | Aetna

(855) 220-6506 • aetna.com/cityofphoenix

To Find a Provider

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

Banner | Aetna HMO

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

The 98point6 option 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**

The 98point6 option also 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

Banner | aetna

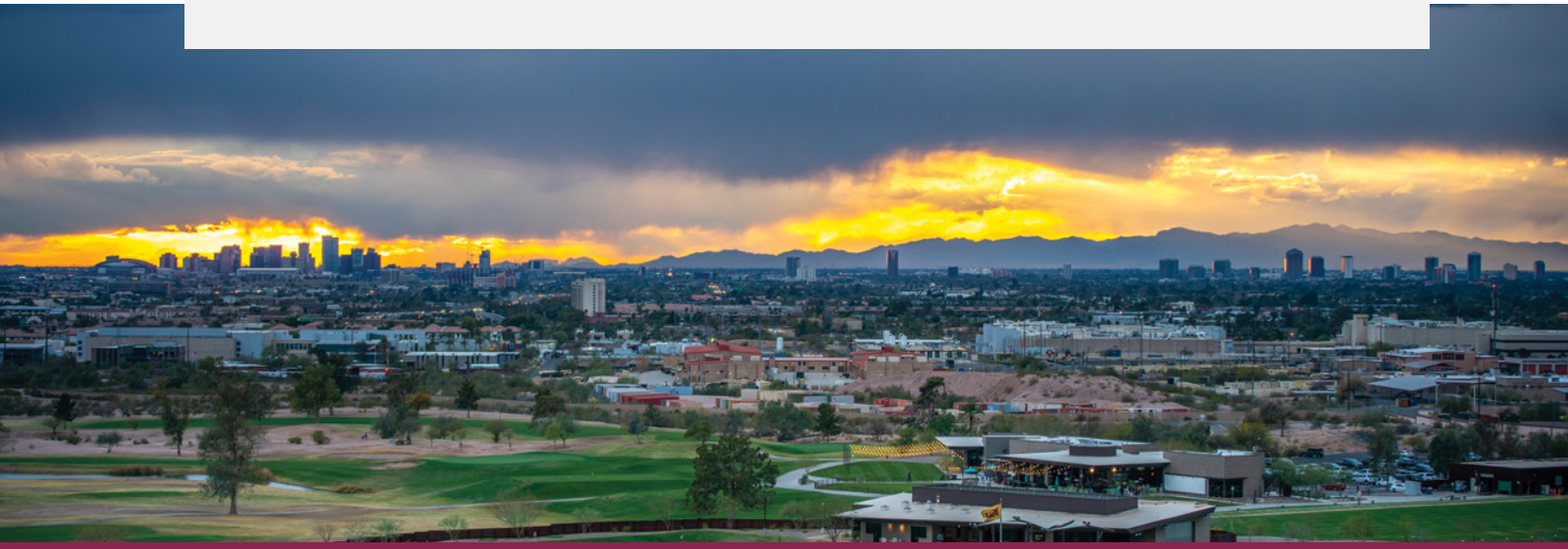
To contact our designated Banner | Aetna representative:

See the Benefits website for current contact information (www.phoenix.gov/benefits)

98point6

98point6 Mobile App

98point6.com/cityofphoenix



Health Plans at a Glance

	BCBS SAVER'S CHOICE	BCBS PPO		BANNER | AETNA HMO
	IN-NETWORK ONLY	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK ONLY
Networks	BCBS PPO	BCBS PPO	Not applicable	Banner | Aetna HMO Broad / Performance
Local or National Network?	National	National	Not Applicable	National
Out-of-Network Coverage?	For emergency services	For emergency services	Yes, with out-of-pocket costs	For emergency services
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited
Calendar Year Deductible	$1,700 for single, $3,400 for all covered family members combined	$600 per covered member to a maximum of $1,800 per family	$1,200 per covered member to a maximum of $3,600 per family	No deductible
Coinsurance	10%	20%	30%	10% applicable to Home Healthcare and Skilled Nursing
Calendar Year Out-of-Pocket Maximum for Medical Services	Single Coverage $3,400 (deductible plus pharmacy copays) Family Coverage $6,800 (deductible plus pharmacy copays)	Medical $1,200 per covered member to a maximum of $3,600 per family Pharmacy $1,500 per covered member to a maximum of $3,000 per family	Medical $2,000 per covered member to a maximum of $6,000 per family Pharmacy Not covered	Medical Performance Network Single: $1,500 Family: $3,000 Broad Network Single: $2,500 Family: $5,000 Pharmacy Single: $1,500 Family: $3,000
Virtual Health Care Banner | Aetna 98point6 BCBSAZ BlueCare Anywhere	$20 copay per visit until the deductible is met, and then is available at 10% coinsurance	$0	N/A	$0
Health Savings Account?	Yes	No	No	No
Prenatal Office Visits	Plan pays 90% of the contracted rate after the calendar year deductible is met	PCMH providers: $10 copay, deductible does not apply Other providers: $30 copay, deductible does not apply, or 20% coinsurance	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	No charge for office visits. Maximum copay for additional maternity tests and services: Performance Network $600/year Broad Network $900/year

