City of Phoenix

2025 RETIREE BENEFITS GUIDE

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THIS BENEFITS GUIDE PROVIDES IMPORTANT INFORMATION FOR CITY OF PHOENIX RETIREES AND SURVIVORS.

YOUR 2025 CITY OF PHOENIX RETIREE BENEFITS

The City of Phoenix appreciates the contributions that our retirees have made in making our City a great place to live, work, and play. Open Enrollment is October 11th through November 8th at 11:59pm. If you have questions about your benefit choices or how to enroll or make changes please call the City Benefits office at 602-262-4777 or send an email to benefits.questions@phoenix.gov. This 2025 Retiree Benefits Guide provides highlights of the City of Phoenix retiree health plans effective January 1, 2025.

IMPORTANT TO NOTE

- Summary plan descriptions, coverage certificates, policies, contracts, and similar documents prevail when questions of coverage arise.
- Non-Medicare health plan premiums include a "Plus One" tier that can save couples hundreds of dollars each month. See page 9 for details.
- Couples with one Medicare individual and one non-Medicare individual have options for coverage. See page 9 for details.
- If you are eligible for Medical Expense Reimbursement Plan (MERP), your MERP payments continue, and the City's retiree medical premiums are reduced by a Qualified City Contribution amount each month.
- If you are a public safety retiree, you may qualify for the monthly State subsidy (Premium Benefit) and the HELPS Act when you enroll in a City retiree medical plan. See pages 16–18 for details.

UPDATING YOUR CONTACT INFO

Please maintain an accurate mailing address with the City of Phoenix. To update an address or phone number:

- General City retirees should contact the City of Phoenix Employees' Retirement System (COPERS) office at (602) 534-4400
- Sworn public safety retirees should contact the City of Phoenix Benefits Office at benefits.questions@phoenix.gov

2025 Highlights

Non-Medicare Medical Plans

The City of Phoenix is implementing an overall premium rate increase of 23.9% on non-Medicare medical plans. It was a difficult, yet necessary, decision that has been made in the interest of sustainability and protection of our retiree medical plans. This year there are no changes to our medical plan offerings outlined on Page 19:

Navigate HMO – Deductible remains $700 (for individuals), with low coinsurance and the convenience of working with a Primary Care Physician who will coordinate your care.

Catastrophic Plan – Deductible remains $5,000 (for individuals) with low premiums and generous coinsurance.

Choice Plus PPO – Deductible remains $1,500 (for individuals) and annual out-of-pocket maximum ($4,000 for individual) with flexibility of using out-of-network providers.

Choice HSA – Deductible increases to $1,650 (for individuals) and increases to $3,300 (family) with low out-of-pocket maximums and the convenience and tax benefits of using a HSA.

Non-Medicare Rx Plan

The City of Phoenix is offering Non-Medicare Prescription drug benefits through Elixir Solutions. Elixir was bought by MedImpact and at some point in the near future there will be an official name change. Once this occurs, communication will be distributed. Comprehensive information about **Elixir** benefits can be found on page 30 of this guide.

If you are seeking to make changes during open enrollment, you must complete the following form:

City of Phoenix Retiree Open Enrollment Form Elections effective 1st of the following month in which the form is received by Benefits Office.	ENROLLMENT TYPE	RETIREMENT	PAYMENT OPTION	MEDICAL REIMBURSEMENT
	☐ NEW ☐ CHANGE ☐ WAIVE ALL COVERAGE	☐ GENERAL CITY (COPERS) ☐ POLICE ☐ FIRE	☐ PENSION DEDUCTION ☐ DIRECT PAY (INSUFFICIENT PENSION)	☐ PEHP ☐ MERP

1. EMPLOYEE I.D. #	2. LAST NAME	FIRST NAME	MI	3. DATE OF BIRTH

4. PHYSICAL ADDRESS	CITY	STATE	ZIP CODE

5. MAILING ADDRESS	CITY	STATE	ZIP CODE

6. PHONE NUMBER	7. Last 4 SSN	8. EMAIL

9. TYPE OF COVERAGE

☐ Retiree ONLY	☐ Retiree + 1	☐ Spouse ONLY (SSN required)	☐ Family **AND** Retiree	☐ Family **NO** Retiree

10. NON-MEDICARE MEDICAL PLAN SELECTION

UNITED HEALTHCARE (UHC) MEDICAL PLAN	☐ NAVIGATE HMO ☐ CATASTROPHIC PLAN ☐ CHOICE HSA ☐ CHOICE PLUS PPO	☐ **Waive** ☐ **No Change**

11. DENTAL AND VISION PLAN		**12. TYPE OF COVERAGE**	
DENTAL	☐ HMO ☐ PPO	☐ Single ☐ Retiree + 1 ☐ Family	☐ Waive ☐ No Change
VISION	☐ Buy Up Vision Plan	☐ Single ☐ Retiree + 1 ☐ Family	☐ Waive ☐ No Change

13. PLEASE FILL IN THE INFORMATION BELOW WHEN ENROLLING OR ADDING/REMOVING DEPENDENTS. (USE A BLANK FORM TO ADD ADDITIONAL DEPENDENTS. INCLUDE YOUR NAME AND MARK AS PAGE 2)

Add or Del	Mark All That Apply	Last Name	First Name	Check Dependent Type	Gender	DOB MM/DD/YYYY	SSN (SSN required for spouse/QDP only coverage)
	☐ Medical ☐ Dental ☐ Vision			☐ Child ☐ Spouse ☐ QDP ☐ QDP Dep			
	☐ Medical ☐ Dental ☐ Vision			☐ Child ☐ Spouse ☐ QDP ☐ QDP Dep			
	☐ Medical ☐ Dental ☐ Vision			☐ Child ☐ Spouse ☐ QDP ☐ QDP Dep			

- ***Dependent verification documents must be received within 31 days of election date.***
- ***By signing this form, I attest that myself or my enrolled dependents are not Medicare eligible. It is my responsibility to notify the City of Phoenix Benefits Office if and when I or my enrolled dependents become eligible for Medicare and are therefore no longer eligible for this coverage.***
- ***The signature below authorizes the above elections and pension check deductions and VERIFIES MY UNDESTANDING OF THIS INFORMATION.***

14. Signature: **15. Date Signed:**

Received By:	Date:	Entered By:

Submit this form and dependent verification to:
Email: benefits.questions@phoenix.gov
Fax: 602-534-2848

Mail to: City of Phoenix
Benefits Office 7th Floor
251 W. Washington Street
Phoenix, AZ 85003

Important Reminders

Two significant changes to the City of Phoenix retiree health plans to be aware of:

Retiree Health Plan Enrollment Period Changes

As recommended by the Health Care Benefits Trust Board and adopted by the City, effective January 1st, 2024, if you are not enrolled in a City retiree health plan, you will not be able to enroll or re-enroll in the City's retiree health plans. This change applies to dental, vision, and non-Medicare medical plans individually.

As of January 1st, 2024, retirees had 31 days from the end of either their active City-sponsored health coverage, or their City COBRA coverage, to elect and submit payment for medical, dental, and vision coverage. If elections were not made within 31 days, the retiree will is not able to enroll in the City's retiree's health plans in the future.

If you are not currently enrolled in the City's health benefits, and are interested in more information, you can visit the City's benefits website.