Health Plans at a Glance

	BCBS SAVER'S CHOICE	BCBS PPO		BANNER	AETNA HMO
	IN-NETWORK ONLY	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK ONLY	
Office Visit, Primary Care	Plan pays 90% of the contracted rate after the calendar year deductible is met.	PCMH providers: $10 copay, deductible does not apply Other providers: 20% coinsurance	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.	Performance Network: PCP: $25 Broad Network PCP: $50	
Office Visit, Specialist		PCMH providers: $10 copay, deductible does not apply Other providers: 20% coinsurance		Performance Network: $50 Broad Network: $80	
Office Visit, Mental Health		Plan pays 80% of the contracted rate after the calendar year deductible is met.		Performance Network: $25 Broad Network: $50	
Outpatient Procedure				$200	
Inpatient Hospitalization				Performance Network: $200 per admit, Max $600 per year Broad Network: $300 per admit, Max $900 per year	
Lab and X-rays (Medically necessary)				Covered 100%	
Physical Therapy / Occupational Therapy*				Plan pays 100% with no deductible or copay	
Home Healthcare / Skilled Nursing				Plan pays 90%	
Hearing Aids				One hearing aid per ear every 2 years	
Urgent Care Facility				$75	
Hospital Emergency Room	Plan pays 80% of the contracted rate after the calendar year deductible is met.*	Plan pays 70% of the contracted rate after the calendar year deductible is met.*		$500 (waived if admitted)	
Eye Exam with Optometrist once every plan year	See page 35				
Chiropractic	36 visits per year paid at 100% of the contracted rate after the calendar year deductible is met	36 visits per year covered at 100% with no member cost share	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	36 visits per year	
Generic Drugs	$10, after deductible	$10	Not covered	$10	
Brand-name Drugs	$40, after deductible	$40	Not covered	$40	
Non-formulary Drugs	$80, after deductible	$80	Not covered	$80	
Specialty Drugs	$100, after deductible	$100	Not covered	$100	
Mandatory Mail Order for Maintenance Medication	Yes, with certain retail pharmacies (CVS, Target, and Fry's)		Not applicable	Yes, with certain retail pharmacies (CVS, Target, and Fry's)	

*If admitted, the coinsurance for inpatient hospitalization will be applied.
Please go to phoenix.gov/benefits for detailed health coverage information. Information on the website supersedes information found in this document.

Pharmacy Benefits

Drug Tiers

The cost of your prescription drugs under the City's pharmacy 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
- Preferred Brand drugs are brand-name medications that are favored by the prescription plan based on drug effectiveness and cost
- Non-Preferred brand drugs are brand-name medications generally covered at the highest copay tier level
- Non-formulary drugs are medications that are excluded and are not on a prescription plan's formulary based on drug effectiveness and cost. These medications may require a Non-Formulary Exception prior authorization and will have a Non Preferred copay if approved.
- Specialty drugs are typically injectable medications requiring a clinical setting or self-administered, have a high cost, and may require special storage and handling. Many traditional retail pharmacies do not have these medications available. Specialty medications are generally exclusive to specialty pharmacies and dispensing is limited to 30 day supply
- To verify if your brand medication is considered Non-Preferred, please contact Elixir. Preferred brand drugs may move to non-preferred status if a generic version becomes available during the year. Any medication newly approved by the FDA will not be covered until reviewed by the Elixir Pharmacy & Therapeutics (P&T) Committee.

elixir → Medimpact

Not all drugs listed are covered by all prescription drug benefit programs. Certain utilization edits and criteria may apply.

Maintenance Medication Requirements

The city's prescription drug plan has a maintenance program requirement that includes:

- Maintenance medications are those you take on an ongoing basis such as to treat high blood pressure or high cholesterol. These medications can be filled three times at no more than 30-day supply increments per dispensing at any Elixir contracted retail pharmacy.
- Thereafter, maintenance medications will only be covered at 90-day supply increments through CVS, Target or Frys or by mail order through Birdi (formerly Elixir) Medication(s) to treat ADHD are considered maintenance medications but not mandated to 90-day supply program
- Short term prescriptions such as antibiotics can be filled at any in-network retail pharmacy.
- Elixir is contracted with 60k+pharmacies within the US including, Bashas, Costco, Safeway, Walmart, Walgreens.
- 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 Birdi mail order
- Set up mail order prescriptions by calling Birdi (formerly Elixir) mail order directly or visiting www.birdirx.com

Elixir is becoming MedImpact

Pharmacy Customer Care:
(833) 803-4402
ctyphoenixsupport@medimpact.com

To contact our designated representative: See the Benefits website for current contact information (**www.phoenix.gov/benefits**).

Save Money

90-days' worth of medication from one of our three retail pharmacies (CVS, Target, or Fry's) or by mail 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!

Preventative Drug List

In some cases, there will not be a cost share charged to the member for a prescription, based on applicable rules and regulations, such as the PPACA.

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	To contact our designated representative, see the Benefits website for current contact information (www.phoenix.gov/benefits)
Blue Cross / Blue Shield	
MedImpact*	

***Elixir is becoming MedImpact** – On February 1st, Elixir was acquired by MedImpact, the nation's largest independent pharmacy benefit and health solutions company.

- Member ID cards will continue to work with no disruption (Rx BIN and Rx PCN will remain the same)
- Customer Care's number will not change: 833-803-4402
- No change to the Pharmacy Network
- Member portals and mobile app will be rebranded but work as before with existing log-in and password.
- Member letters and forms will begin to change to MedImpact colors and logos.
- As additional information becomes available updates will be posted on the benefits website.

ROSSON HOUSE MUSEUM
AT HERITAGE SQUARE

CONTACT CITY STAFF WITH QUESTIONS ABOUT ELIGIBILITY, ENROLLMENT, QUALIFIED LIFE EVENTS (QLE), PREMIUM DEDUCTIONS, RETIREMENT COVERAGE, AND MORE:

City of Phoenix Benefits Office: (602) 262-4777 or benefits.questions@phoenix.gov

Behavioral Health Benefits

As we all adapt to new ways of living and working, attending to mental and emotional health issues needs to be a priority! 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.

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 deductible and coinsurance apply for in-network providers.

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 a broad network of providers and facilities to meet your needs. 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.

Banner | Aetna HMO Plan

Local behavioral health professionals and facilities are available through the HMO's Broad or Performance provider networks. Pre-certification is required for covered non-emergency inpatient services.

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

The City of Phoenix is committed to supporting the mental and emotional well-being of our employees and their family members.

The City's Employee Assistance Program (EAP) is offered through ComPsych Guidance Resources, where you can find the care, information, and resources needed for optimal mental and emotional wellness.

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

COMPSYCH®
GuidanceResources® Worldwide

ComPsych Guidance Resources

844-819-4775 • guidanceresources.com • Contact the benefits office for more information
Mobile App: GuidanceNow®

Employee Assistance Program

Are You in Need of Long-term Counseling?

ComPsych® GuidanceResources® Worldwide

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 refer to Page 30.

Eligibility for EAP Services

EMPLOYEE GROUP	CLINICAL SUPPORT COUNSELING			WORK AND LIFE SERVICES	ELDER CARE SERVICES
	FACE-TO-FACE	WEB VIDEO	TELEPHONIC		
Full-time	12 sessions per incident per eligible family member	12 sessions per incident per eligible family member		Yes	Yes
Part-time	None	12 sessions per incident per eligible family member		Yes	No

With supervisory approval, you may have up to three EAP visits per year on City time.

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 (ARS 38-672 & 38-673)

Police Officers, Firefighters, 911 dispatchers, and other positions covered by the city's contract who have experienced a traumatic event on duty and need counseling have access to a benefit of 36 free counseling sessions per incident. Sessions must be completed within 12 months from initial session. If you have questions regarding eligibility, please contact the benefits office.

If you'd like to use this benefit, learn more about the six qualifying categories of traumatic events, or confirm your providers coverage, please contact ComPsych at _COPTigerActRequest@compsych.com.

CIGNA Dental Plans

Choice of 3 Plans: Dental PPO, Dental PPO Plus, and Dental HMO

We value your smile! It is one of the best ways to communicate to our community that the City of Phoenix is a great place to live, work, and play. We encourage you and your family to use your dental benefits to preserve 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 preventative services in-network are covered at 100%!
- No deductible for preventive exam, cleaning, and X-rays
- Majority of other services are covered at 80%.
- There is a calendar year deductible of $50 for individuals and maximum of $150 for families, meaning you pay 100% of the deductible of non-preventative 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 for members up to age 19.
- Adults undergoing Orthodontia care in 2024 are grandfathered and must contact Cigna at 800-244-6224 for transition benefits.

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 the following enhancements:

- All preventative services in-network are covered at 100%!
- Adult and child orthodontia are covered under this plan
- The maximum annual benefit per member is $3,000 per calendar year instead of $2,000
- Implant coverage is included, 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, both the PPO and PPO Plus plan have a missing tooth limitation. Please contact Cigna before enrolling for more information.