Non-Medicare Medical Retiree Plan Sunset

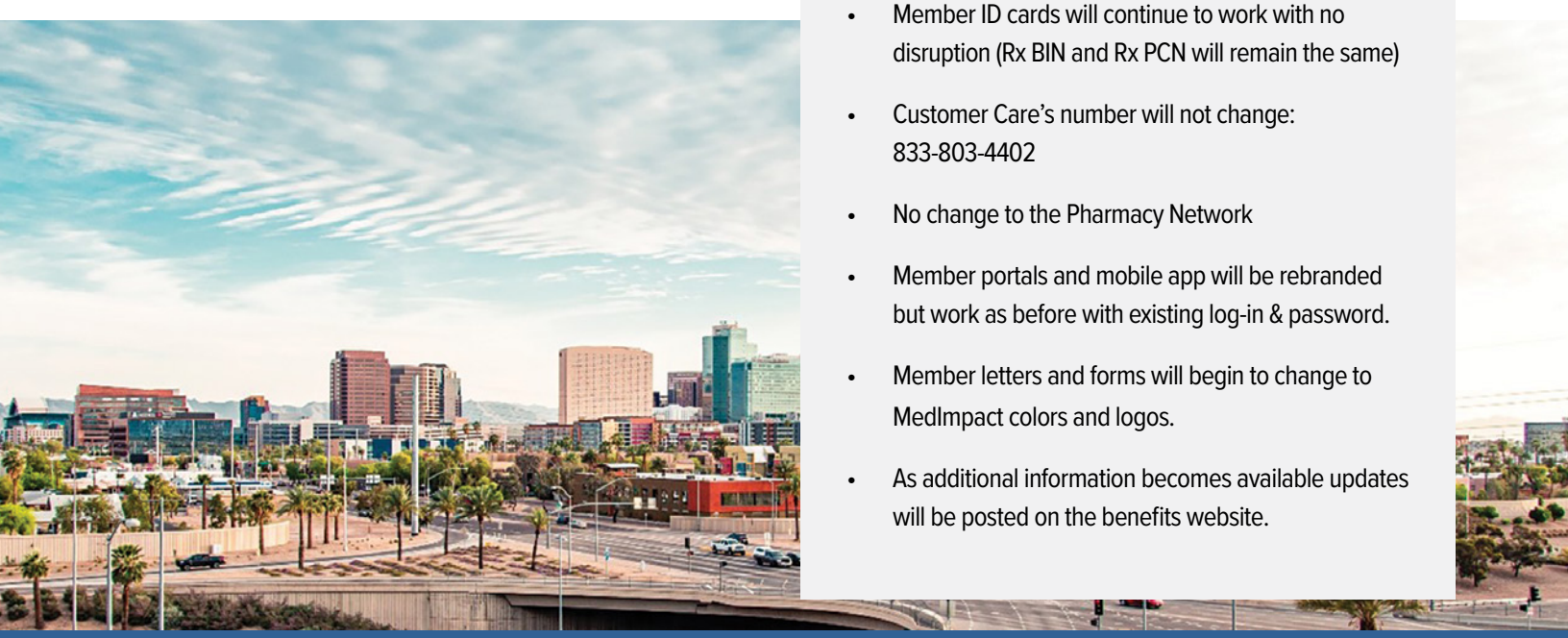
The non-Medicare medical retiree plans will end and no longer be available on December 31st, 2025. If the plan is unable to procure re-insurance (stop loss) and/or enrollment falls below a threshold where costs are no longer sustainable, the plans would sunset sooner than December 31st, 2025. This does not apply or affect the available Medicare plans.

As the sunset date approaches, the City will partner with benefits consultants and insurance carriers to offer education and training regarding navigating enrollment in non-Medicare plans offered through the federal marketplace.

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.



Overview Of Benefit Programs

BENEFIT	WHO IS ELIGIBLE*	SEE PAGE:
UnitedHealthcare Non-Medicare Medical Plans	Eligible Retirees and Dependents under age 65, and those over age 65 who do not qualify for Medicare	19
Elixir Pharmacy Non-Medicare Pharmacy Plans	Eligible Retirees and Dependents under age 65, and those over age 65 who do not qualify for Medicare	31
AARP/UHC Supplemental Medicare Plans	Eligible Retirees and Dependents age 65 and older enrolled in Medicare Part A and B	32
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Davis Vision by MetLife	All Eligible Retirees and Eligible Dependents	37
Elder Care Resources	All Eligible Retirees	39
MetLife Pet Insurance	All Eligible Retirees	39
ARAG Legal Insurance Plan	All Eligible Retirees	40

*Deferred retirees are not eligible to participate in City-sponsored benefits

Who's Eligible For Coverage

Eligible Retirees

- Retired from City due to credited service or approved medical retirement

Eligible Dependents

- Your legally married spouse
- Your qualified domestic partner (QDP) (approval process required). If your QDP has a break in coverage QDP recertification is required.
- Children up to the age of 18 who live with you for whom you have legal custody or court-approved guardianship (until custody / guardianship expires)
- Your children up to age 26 if they are your:
  - Biological child or adopted child
  - Stepchildren while you are legally married to their parent
  - Qualified domestic partner's biological children while the qualified domestic partnership is approved and intact

Note: For children to be enrolled in a health plan, either the retiree or their non-Medicare eligible spouse or partner must be enrolled. Children are automatically removed from coverage the last day of the month in which they turn 26. Children may be eligible for coverage beyond age 26 if they are enrolled in the City's medical and/or dental plan the day before they turn 26, are primarily supported by you, and are incapable of self-sustaining employment due to permanent disability. An application and medical information must be provided to UnitedHealthcare within 31 days of the child turning age 26. For more information, contact the City's Benefits Office at (602) 262-4777 or email **benefits.questions@phoenix.gov**.

31 Day Enrollment Rule

Retirees will have 31 days from the end of either their active City-sponsored health coverage, or their City COBRA coverage, to elect and submit payment for medical, dental, and vision coverage. If elections are not made within 31 days, the retiree will be unable to enroll in the City's retiree's health plans in the future.

If you drop a City Retiree Health Plan, you cannot re-enroll in that plan at a later date.

Making Changes Mid-Year

Outside of Annual Open Enrollment, you can only change your benefit elections when you experience a Qualified Life Event within the applicable deadline (found in chart) - a chart can be found on the benefits website in the document library (www.phoenix.gov/benefitsretiree).

Please note the retiree must be enrolled in a City health plan for qualified life events to apply.

IMPORTANT NOTE

The non-Medicare Spouse or qualified domestic partner of a Medicare retiree can enroll in a City Retiree non-Medicare medical plan, whether or not the retiree is enrolled in a City plan. Premium payments must be deducted from your monthly pension check.

Paying For Your Health Plans

The City offers the convenience of paying your monthly premiums for medical, dental, and/or vision coverage from your monthly pension checks or by direct payment if your pension is not sufficient to cover monthly premium amounts. Please contact the benefits office to set up the direct payment.

NON-MEDICARE RETIREE 2025 MONTHLY MEDICAL PLAN PREMIUMS			
	FULL PREMIUM* (PEHP PREMIUM)	QUALIFIED CITY CONTRIBUTION	REDUCED PREMIUM (MERP PREMIUM)
CATASTROPHIC PLAN			
Single	$1,311.44	$105	$1,206.44
Retiree +1**	$2,753.98	$375	$2,378.98
Family	$3,475.28	$375	$3,100.28
CHOICE HSA PLAN			
Single	$1,529.32	$105	$1,424.32
Retiree +1**	$3,211.58	$375	$2,836.58
Family	$4,052.72	$375	$3,677.72
CHOICE PLUS PPO PLAN			
Single	$1,971.28	$105	$1,866.28
Retiree +1**	$4,139.68	$375	$3,764.68
Family	$5,223.86	$375	$4,848.86
NAVIGATE HMO PLAN			
Single	$1,745.26	$105	$1,640.26
Retiree +1**	$3,665.00	$375	$3,290.00
Family	$4,624.78	$375	$4,249.78

*Public Safety retirees should also deduct the amount of Premium Benefits (State Subsidy) they receive for their "bottom line" cost.
**Retiree +1 coverage is treated as family coverage.