HMO DENTAL PLAN

- The HMO Dental 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 by contacting Cigna
- A fee schedule determines the amount you pay for dental treatment

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

CIGNA Dental Plans

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 for single coverage and $150 for family coverage Deductible does not apply to preventive or orthodontia service			
Cleanings, exams, X-rays	No charge	Plan pays 100% of covered charges	Plan pays 80% of reasonable and customary charges	Plan pays 100% 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	Plan pays 80% of covered charges after deductible	Plan pays 80% of reasonable and customary charges after deductible	Plan pays 80% of covered charges after deductible	Plan pays 80% of reasonable and customary charges after deductible
Implant benefit	None	None	None	Plan pays 80% of covered charges after deductible	Plan pays 80% of reasonable and customary charges after deductible
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 HMO Dental Coverage and Fee Schedule	$4,000 per child dependent (up to 19 years old)*		$4,000 per person	

*Adult members that are utilizing the adult orthodontia benefit in the PPO Plan as of December 31, 2024 will be grandfathered.

Please go to phoenix.gov/benefits for detailed dental coverage information. Information on the website supersedes information found in this document.

Cigna Dental Oral Health Integration Program

More coverage is available with certain health conditions but not limited to those listed below, please contact Cigna at (800) 564-7642 to learn more. Oral Health integration program flyer.

	HEART DISEASE	STROKE	DIABETES	MATERNITY	CHRONIC KIDNEY DISEASE	ORGAN TRANS-PLANTS	HEAD & 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)

Because seeing clearly is so important, vision benefits are automatically included in your health plan.

CORE VISION COVERAGE	BANNER	AETNA HMO / BCBS PPO	SAVER'S CHOICE
Maximum Annual Benefit (Saver's Choice)	N/A		$500 maximum for eyewear (glasses and contacts combined)
Standard Contact Lens Fit and Follow Up	Not covered for all plans		Not covered for all plans
Exam once every plan year	$25		100% after deductible
Frames once every plan year	$30 credit		$500 maximum after deductible (frames and contacts combined)
Single Vision Lenses once every plan year	$20 – $40 credit		$500 maximum after deductible (frames and contacts combined)
Contacts	$75 credit		$500 maximum after deductible (frames and contacts combined)
Vision Provider Network	Banner | Aetna Vision Network Blue Cross Network		Blue Cross Network

Davis Vision by MetLife Buy-Up Plan

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

VISION CARE SERVICE	IN-NETWORK BENEFIT	OUT-OF-NETWORK REIMBURSEMENT
Eye Exam, Glasses	$10 Co-pay	Up to $40
Standard Contact Lens Fit and Follow Up	Included	Up to $175
MATERIALS		
Frame Allowance	Davis Vision Network Collection Fashion, Designer and Premier - Covered in Full. Non-Collection Frames: covered up to $175 retail value, including at participating Walmart, Costco and Sam's Club retailers, Warby Parker and Target	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

Did you know the Buy-Up Vision plan includes a Lasik Reimbursement of $200, which is available for any provider, in-network or out-of-network, payable once per lifetime. All members also have access to discounts for Lasik-related services of up to 50% when they use a provider under the QualSight program. Contact QualSight for assistance in locating a provider and scheduling their service. Members are eligible for the discounts in addition to the $200 benefit.

Davis Vision by MetLife

VISION CARE SERVICE	IN-NETWORK BENEFIT	OUT-OF-NETWORK REIMBURSEMENT
Polycarbonate Lenses (adults & children)	Included	Up to $40
Standard Scratch Resistant Coating	Included	Up to $40
Standard Tint (all gradients)	Included	Up to $40
Standard Anti-Reflective Coating	Included	Up to $40
Transitions	Included	Up to $40
CONTACT LENSES		
Elective	$175 allowance	Up to $175
Medically Necessary	Included with prior approval	Up to $250 prior approval required
Standard Contact Lens Fit and Follow Up	Included	Up to $175
Specialty or First-Time Contact Lens Fit and Follow Up	$60 allowance + 15% discount on overage	Up to $175
FREQUENCY		
Eye Examination	Once every calendar year	
Lenses, Contact Lenses	Once every calendar year	
Frames	Once every calendar year	
Sunglasses at Prime Eye Care	Once every calendar year ($175 allowance for standard or prescription sunglasses) with eye exam. Some exclusions/restrictions apply.)	

Note: You can only apply coverage to either the purchase of glasses or contacts, but not both within the same calendar year.

DavisVision® By MetLife

(833) EYE-LIFE

Member website:
www.metlife.com/mybenefits.

HOW MUCH DOES THE DAVIS VISION BY METLIFE BUY-UP PLAN COST?

If you sign up for the Davis Vision by MetLife Buy-Up Plan, you will see a paycheck deduction in the first two paychecks of each month:
Employees = $5.54
Family = $13.06

Flexible Spending Account (FSA)

A Tax-Free Way to Pay for Extra Expenses

Now is the time to make the most of your hard-earned dollars! Enrolling in a Flexible Spending Account can help you to save and pay for eligible Health Care and Dependent Care expenses with pre-tax dollars.

Compare the 3 Types of FSAs Offered:

	HEALTH CARE FSA	LIMITED PURPOSE HEALTH CARE 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 See Publication 502 for a list of eligible expenses	Eligible dental and vision expenses only See Publication 502 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 See Publication 503 for a list of eligible expenses
How much can I contribute?*	Up to $3,200*	Up to $3,200*	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).		Dependent Care FSA contributions are only available after the payroll deduction occurs.
What happens if I don't use it?	For 2025 FSA and Dependent Care FSA funds, the standard two and a half month grace period will apply, and you have until March 15th, 2026 to incur claims and until March 31, 2026 to submit claims using your FSA card or via reimbursement. Unused 2025 funds will be forfeited.		
How do I get reimbursed?	Use your OPTUM Financial/Connect Your Care debit card, or log on to www.optum.com/cyc		
Unsubstantiated claims	Unsubstantiated claims in the current plan year may result in the FSA card being turned off. You will have until March 31st of the following Plan Year to substantiate year-end claims.		

*Maximum contribution amounts are subject to change once 2025 contribution limits are announced by the IRS. If you elect the maximum amount for 2025 the City will automatically increase your contribution to the 2025 maximum amount once released.

Important Information

Flexible Spending Account enrollment does not automatically roll over from one year to the next.
Annual re-enrollment is required.

Flexible Spending Account (FSA)

Annual Enrollment in FSA Benefits is Required

You must sign up for FSA accounts every year; your prior year elections do not continue into the new plan year. By enrolling in FSA, 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 FSA Health Care Account available through Optum Financial, you can request a debit card pre-loaded with your annual FSA health care contribution. You can be reimbursed using the Optum Financial 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 Optum Financial receiving your claim and documentation.

Eligible expenses must be incurred on or before March 15, 2026 for the calendar year 2025 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 FSA amount when you contact the Benefits Office within applicable time-frame. Please review the Qualified Life Events Chart on the Benefits website under Document Library.

If enrolled in a general purpose FSA in 2024 and electing the Saver's Choice High Deductible Health Plan in 2025, you must spend your FSA dollars to $0 before 12/31/2024 to be eligible for the City HSA contribution in January 2025. If more than a $0.00 balance exists in your general purpose FSA account, your City HSA contribution will be postponed until after the FSA grace period of 3/15/2025.

Expense Reimbursement

Find an alphabetical list of eligible expenses at the Optum Financial website. Submit your expenses for reimbursement online, by fax, by mail, or via the Optum Financial mobile app.

OPTUM Financial™

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 the Optum website (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.

If You Receive a Call...

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.

Don't Forget

The IRS traditionally imposes 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.

Be sure to review the grace period information on Page 37, and if it is your first time electing FSA, be conservative in your estimate of how much money you'll spend.

Optum Financial

(877) 292-4040
www.optum.com/cyc
Mobile App: Optum Financial

Life Insurance

securian FINANCIAL®

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 note that the City of Phoenix is required by IRS rules to tax you on the amount of coverage exceeding $50,000 per year. While the life insurance benefit is not taxable, the premium required to pay for the excess coverage is.

Designate and/or add beneficiary using eCHRIS. A beneficiary's information cannot be deleted or changed due to record keeping policies. You can find directions on how to update your beneficiary by using this link or by visiting phoenix.gov/benefits.

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, 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)
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)

Additional Information

- 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.
- There is an aggregate limit payable under the commutation AD&D that will not exceed $3,000,000

Life Insurance

Occupational Accidental Death & Dismemberment

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

Commuter Life Insurance

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

Police reservists are not eligible for commuter life AD&D.

Important Information

Check your life insurance beneficiary every year in eCHRIS to be sure it's accurate and up-to-date. You can change your beneficiary, but beneficiary information cannot be deleted due to record keeping policies. Sign in to eCHRIS Self-Service and click the Benefits tile to review your beneficiaries.

Learn More

Visit Securian's educational microsite for additional educational resources and more information about your life insurance benefits.