Couples With A Combination Of Medicare & Non-Medicare Status

Good news! The City of Phoenix retiree medical plans accommodate most Medicare/non-Medicare family combinations, which means if you and your spouse/qualified domestic partner each have different Medicare/non-Medicare status, you can tailor coverage to your needs:

- Each of you can enroll in different Medicare Supplement Plans, or
- One can enroll in a Medicare Plan and the other can enroll in a non-Medicare Plan

For dental and vision plans, the retiree must be enrolled in coverage to extend coverage to eligible dependents.

2025 MONTHLY DENTAL PLAN PREMIUMS – ALL RETIREES		
	CIGNA DENTAL PPO	CIGNA DENTAL HMO
Single	$58.52	$26.40
Retiree +1	$128.50	$54.84
Family	$187.34	$82.26

Dental premiums must be deducted from pension. No direct pay option is available.

2025 MONTHLY VISION PLAN PREMIUMS – ALL RETIREES	
	DAVIS VISION BY METLIFE
Single	$11.55
Retiree +1	$21.83
Family	$26.57

Vision premiums must be deducted from pension. No direct pay option is available.

2025 MONTHLY LEGAL PLAN PREMIUMS – ALL RETIREES	
	ARAG LEGAL PLAN*
Value Plan	$11.65
Buy-Up Plan	$23.70

*Enrollment and premium payments are handled directly through ARAG Legal Insurance.

Medicare Supplement Plans & Medicare Pharmacy Plans

At the time of printing, rates have not been released by CMS/Medicare. Rates will be available in the AARP/UHC enrollment guide. You can contact AARP/UHC directly and ask to have an AARP/UHC enrollment guide mailed to your home. **For questions regarding Medicare coverage, please call the AARP/UHC customer service group at (844) 488-3960.**

Reducing Your Out-Of-Pocket Health Care Costs

At-a-Glance

The City of Phoenix provides financial resources to help eligible retirees reduce the cost of their health care, whether it's your premium or your out-of-pocket cost. You may be eligible for one or more of these programs.

PROGRAM NAME	WHO ARE YOU?	WHAT YOU'RE ELIGIBLE TO RECEIVE	LEARN MORE
Post-Employee Health Plan (PEHP)	You were hired as of August 1, 2007 or later, or You were more than 15 years away from pension eligibility as of August 1, 2007.	If you were enrolled in a City-sponsored employee health plan, you can use accumulated City PEHP contributions to pay for post-employment health expenses.	Page 12
Medical Expense Reimbursement Plan (MERP) – includes Basic MERP, Supplemental MERP, and for General City retirees, Category MERP	You retired between August 1988 and July 2007, or You were working for the City on August 1, 2007 and on that date were within 15 years of City service retirement.	MERP payments are made directly to you or your pension survivor each month to help pay for medical premiums and/or other out-of-pocket health care expenses.	Page 13
Qualified City Contribution (QCC)	You are a MERP-eligible retiree enrolled in a City-sponsored medical or Medicare coverage through the City's billing agreement.	An amount from the City MERP Trust reduces the full premium amount of City-sponsored retiree medical plans since 2007.	Page 15
Public Safety Personnel Retirement System (PSPRS) Premium Benefit*	You are a public safety retiree.	A state-funded monthly subsidy (Premium Benefit) reduces your monthly premium expense by $100 to $260 per month.	Page 16
HELPS Act* (Public Law 109-280 Sec. 845)	You are a public safety retiree.	You have the option to reduce your taxable income up to $3,000 when paying for health care premiums from an eligible retirement account.	Page 18

* See "Public Safety Retiree Information" on pages 16-18 for more details about these money-saving programs available to Public Safety Retirees.

Post Employment Health Plan (PEHP)

Employees enrolled in a City sponsored employee medical plan receive a monthly contribution in the amount of $150.00 to an individual PEHP account. Funds can be used to cover qualified post employment health expenses.

PEHP eligible employees are those who:

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

For more information about the PEHP, go to phoenixdcp.com or email questions to dcp.benefits@phoenix.gov. For questions regarding PEHP eligibility, contact the Benefits Division.

Medical Expense Reimbursement Plan (MERP)

The City of Phoenix Medical Expense Reimbursement Plan (MERP) offsets your medical premiums and/or other out-of-pocket health care expenses. You are eligible for MERP if:

- You retired between August 1988 and July 2007, or
- You were working for the City on August 1, 2007 and on that date were within 15 years of City service retirement. There are several different types of MERP, which are described below.
- You are not currently enrolled in PEHP — employee cannot receive MERP and PEHP at the same time.

Basic MERP

Eligible retirees receive Basic MERP whether or not they are enrolled in a City retiree medical plan. MERP is paid via check or direct deposit into the same account you receive your pension payment each month for general City retirees. For Public Safety retirees, you must update your direct deposit information with the Benefits Office. *MERP is not directly applied towards City premium deductions and acts as a reimbursement monthly.*

- Basic MERP provides eligible retirees with a monthly amount to offset out-of-pocket health expenses such as medical premiums, deductibles, copays, dental care, vision care, etc.
- Basic MERP is tax-free, if you use all of it for eligible health expenses in the same calendar year in which you receive it. If you do not use all the Basic MERP you receive for health expenses, you should return the remainder to the City of Phoenix or declare it as income and pay taxes accordingly.
- If you are retired and re-hired at the City of Phoenix, become PEHP eligible in your new employment instance, and enroll in City benefit plans, you are not eligible to receive both PEHP and MERP payments. MERP will stop during employment and you will begin receiving PEHP for the duration of employment while enrolled in City of Phoenix coverage.

See the table below for the Basic MERP amount you may receive.

BASIC MERP	
ELIGIBILITY	MONTHLY MERP AMOUNT
Under age 60, or over age 60 with less than 5 years of credited City service	$117
With 5 to 14 years of active credited City service	$135
With 15 to 24 years of active credited City service	$168
With 25 years or more of active credited City service	$202
All sworn Fire Fighter retirees without regard to years of service	$202
Middle Managers and Executives retiring on or after 7/1/06	$202
General City Supervisory and Professional retiring on or after 7/1/07	$202
Police Supervisory and Professional retiring on or after 7/1/07	$202

Medical Expense Reimbursement Plan (MERP)

Category MERP

Retirees from certain Benefit Categories and who are enrolled in City retiree medical coverage may receive an additional $100 per month in Category MERP. The table below explains when a retiree from each Benefit Category is eligible for Category MERP and is organized in date order from left to right.

CATEGORY MERP				
EMPLOYEE GROUP	**SUPERVISORY & PROFESSIONAL, MIDDLE MANAGER, EXECUTIVE, CITY MANAGER**	**UNIT 3 & UNIT 8**	**UNIT 1**	**UNIT 2**
Effective Date #1	Retired 7/1/98 – 6/30/09	Retired 7/1/07 – 6/30/09	Retiring on or after 7/1/06	Retiring on or after 7/1/09
Criteria	Not Medicare eligible and enrolled in family City retiree medical coverage	Not Medicare eligible and enrolled in family City retiree medical coverage	–	–
Effective Date #2	Retired on or after 7/1/2009	Retired on or after 7/1/2009	Enrolled in City retiree medical coverage	Enrolled in City retiree medical coverage
Criteria	Not Medicare eligible and enrolled in City retiree medical coverage	Not Medicare eligible and enrolled in City retiree medical coverage.	–	–
When Category MERP Ends*	Ends if City retiree medical coverage is waived or upon Medicare eligibility	Ends if City retiree medical coverage is waived or when retiree become eligible for Medicare	Ends if City retiree medical coverage is waived	Ends if City retiree medical coverage is waived or when retiree become eligible for Medicare

*Category MERP ends for all retirees when the City's non-Medicare retiree medical plans end, no later than December 31st, 2025.

Medical Expense Reimbursement Plan (MERP)

Supplemental MERP

You may qualify for a Supplemental MERP amount in addition to other types of MERP benefits. If you qualify, Supplemental MERP is added to your Basic MERP each month.

Supplemental MERP is based on your gross annualized pension amount and is intended to offer additional assistance to retirees with smaller pensions. See the table below.

SUPPLEMENTAL MERP	
GROSS ANNUALIZED PENSION AMOUNT	SUPPLEMENTAL MERP AMOUNT
Up to $10,000	$50/month
$10,001 – $15,000	$40/month
$15,001 – $20,000	$25/month
$20,001 – $25,000	$10/month

Qualifications for Supplemental MERP are based on your pension amount each year. If you receive more than one City pension (as a retiree and a survivor, for example) they are combined to determine eligibility.

Qualified City Contribution For MERP Recipients

The Qualified City Contribution is another way the City helps reduce retiree premiums for MERP eligible retirees. The Qualified City Contribution (QCC) amounts for 2025 are:

QUALIFIED CITY CONTRIBUTION (QCC) AMOUNTS FOR 2025	
Non-Medicare, Single	$105 per month
Non-Medicare, Plus One or Family	$375 per month
Medicare Supplemental Plans (except for Unit 5 Fire retirees)	$30 per month
Medicare Supplemental Plans for Unit 5 Fire retirees	$90 per month

Public Safety Retiree Information

Reducing Your Out-Of-Pocket Health Care Costs

In addition to the City-sponsored benefit plans, Public Safety retirees and survivors have health plan options available through the Arizona State Retirement System (ASRS), which provides retiree coverage for the Public Safety Personnel Retirement System (PSPRS). You can find ASRS retiree health plan information online at www.azasrs.gov or by contacting PSPRS Benefits Office at (602) 255-5575.

PUBLIC SAFETY SUBSIDY (PREMIUM BENEFIT)

If you are a retiree of the state-regulated Public Safety Personnel Retirement System (PSPRS), you may be eligible to receive a "premium benefit," otherwise known as a subsidy, to offset medical premium costs while you are retired. You are eligible for the PSPRS State subsidy if your medical coverage is provided through COBRA or direct enrollment with eligible insurance carriers.

The City may administer the PSPRS State Subsidy benefit for City COBRA medical coverages and direct enrollments with a private insurance carrier.

HOW MUCH IS THE PSPRS STATE SUBSIDY?

The following table shows the maximum subsidy amount you could qualify to receive based on single or family coverage and Medicare status:

MONTHLY STATE SUBSIDY (PREMIUM BENEFIT) AMOUNT FOR REDUCING PREMIUM PAYMENT				
WITHOUT MEDICARE		WITH MEDICARE SUPPLEMENT		COMBINATION
Retiree Only $150	Retiree & Dependents $260	Retiree Only $100	Retiree & Dependents $170	At least one with Medicare, others without $215

PSPRS is currently updating their pension administration system which will be unveiled in several phases. The update to PSPRS's system could cause the City's annual renewal forms and processes to change in 2025 as it relates to administering Public Subsidy for City Public Safety retirees.

What Is Not Eligible For Reimbursement

The following health coverages do not qualify for the PSPRS subsidy:

- Medicare Part A, B, and D premiums are not applicable, however, Medicare Supplemental premiums do qualify.
- Vision and dental premiums that are not ASRS or City of Phoenix coverages.
- When the retiree is a dependent on a spouse's or domestic partner's coverage.
- Subsidy may not be eligible if coverage is through an employer's group health plan and you are not already receiving subsidy for that coverage.

No action is required if you are enrolled in a City of Phoenix retiree medical plan or an ASRS Retiree medical or dental plan. The subsidy is automatically applied to reduce your premium(s) before it is deducted from your pension checks.

Required Documentation

If you have medical coverage from a source other than the City of Phoenix or ASRS, you are required to provide documents and the public subsidy form to the to the City's Benefits Office when you initially apply and during the annual audit. To receive the PSPRS State subsidy, you will be asked to provide verification of your coverage and the premium amount for the coverage.

Please look for information in the mail around February/March requesting the required documentation for the annual renewal of your subsidy.

Questions

Please contact the Public Safety Subsidy Coordinator at **(602) 262-4777** or email public.subsidy@phoenix.gov.

To prevent interruption in the monthly Public Subsidy benefit, it is the retiree's responsibility to notify the City Benefit's Office if there is a change to the insurance plan, premium, or coverage tier in which they are enrolled.

Keep Your Address Updated

It is important to keep your address current with the Benefits Office to ensure you receive all applicable mailings sent to you by the City. Public safety retirees may update their address in writing by sending an email to benefits.questions@phoenix.gov.

Helps Act (Public Law 109-280 Sec. 845)

If you are an eligible public safety retiree, you can elect to reduce your taxable income when you use eligible retirement plan distributions to pay the premiums for health insurance or long-term care insurance. The premiums can be for coverage for you, your spouse, or dependents. You can exclude from income the smaller of the insurance premiums or $3,000.

An eligible retirement plan is a governmental plan that is:

- A qualified trust,
- A section 403(a) plan,
- A section 403(b) annuity, or
- A section 457 plan.

If you are enrolled in a retiree medical plan through ASRS or enrolled in a retiree plan through the City of Phoenix, your premiums are deducted from your pension checks and you are automatically eligible for this tax reduction. If you are enrolled through another source, you may use funds from your 457 plan to pay premiums and reduce your taxable income. Please contact Nationwide at **(602) 266-2733** to learn more.

Non-Medicare Health Plans

Every plan offers generous coverage and broad provider networks.

The City is pleased to offer four distinct medical plan options for non-Medicare retirees:

- Choice HSA
- Choice Plus PPO
- Navigate HMO
- Catastrophic Plan

All four plans feature Elixir pharmacy benefits, in-network savings, and free in-network preventive care in 2025.

Medical Coverage Needs

You have three coverage levels to choose from when enrolling in City-sponsored retiree health plans:

- Retiree
- Retiree Plus One
- Retiree Plus Family

United Healthcare

About Tier 1 Providers in Choice and Choice Plus Network

Tier 1 physicians are doctors and specialists who are recognized for providing the greatest value for your health benefits. UHC updates their Tier 1 providers annually. Please visit www.myuhc.com to search for a Tier 1 provider.

Tier 1 lab and X-ray are freestanding lab and X-ray facilities (not hospital-based).

Tier 1 outpatient surgery benefits are paid when services are performed at an ambulatory surgery center or physician's office.

Finding UHC Network Providers

Visit www.myuhc.com and select the plan you're interested in and click Search the Provider Network to review providers.