securian.com/phoenix-insurance

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: Guaranteed Issue: As a new hire you have a one-time opportunity to elect up to $150,000 in coverage and up to $50, 000 in coverage for your spouse/QDP without evidence of insurability (EOI).** *For Optional Life Insurance only - You have an additional 14 days outside of the 31 days to enroll in optional life insurance. You must contact the Benefits office for enrollment assistance during this 14-day period	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, unless underwriting is required	Make your request for increase in coverage through eCHRIS Self-Service, unless underwriting is required	Make your request for increase in coverage through eCHRIS Self-Service
When is Evidence of Insurability (EOI) (Underwriting) Required?	EOI required outside of Newly Eligible, Annual Enrollment or QLE Required for coverage amounts over $150,000 or required if coverage is under $150,000 and request for increase is above $20,000	Required for coverage amounts over $50,000 at newly eligible Required if coverage is under $50,000 and request for increase is above $20,000 at annual enrollment. Required to enroll for the first time when elected outside of newly eligible.	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 or January 1st of the following year when elected during open enrollment	First of the month following underwriting approval or January 1st of the following year when elected during open enrollment	First of the month following election or January 1st of the following year when elected during open enrollment
When is coverage reduced or stopped?	Employee optional Life 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	Please contact the Benefits Office if you no longer have any eligible dependents for Optional Child(ren) Life. Termination of coverage will be completed on a prospective basis.
During Annual Open Enrollment	Employee: Enroll for up to $20,000 or increase existing coverage by up to $20,000; not to exceed a new total of $150,000	Spouse: Increase existing coverage by up to $20,000; not to exceed a new total of $50,000	

Submission of Evidence of Insurability (Underwriting)

Lifebenefits.com/submitEOI • Group Policy #34390 Access Key: Phoenix

Additional Benefits

ARAG Legal Insurance

ARAG® provides a national network of attorneys available to you, your spouse or qualified domestic partner (QDP), and eligible children, for a wide variety of personal legal needs. This lets you address your covered legal situations with a network attorney for legal help and representation and saves thousands of dollars, on average, for legal needs. Network attorney fees are 100% paid in full for most covered matters.

- Value Plan - $11.65 per month for the most common legal services
- Buy-Up Plan - $23.70 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 annual open enrollment or during your 31 day initial eligibility enrollment window

Legal insurance gives you access to local network attorneys. They can address the legal matters you and your family may encounter in life – and help you resolve them.

Valuable Protection

- Both plans cover a wide range of legal needs. The Buy-Up Plan includes added protection:
  - Child Custody and Support
  - Divorce
  - Identity Theft Protection
  - Services for Parents/Grandparents
  - Trusts
  - And more!

*Limitations and exclusions apply.

For More Information Contact ARAG

ARAG
Call: (800) 835-3425
For complete plan details, visit: ARAGlegal.com/plans
(Access Code: 16922phx)

ARAG
Legal Insurance

Additional Benefits

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.

Pet Insurance

Because we all love our pets, the City will continue to offer pet insurance in 2025 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.

TrueConnect

(561) 270-5981
TrueConnectloan.com

MetLife Pet Insurance

(855) 270-7387
MetLifepetinsurance.com

Saving for Retirement

Building Your Future Together

You work hard and deserve a relaxing and rewarding retirement! Through our retirement programs, the City provides 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.

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 Retirement Department. 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

CITY OF PHOENIX DEFERRED COMPENSATION PLANS *Building your future together*

Nationwide®

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 shown in the table on the following page.

New Employees!

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

Nationwide Retirement Solutions

(800) 891-4749 • phoenixdcp.com

Saving for Retirement

CITY CONTRIBUTION TO YOUR 401(A) ACCOUNT	
BENEFIT CATEGORY	JULY 8, 2024 - JUNE 30, 2025
001	0.45%
002	3.62%
003	2.36%
004	2.56%
005	4.42%
006	1.50%
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. You can direct your contribution to pre-tax (traditional) or post-tax (Roth).

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 20 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. If an employee returns to the City for employment and was receiving MERP as a retiree they cannot receive MERP and PEHP.

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
- PEHP eligible City spouse enrolled in City medical coverage.

To receive the PEHP contribution, a City of Phoenix employee, enrolled as a spouse/QDP on a City of Phoenix active medical plan, must enter their social security number (SSN) or tax identification number (TIN) into eCHRIS.

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 child 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 20 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.

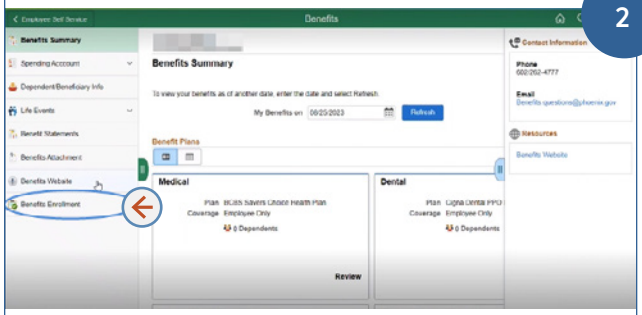
How to Enroll in Benefits

Enroll Online Through eCHRIS Self-Service

1. CLICK ON THE BENEFITS TILE AS SHOWN IN THE BLUE CIRCLE.
2. ON THE LEFT SIDE OF THE SCREEN, LOCATE AND CLICK ON BENEFITS ENROLLMENT, AS SHOWN IN THE BLUE CIRCLE.
3. FOLLOW THE ON-SCREEN PROMPTS TO ENROLL IN YOUR BENEFITS FOR 2025
4. CLICK “PRINT VIEW” IN THE BLUE CIRCLE TO PRINT YOUR BENEFITS STATEMENT SHOWING YOUR 2025 ELECTIONS. KEEP THIS STATEMENT FOR YOUR RECORDS.