Attention: Retirees Who Are Enrolled in Medicare Part B Before Reaching Age 65

If you enroll in one of the City's non-Medicare health plans, Medicare will be your primary insurance. The City's health plan will be your secondary and will only pay 20% of your health costs. It will very likely be more cost-effective to enroll in a Medicare Advantage or Supplement plan instead. You can consider switching to a Medicare Supplement through UHC/AARP when you reach age 65. Please contact the Benefits Office if you are in this situation and have questions. Please note that retirees and/or their spouses will be removed from non-Medicare medical coverage the last day of the month prior to their 65th birthday month. For example, if a retiree becomes Medicare eligible as of 9/1/2025, their coverage under the non-Medicare medical plan would terminate as of 8/31/2025.

Comparing The Plans

	NAVIGATE HMO	CATASTROPHIC PLAN	CHOICE HSA**	CHOICE PLUS PPO
UHC NETWORK	**NAVIGATE**	**UHC TIER 1 & BROAD**	**UHC TIER 1 & BROAD**	**UHC TIER 1 & BROAD**
Nationwide network (includes Mayo & Banner)	X	✔	✔	✔
Smaller, Arizona-only network	✔	X	X	X
Save when using Premium Tier 1 providers in the Choice and Choice Plus networks	X	✔	✔	✔
Can use out-of-network providers	X	X	X	✔
Must use a Primary Care Physician (PCP) to coordinate care and obtain referrals to specialists	✔	X	X	X
Can open an HSA*	X	X	✔	X
Annual in-network deductible for individual coverage**	$700	$5,000	$1,650	$1,500
Cost for in-network physician/PCP office visit	$35	$40 co-pay for Tier 1 PCP. $60 for all other in-network providers (non Tier 1)	10%-20% after deductible	10%-20% after deductible
Lowest to highest premiums	High	Lowest	Low	Highest

*For HSA information, see page 29
**Deductible does not apply for in-network emergencies

Navigate HMO Plan Key Features

	NAVIGATE HMO
NETWORK	**NAVIGATE**
Coverage applies to...	**In-Network Only**
Lifetime Maximum Benefit	Unlimited
Health Savings Account?	No
Calendar-Year Deductible (Embedded)	$700 Single, $1,400 Family
Coinsurance	Plan pays 100% or 90%
Calendar-Year Out-of-Pocket Maximum (includes deductible)	$6,600 Single, $13,200 Family
Out-of-Network Coverage?	Emergency services only
PCP Selection Required?	Yes
Referral Required to See Specialist?	Yes
Preventive Care	Plan Pays 100%
Office Visit, Primary Care	$35
Office Visit, Specialist	$50 copay with referral, $60 without a referral
Office Visit, Mental Health	$35
Virtual Visits (Telemedicine)	$0
Outpatient Procedure or Surgery	Deductible, $150 copay, then 100%
Hospitalization	Deductible, $250 copay per day, max $450
Lab and X-rays	100%
CT, PET, MRI, Nuclear Medicine	Plan pays 90% after deductible

Navigate HMO Plan Key Features

	NAVIGATE HMO
NETWORK	**NAVIGATE**
Coverage applies to...	**In-Network Only**
Urgent Care Visit	$75
Emergency Room Visit	$200
Rehabilitative Services (Speech, Physical & Occupational Therapies)	$35 copay
Chiropractic	$35 copay
Hearing Aids	Plan pays 90% after deductible every 2 years per ear
Vision Exam	$35 (every calendar year)
Pharmacy Benefits by Elixir* *Elixir to become MedImpact	$20 Tier 1, $35 Tier 2, $50 Tier 3 2.5x for mail order and 90-day retail, Pharmacy costs help fulfill deductible

THE NAVIGATE HMO PLAN MAY BE FOR YOU IF YOU LIKE:

- **Low deductibles**
- Low coinsurance
- The convenience of working with a Primary Care Physician who will coordinate your care

Catastrophic Plan Key Features

	CATASTROPHIC PLAN
NETWORK	**UHC (TIER 1 & BROAD)**
Coverage applies to...	**In-Network Only**
Lifetime Maximum Benefit	Unlimited
Health Savings Account?	No
Calendar-Year Deductible (Embedded)	$5,000 Single, $10,000 Family
Coinsurance	Plan pays 90% after deductible (Tier 1) Plan pays 80% after deductible (Broad UHC network)
Calendar-Year Out-of-Pocket Maximum (includes deductible)	$7,500 Single, $15,000 Family
Out-of-Network Coverage?	Emergency services
PCP Selection Required?	No
Referral Required to See Specialist?	No
Preventive Care	Plan Pays 100%
Office Visit, Primary Care	$40 Tier 1 - $60 Broad Network (non Tier 1)
Office Visit, Specialist	$60 Tier 1 - $80 Broad Network (non Tier 1)
Office Visit, Mental Health	$40
Virtual Visits (Telemedicine)	$0
Outpatient Procedure or Surgery Inpatient	Plan pays 90% after deductible (Free-standing or ambulatory surgical center/office) Plan pays 80% after deductible (Hospital-based center)

Catastrophic Plan Key Features

	CATASTROPHIC PLAN
NETWORK	**UHC (TIER 1 & BROAD)**
Coverage applies to...	**In-Network Only**
Inpatient Hospitalization	Plan pays 80% after deductible
Lab and X-rays	Plan pays 90% or 80% after deductible (depending on location, 90% free-standing/office, 80% Hospital-based center)
CT, PET, MRI, Nuclear Medicine	Plan pays 90% or 80% after deductible (depending on location, 90% free-standing/office, 80% Hospital-based center)
Urgent Care Visit	$75
Emergency Room Visit	Plan pays 80% after deductible
Rehabilitative Services (Speech, Physical & Occupational Therapies)	$40 copay
Chiropractic	$40 copay
Hearing Aids	Plan pays 90% after deductible every 2 years per ear
Vision Exam	$40 (every calendar year)
Pharmacy Benefits by Elixir* *Elixir to become MedImpact	$20 Tier 1, $35 Tier 2, $50 Tier 3 2.5x for mail order, Pharmacy costs help fulfill deductible

THE CATASTROPHIC PLAN MAY BE FOR YOU IF YOU LIKE:

- **Low premiums**

Choice HSA Plan Key Features

	CHOICE HSA
NETWORK	**UHC (TIER 1 & BROAD)**
Coverage applies to...	**In-Network Only**
Lifetime Maximum Benefit	Unlimited
Health Savings Account?	Yes
Calendar-Year Deductible (True Family—Non-Embedded)	$1,650 Single, $3,300 Family
Coinsurance	Plan pays 90% after deductible (Tier 1) Plan pays 80% after deductible (Broad UHC network)
Calendar-Year Out-of-Pocket Maximum (includes deductible)	$4,000 Single, $7,900 Family
Out-of-Network Coverage?	Emergency services only
CP Selection Required?	No
Referral Required to See Specialist?	No
Preventive Care	Plan pays 100%
Office Visit, Primary Care	Plan pays 90% after deductible (Tier 1) Plan pays 80% after deductible (Broad UHC network)
Office Visit, Specialist	Plan pays 90% after deductible (Tier 1) Plan pays 80% after deductible (Broad UHC network)
Office Visit, Mental Health	Plan pays 90% after deductible
Virtual Visits (Telemedicine)	$0 after deductible
Outpatient Procedure or Surgery Inpatient	Plan pays 90% after deductible at ambulatory surgical center or doctor's office, Plan pays 80% after deductible at hospital-based surgical center

Choice HSA Plan Key Features

	CHOICE HSA
NETWORK	**UHC (TIER 1 & BROAD)**
Coverage applies to...	**In-Network Only**
Inpatient Hospitalization	Plan pays 80% after deductible
Lab and X-rays	Plan pays 90% or 80% (depending on location, 90% free-standing/office, 80% Hospital-based center)
CT, PET, MRI, Nuclear Medicine	Plan pays 90% or 80% (depending on location, 90% free-standing/office, 80% Hospital-based center)
Urgent Care Visit	Plan pays 90% after deductible
Emergency Room Visit	Plan pays 80% after deductible
Rehabilitative Services (Speech, Physical & Occupational Therapies)	Plan pays 90% after deductible
Chiropractic	Plan pays 80% after deductible
Hearing Aids	Plan pays 80% after deductible every 2 years per ear
Vision Exam	Plan pays 90% after deductible (every calendar year)
Pharmacy Benefits by Elixir* *Elixir to become MedImpact	Pay contracted rate for pharmacy costs until the deductible is met; then costs shift to copays. Pharmacy costs help fulfill the deductible.