1

2



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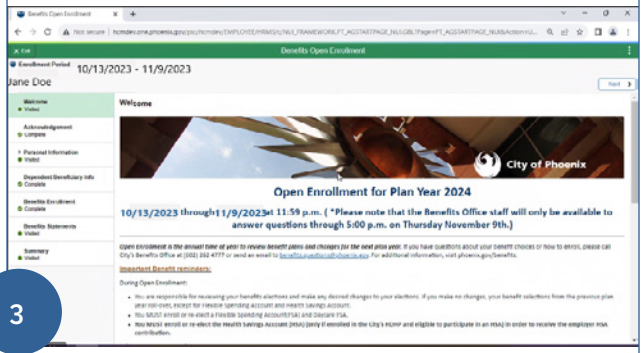

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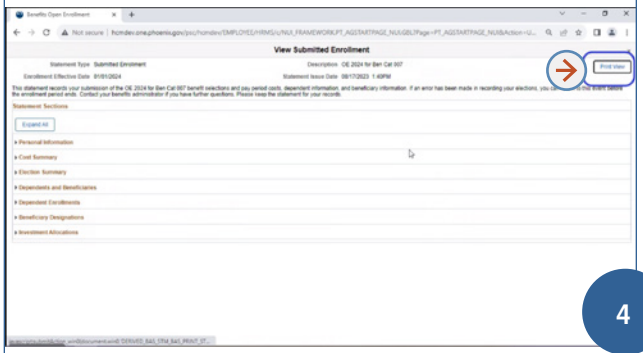

Who to Contact

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
- You have an unresolved problem with one of our benefits vendors

City of Phoenix Benefits Office

Visit: phoenix.gov/benefits

Email For Benefits:
benefits.questions@phoenix.gov

Email For Wellness:
be.healthy@phoenix.gov

Call: (602) 262-4777

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

BENEFITS VENDOR	CONTACT INFORMATION
Banner | Aetna	http://www.aetna.com/cityofphoenix 24-Hour Customer Service Line: **(855) 220-6506** See the Benefits website for current contact information (www.phoenix.gov/benefits)
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** To contact our designated BCBS representative, see the Benefits website for current contact information (www.phoenix.gov/benefits) Member Services: **(602) 864-4857**

Who to Contact

BENEFITS VENDOR	CONTACT INFORMATION
BlueCare Anywhere Virtual Health Visits through BCBS of Arizona	BlueCareAnywhereAZ.com App: BlueCareAnywhere
HealthEquity Health Savings Account (HSA) for Saver's Choice Health Plan (HDHP)	healthequity.com/phoenix Member Services: **(877) 582-4793**
Elixir Pharmacy Benefits	elixirsolutions.com No registration necessary To contact our designated Elixir representative, see the Benefits website for current contact information (www.phoenix.gov/benefits) Elixir Customer service: **(833) 803-4402** (24-Hour Assistance)
ComPsych Guidance Resources Employee Assistance Program (EAP)	guidanceresources.com Web ID: PhoenixEAP App: GuidanceNow® Member Services: **(844) 819-4775**
Cigna Dental Benefits	mycigna.com **(800) 244-6224** Registration Questions and Password Reset: **(800) 853-2713**
Davis Vision by MetLife Vision Buy-Up Plan	Direct Dial to the vision line is: **(833) EYE-LIFE** Website: www.metlife.com/mybenefits.
DCP Program 457b/401a/PEHP	dcp.benefits@phoenix.gov
OPTUM | Connect Your Care FSA and COBRA	www.optum.com/cyc Member Services: **(877) 292-4040**
Securian – Minnesota Life Life Insurance Plan	Lifebenefits.com/submitEOI Group Policy Number: 34390 Access Key: Phoenix **(800) 872-2214**
ARAG Legal Insurance Plan	ARAGlegal.com/plans Access Code: 16922phx Member Services: **(800) 835-3425**
MetLife Pet Insurance Plan	MetLifepetinsurance.com **(800) GET-MET8** **(855) 270-7387**
Nationwide Retirement Solutions	phoenixdcp.com Phoenix Nationwide Office **(602) 266-2733**

Glossary

Deductible: Generally, you must pay all the costs from providers up to the deductible amount before the Plan begins to pay.

- **Saver's Choice Plan** – If you have other family members on the plan, there is no individual deductible, meaning the overall family deductible must be met before any family member receives post-deductible benefits.
- **PPO Plan** – If you have other family members on the plan, each family member must meet their own individual deductible before the individual receives post-deductible benefits.

Coinsurance: The percentage of costs a patient pays for medical expenses after meeting the deductible. Coinsurance is a type of cost-sharing where the member and the Plan split the responsibility for paying for covered benefits.

Copay: A fixed out-of-pocket amount paid by a member for a covered benefit.

Out-of-Pocket Maximum (Medical/Prescription Drug): A limit on the amount of money a member will pay for covered health care services in a plan year. Once this limit is met, the Plan will pay 100% of all covered health care costs for the rest of the plan year. This can encompass prescription drugs or not, please see plan designs for specifics.

In-Network: Services that are provided by a carrier network and results in a higher benefit level (coinsurance) by the Plan, which results in an overall lower cost to the covered member.

Out-of-Network: Providers who do not have a contract with the carrier and typically results in higher costs to the Plan and member. Most services are not covered by out-of-network providers except in very limited circumstances. Be aware you network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services to confirm their network status.

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.

Legal Notices

DEPENDENTS INELIGIBLE FOR HEALTH COVERAGE

Employees selected for audits will be required to provide documentation proving that each person enrolled in their health plan meets the eligibility definition. If the audit determines an ineligible dependent, the following actions will be taken:

- Claims pending for ineligible dependents will be stopped
- Claims paid for ineligible dependents will be reversed; if reversal is unsuccessful, claims paid for ineligible dependent(s) will be calculated at the non-contracted rates and will be deducted from the employee's wages through payroll deduction, collections, and other means as available
- Disciplinary action, up to and including dismissal may be recommended to the HR Director

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, the 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 benefits.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).

PROVIDER CHOICE NOTICE

The City of Phoenix health plan generally allows the designation of a Primary Care Provider (PCP). You have the right to designate any PCP who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the City of Phoenix Benefits Office at benefits.questions@phoenix.gov or (602) 262-4777.

You do not need prior authorization from the health plan or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the City of Phoenix Benefits Office at benefits.questions@phoenix.gov or (602) 262-4777.

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.

Legal Notices

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:

Legal Notices

- 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.

Legal Notices

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

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a network doctor or other health care provider, you generally owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. However, if you see an out-of-network provider or visit an out-of-network facility, your costs may be higher.

"Out-of-network" describes providers and facilities that haven't signed a contract with the City of Phoenix Health Plan. Out-of-network providers may be permitted to bill you for the difference between what the Plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than your costs would be in-network for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when

Legal Notices

you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is the Plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for emergency services, including services you may receive after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections. You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

Your health plan generally must:

Cover emergency services without requiring you to get approval for services in advance (prior authorization).

Cover emergency services by out-of-network providers.

Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the No Surprises Help Desk at 1-800-985-3059.

Visit https://www.cms.gov/nosurprises/consumers/complaints-about-medical-billing for more information about your rights under federal law.

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

Legal Notices

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.

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

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

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

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

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

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

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

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 participating in the City of Phoenix's wellness program, you are agreeing that you have read and understood this notice 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

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confidentiality requirements. The genetic information that you provide will be used to offer you services through the wellness program, such as onsite preventive care, health coaching, webinars or classes You also are encouraged to share your results or concerns with your own doctor.

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

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

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

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

CONTINUATION COVERAGE RIGHTS UNDER COBRA INTRODUCTION

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

This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage, as described below.

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

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 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.

WHAT IS COBRA CONTINUATION COVERAGE?

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

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

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

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

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

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

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

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

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

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

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

DISABILITY EXTENSION OF 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

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

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

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

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

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

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under 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.

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KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

PLAN CONTACT INFORMATION

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

IMPORTANT NOTICE FROM CITY OF PHOENIX ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

This notice affects you only if you will become eligible for Medicare Part D in the next year (see 1 below).

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the City of Phoenix (see 2 below) and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The City of Phoenix has determined that the prescription drug coverage offered by the City of Phoenix PPO Actives, Savers Choice Actives, and Banner-Aetna HMO Health Plan (collectively, "City of Phoenix Health Plans") is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be

eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current City of Phoenix coverage will not be affected.

Prescription drug coverage is an integral part of the City of Phoenix Health Plans. You cannot drop prescription drug coverage under City of Phoenix Health Plans without also dropping your medical plan coverage. You need to be aware that you and your dependents may not be able to get this coverage back until Open Enrollment or until you have a qualifying event.

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When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with the City of Phoenix and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage:

Contact the City of Phoenix Benefits office at (602) 262-4777 or email benefits.questions@phoenix.gov for further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the City Phoenix health plan changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage:

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: 08/19/2022
Name of Entity/Sender: City of Phoenix
Contact--Position/Office: City of Phoenix Benefits Office
Address: 251 W. Washington Street, 7th FL,
Phoenix, AZ 85003
Phone Number: (602) 262-4777

City of Phoenix

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