THE CHOICE HSA PLAN MAY BE FOR YOU IF YOU LIKE:

- Low out-of-pocket maximums
- The convenience and **tax benefits** of using a HSA to pay for deductibles and qualified health care related expenses.

Choice Plus PPO Plan Key Features

	CHOICE PLUS PPO	
NETWORK	**UHC (TIER 1 & BROAD)**	
Coverage applies to...	**In-Network Only**	**Out-of-Network Only**
Lifetime Maximum Benefit	Unlimited	
Health Savings Account?	No	
Calendar-Year Deductible (Embedded)	$1,500 Single, $3,000 Family	$3,000 Single, $6,000 Family
Coinsurance	Plan pays 90% or 80%	Plan pays 60%
Calendar-Year Out-of-Pocket Maximum (includes deductible)	$4,000 Single, $7,900 Family	$8,000 Single, $15,800 Family
Out-of-Network Coverage?	Yes	
PCP Selection Required?	No	
Referral Required to See Specialist?	No	
Preventive Care	Plan pays 100%	Not Covered
Office Visit, Primary Care	Plan pays 90% after deductible (Tier 1) Plan pays 80% after deductible (Broad UHC network)	Plan pays 60% after deductible
Office Visit, Specialist	Plan pays 90% after deductible (Tier 1) Plan pays 80% after deductible (Broad UHC network)	Plan pays 60% after deductible
Office Visit, Mental Health	Plan pays 90% after deductible	Plan pays 60% after deductible
Virtual Visits (Telemedicine)	$0	N/A
Outpatient Procedure or Surgery Inpatient	Plan pays 90% after deductible at ambulatory surgical center or doctor's office, Plan pays 80% after deductible at hospital-based surgical center	Plan pays 60% after deductible

Choice Plus PPO Plan Key Features

	CHOICE PLUS PPO	
NETWORK	**UHC (TIER 1 & BROAD)**	
Coverage applies to...	**In-Network Only**	**Out-of-Network Only**
Inpatient Hospitalization	Plan pays 80% after deductible	Plan pays 60% after deductible
Lab and X-rays	Plan pays 90% after deductible at freestanding lab, Plan pays 80% after deductible at hospital-based lab	Plan pays 60% after deductible; pre-authorization may be required
CT, PET, MRI, Nuclear Medicine		
Urgent Care Visit	Plan pays 90% after deductible	Plan pays 60% after deductible
Emergency Room Visit	Plan pays 80% after deductible	Plan pays 80% after deductible (and must notify the Plan)
Rehabilitative Services (Speech, Physical & Occupational Therapies)	Plan pays 80% after deductible	Plan pays 60% after deductible
Chiropractic	Plan pays 80% after deductible	Plan pays 60% after deductible
Hearing Aids	Plan pays 80% after deductible every 2 years per ear	Plan pays 60% after deductible every 2 years per ear
Vision Exam	$25 (every calendar year)	Plan pays 60% after deductible once per year
Pharmacy Benefits by Elixir* *Elixir to become MedImpact	$20 Tier 1, $35 Tier 2, $50 Tier 3 2.5x for mail order, Pharmacy costs help fulfill deductible	N/A

THE CHOICE PLUS PPO PLAN MAY BE FOR YOU IF YOU LIKE USING OUT-OF-NETWORK PROVIDERS AND DON'T MIND PAYING EXTRA FOR THAT PREFERENCE.

Health Savings Account (HSA)

If you are enrolled in the Choice HSA Plan, you can open a Health Savings Account (HSA) through any HSA custodian such as any bank, credit union, insurance company, brokerage, or other Internal Revenue Service (IRS)-approved financial institution which offers HSAs—or you can keep funding the one you are already enrolled in. An HSA can be used to pay for qualified medical, prescription drug, dental, vision, and over-the-counter health expenses. **You may also use HSA funds to pay for certain Medicare premiums and long-term care expenses.**

Who's Eligible To Open An HSA Account?

- You must be enrolled in the City's Choice HSA Plan or other high deductible health plan.

Who's Not Eligible To Open An HSA Account?

- You cannot be enrolled in other medical coverage, including a spouse's group health plan, Medicare, or receiving health care through the VA.
- You cannot be claimed as a dependent on someone else's tax return.
- You cannot use an HSA to pay for health care expenses incurred by a domestic partner.

Benefits of HSAs

PAY FOR HEALTH CARE EXPENSES

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

ENJOY TAX SAVINGS

With an HSA, you can enjoy tax savings on contributions, interest earned (once HSA reaches a certain amount), and paying for qualified health care expenses.

FUND YOUR FUTURE

Money left in your HSA at the end of each year rolls over to the next year. You can use your HSA to fund qualified medical expenses during retirement. Once you turn 65 years of age, funds may be used for non-medical purposes (regular income taxes apply).

Important Note: Be sure to review IRS rules before making contributions and distributions.

CONTRIBUTING TO AN HSA

You can contribute to your HSA after-tax as long as you meet IRS rules for eligibility. Contact your financial advisor for information.

For 2025, HSA contribution limits are:

- $4,300 for single coverage
- $8,550 for family coverage
- $1,000 additional "catch up" amount, if you are 55 or older

Wellness Programs For Non-Medicare Enrollees

Our retirees continue to make positive contributions to the City of Phoenix long after they have left employment. We offer retiree wellness programs to support you and your family as you continue to live a healthy, active, and productive life.

Real Appeal® Weight Loss Program

Real Appeal is a free, online weight loss program available to you and eligible family members through your health benefits plan. The program offers a variety of services to help you reach your ideal weight:

- Transformation Coach and online group sessions
- Digital tools to help track your food, activity, and weight loss progress
- A Success Kit with recipes, scales, workout DVDs, and more – shipped right to your door!

Visit Realappeal.com
Call (844) 924 7325

Real Appeal®

Members can also access Real Appeal by visiting myuhc.com > Health Resources > Real Appeal.

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.

Pharmacy Benefits

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

Over 90-days' worth of medication from one of our three retail pharmacies (CVS, Target, or Fry's) or by mail through Birdi. (Pay only 2.5x 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.

Pharmacy Benefits

elixir → MedImpact

Drug Tiers

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

- Generic drugs contain the same active ingredients as their brand-name equivalents and meet the same federal standards for safety, but typically cost significantly less
- Preferred Brand drugs are brand-name medications that are favored by the prescription plan based on drug effectiveness and cost
- Non-Preferred 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.

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 2.5x 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.

Medicare Health Plans

City of Phoenix Medicare-eligible retirees and/or their Medicare-eligible spouse/QDP can enroll in AARP/UnitedHealthcare Supplement Plans (these are not City sponsored Medicare plans.) Additionally, a Qualified City Contribution (QCC) discount of $30 or $90 retirees would apply towards a retiree and/ or their spouse/QDP supplement plan enrollment if the retiree is MERP eligible.

RETIREE GROUP	QCC
General City	$30.00
Police	$30.00
Fire (Unit 5 retirees only)	$90.00

New to Medicare

Becoming Medicare eligible opens many options for your health care coverage. Your initial opportunity to enroll into Medicare Part A and Part B begins 3 months before your 65th birthday, includes your birthday month, and 3 months after you've turned 65. It is imperative to enroll into Part B during the initial eligibility period to avoid premium penalties being applied by Centers for Medicare & Medicaid Services (CMS). Often, those currently receiving Social Security will be automatically enrolled. For more information on enrolling into Medicare, please visit medicare.gov or call **(800) 633-4227.** The City of Phoenix also has a Medicare Broker, Kenny Tims, that is available to assist with UHC Medicare Plan enrollment and can be reached at (602) 380-5197 or at healthmarkets.com/ktims.

Attaching Coverage To Your City Of Phoenix Pension

To receive the QCC premium discount for a new supplement enrollment for a retiree and/or their spouse/QDP, MERP eligible retirees must elect to have the supplement plan premium(s) deducted via pension by completing a "Retiree Authorization to Deduct Medicare Premiums" form. Additionally, AARP/UnitedHealthcare pharmacy plan premium can be attached for pension deduction although the QCC discount is only for supplement plans. Pension attachment is on a prospective basis. The form can be found in the Document Library on phoenix.gov/benefitsretiree. Contact the Benefits Office at **(602) 262-4777** for questions on how to complete the attachment form.

Key Items to Remember About the AARP/UnitedHealthcare Supplement Plan Options

- Must be Medicare Eligible
- Must be enrolled in Medicare Part B prior to beginning enrollment process for a supplement policy
- Medicare Part B premiums, other insurance carriers outside of AARP/UnitedHealthcare, or Advantage plans cannot be linked to your pension for deduction
- An authorization form is required to link AARP/UnitedHealthcare supplement premium(s) to your pension. No action is needed for supplement plans already attached

To be eligible for these plans, you or your spouse/QDP must be an AARP member.

AARP Membership

UnitedHealthcare will pay for your first year of membership if you are a new enrollee into an AARP/UnitedHealthcare plan. If you are a current AARP member and need to renew your membership, please contact AARP at **(888) 687-2277**.

Medicare Health Plan Enrollment

Enrollment Period

The AARP/UHC Medicare Supplement plan is available to enroll at any time during the year.

The **Prescription Drug Plan** enrollment is only available during the Medicare Open Enrollment period of **October 15th through December 7th** or with a special election period (SEP), as determined by Medicare enrollment guidelines.

Supplement & Pharmacy Coverage Are Separate Choices

The AARP/UnitedHealthcare supplement plans offered are individual policies based on your own eligibility and do not include pharmacy coverage. Pharmacy coverage is independent of your supplemental policy, which enables you to enroll through AARP/ UnitedHealthcare for supplemental and pharmacy or choose a different company for either. **Only AARP/UnitedHealthcare supplements and/or pharmacy enrollments can be attached to your monthly pension.**

If you enroll after your initial Medicare eligibility period, underwriting may occur when you apply to change from one Medicare plan to another, or from one insurance company to another. Everyone has the right to apply for coverage, however, please do not cancel your current medical plan unless you are notified by AARP/UHC that your application was accepted, and you have been enrolled for 2025. Please contact AARP/ UnitedHealthcare for questions regarding their underwriting process at **(844) 488-3960**.

Important

If you submit an enrollment application for a Medicare Supplement plan coverage through AARP /UnitedHealthcare, do not terminate your current Medicare plan until **you have been accepted by AARP/United Healthcare.** Be sure to respond to calls or inquiries from AARP/UHC promptly, in order to receive a timely application decision.

BY PHONE (RECOMMENDED):

- For medical benefits coverage and pharmacy benefits coverage, call AARP/UHC at **(844) 488-3960**.
- Hours of operation:
  - **10/1 – 3/31:** 8am – 8pm local time 7 days a week
  - **4/1 – 9/30:** 8am – 8pm local time Monday - Friday

BY PAPER (MEDICAL ONLY):

- The Medicare Supplement enrollment form is included in the enrollment packet. You may request a packet by calling AARP/UHC at **(844) 488-3960**.

ONLINE:

- For medical coverage, you may enroll online through https://www.AARPMedicareplans.com (City of Phoenix Medicare Supplement Plan: 1505)
- For Medicare Part D prescription drug coverage, enroll at https://www.AARPMedicareplans.com (City of Phoenix PDP Plan: 24979-002)

Tips For Completing Your AARP/UHC Enrollment Form

To ensure you fill out your enrollment form completely, have your health history information on hand, such as:

- Your Medicare information, including your Medicare number
- A list of all medications you're currently taking
- Surgeries and hospitalizations you've had for the last two years

Medicare Pharmacy Benefits

Four Medicare Part D prescription drug plans are available to you through AARP/UHC*. Pharmacy benefit plans do not require underwriting. Please note that information shown below is for 2024. 2025 information is not available at time of printing.

HOW EACH PLAN DIFFERS:	THE AARP® MEDICARERX PREFERRED (PDP)	THE AARP® MEDICARERX SAVER (PDP)
Annual Prescription Drug Deductible	$0	$590
Network of Preferred Pharmacies (get highest retail coverage when you use a preferred pharmacy). For current benefit plan information visit www.aarpmedicareplans.com	• Available in all regions • No Deductible • Preferred Formulary • Broad Pharmacy Network • $0 Tier 1 & Tier 2 Home Delivery	• Available in all regions • Basic Formulary • Broad Pharmacy Network

*The AARP MedicareRx Preferred and Walgreens plans are available in all 50 states. The AARP MedicareRx Saver and Basic plans are state specific. Whether you call to enroll or enroll online, you will be directed to which plan is available in your state.

To check whether the medication you're currently taking is covered under your new plan, go to www.aarpmedicareplans.com or call Customer Service with questions at **(844) 488-3960**.

ID Cards

Once you're enrolled in medical and prescription drug coverage, you may receive up to three identification cards:

1. If you are a new AARP member, you'll receive an AARP card.
2. All approved medical plan participants will receive a UHC medical ID card.
3. If you enroll in a Medicare Part D prescription drug plan, you'll receive a separate prescription drug ID card.

WITH MEDICARE — MEDICAL & PHARMACY ARE SEPARATE DECISIONS

Please note that for Medicare retirees, the decision for medical and pharmacy coverage are separate decisions. You can choose to enroll in just the Medicare Supplement, just pharmacy, or both. This means the coverage is considered stand-alone and they do not need to be through the same insurance company. **Only a Medicare supplement through AARP/UnitedHealthcare will be eligible for the QCC discount off premiums.**

Retiree Dental Plans

We value your smile! There is no time like the present to get caught up on all your dental care needs! The City of Phoenix offers two dental plan options for retirees, so you can preserve your teeth and your smile for years to come!

CIGNA DENTAL PPO	CIGNA DENTAL HMO
National PPO network of dentists	In-network services covered only—if electing the Dental HMO, be sure your dentist is a network provider. Your assigned dentist must be located within 25 miles of your residence address for coverage to apply
In-network and out-of-network care is covered, but you may pay more with an out-of-network dentist	No deductible
Calendar year deductible	No maximum for most covered services
Deductible waived for preventive services	Free preventive care
All services covered at 80%	Patient Charge Schedule (PCS) for dental services
Maximum annual benefit per member, $2,000/calendar year	

Dental premiums must be deducted from pension. No direct pay option is available.

Primary Care Dentist (PCD) For Cigna Dental HMO

Under the Cigna Dental HMO, all of your dental care is coordinated by a Primary Care Dentist (PCD). Each covered family member will be assigned to a network dentist upon enrollment, but you can change the assignment by calling **Cigna Dental at (800) 244-6224**. If you contact Cigna Dental by the 20th of the month, your assigned dentist will be changed by the 1st of the next month. When searching for a dentist, select from the Cigna Dental Care Access Plus network.

Dental Coverage Levels

You have three coverage levels to choose from when enrolling in dental benefits:

MONTHLY RATES	PPO	HMO
Retiree	$58.52	$26.40
Retiree + One	$128.50	$54.84
Retiree + Family	$187.34	$82.26

Dental premiums must be deducted from pension. No direct pay option is available.

FOR MORE INFORMATION OR TO FIND AN IN-NETWORK DENTIST:
Call **(800) 244-6224** or visit www.myCigna.com

Dental Plan Comparison

	CIGNA DENTAL PPO		CIGNA DENTAL HMO**
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK ONLY
Dentists	Total Cigna DPPO Network	Any licensed dentist in the U.S.	Dental Care Access Plus Network
Network Features	Large, national network of dentists and dental specialists		Smaller, local-only network of dentists with Features fewer dental specialists
Calendar Year Deductible	$50 individual, $150 family (Deductible does not apply to preventive services)		None
Calendar Year Benefits Maximum	$2,000		None
Diagnostic & Preventive Care Cleanings, exams, Xrays: 2 per calendar year	Plan pays 80% of covered charges (no deductible)	Plan pays 80% of Reasonable & Customary Charges* (no deducible)	No charge
Basic Restorative Care Extractions, fillings, root canals, oral surgery, repairs to bridges, crowns, and dentures	Plan pays 80% of covered charges (after deductible)	Plan pays 80% of Reasonable & Customary Charges* (after deductible)	Based on Dental HMO Coverage and Fee Schedule
Major Restorative Care Implants, inlays and onlays, bridges, crowns, and dentures	Plan pays 80% of covered charges (after deductible)	Plan pays 80% of Reasonable & Customary Charges* (after deductible)	
Implants	Plan pays 80% of covered charges (after deductible)	Plan pays 80% of Reasonable & Customary Charges* (after deductible)	

*Reasonable & Customary Charges: The average fee charged by a particular type of health care practitioner within a geographic area.
**Cigna DHMO plan is not available in the following states: AK, ME, MT, NH, NM, ND, PR, SD, VI, VT, and WY. Covered expenses will not include and no payment will be made for Orthodontia services.

Retiree Vision Plan with Davis Vision by MetLife

Your eyes are your window to the world, so keeping them healthy is a wise investment of your resources. You may enroll in a vision plan that provides coverage toward one pair of glasses or contact lenses once each calendar year.

The vision plan provides coverage for exams and a wide selection of frames and lens options to include progressive lenses, tinted lenses, transition lenses, and polycarbonate lenses. The network includes the following vision providers, as well as many independent providers:

- Nationwide Vision
- Visionworks
- America's Best Contacts & Eyeglasses
- Walmart
- Sam's Club
- JCPenney Optical
- Eyeglass World
- Warby Parker
- Target Optical

Vision Coverage Levels

You have three coverage levels to choose from when enrolling in vision benefits:

MONTHLY RATES	
Retiree	$11.55
Retiree + One	$21.83
Retiree + Family	$26.57

Vision premiums must be deducted from pension. No direct pay option is available.

For More Information, Or To Find An In-Network Provider:

Davis Vision by MetLife
Call: 833-EYE-LIFE

Members should visit www.metlife.com/mybenefits.

DavisVision® By MetLife

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.

Retiree Vision Plan with Davis Vision by MetLife

VISION CARE SERVICE	IN-NETWORK	OUT-OF-NETWORK
Eye Exam	$10 co-pay	Up to $40
Materials	No co-pay for base lenses	Up to $50
Frame Allowance All Frames from the Davis Vision Exclusive Collection are covered in full	$175 retail value at participating Walmart, Costco, Sam's Club, and other retail locations	Up to $50
MEMBER CHARGES		
Single Vision Lenses	Included	Up to $40
Bifocal Lenses	Included	Up to $60
Trifocal, Lenticular Lenses	Included	Up to $80
Standard & Premium Progressive Lenses	Included	Up to $60
Polycarbonate Lenses (adult & children)	Included	Up to $40
Standard Scratch Resistant Coating	Included	Up to $40
Premium Scratch Resistant Coating	$30 Member Charge	Up to $40
Standard Tint (all gradients)	Included	Up to $40
Standard Anti-Reflective Coating	Included	Up to $40
Transitions	Included	Up to $40
Ultraviolet Coating	Included	Up to $40
CONTACT LENSES		
Elective	$175 allowance	Up to $175
Medically Necessary	Included with prior approval	Up to $250
Conventional Contact Lens Fit and Follow-Up	Included	Up to $175
Specialty Contact Lens Fit & Follow-Up	$60 allowance plus 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 (up to $175 allowance)	Free at Prime Eye Care locations (Limitations apply)	

Elder Care Support

The City of Phoenix understands the benefits we provide are more valuable than ever to our members, especially for our retirees. We are committed to supporting the well-being of our retirees and their family members as we adjust to living in the "new normal."

Elder Outreach is available to you through ComPsych Guidance Resources. One phone call puts you in touch with a credentialed care manager who specializes in the medical care of older adults. The Elder Care Specialist will come to your home to assess your needs and develop a customized support plan. Together, you can consider your housing options, home health services, safety management, health management, social engagement, nutritional counseling, cognitive monitoring, mental health, grief counseling, and more.

Get the support you need!

ComPsych Guidance Resources
Call: (844) 819-4775
TDD: (800) 697-0353
Visit: guidanceresources.com
Access Code: Please contact the benefits office
Download the app: GuidanceNow®

ComPsych®
GuidanceResources® Worldwide

Pet Insurance

Because we all love our pets, the City will continue to offer pet insurance at a group discount in 2025 through MetLife Pet Insurance. Investing in pet insurance can ease the burden of making medical decisions that can have a big financial and emotional impact on you and your family.

- 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 your pet's species, age, breed, and ZIP code
- 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 by you directly to MetLife (premiums are not paycheck deductible)

MetLife Pet Insurance

(855) 270-7387
MetLifepetinsurance.com

ARAG Legal Insurance

Retirement is an important time to get your legal affairs in order. 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 open enrollment and last for the calendar year

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: 16922ret)

ARAG
Legal Insurance

How to Enroll in Retiree Benefits

IMPORTANT 2025 OPEN ENROLLMENT DATES	
RETIREE BENEFIT	**ENROLLMENT PERIOD**
AARP/UHC Medicare Supplement plan	Any time of year
Retiree Medicare Part D Prescription Drug Plans	Oct. 15th - Dec. 7th (or with a special election period as determined by Medicare enrollment guidelines)
Retiree non-Medicare Health Plans including Elixir Pharmacy	Oct. 11th - Nov. 8th, 2024 by 11:59 PM MT*
Retiree Dental & Vision Plans	Oct. 11th - Nov. 8th, 2024 by 11:59 PM MT*
Elder Care Support, Pet Insurance	Any time of year
Legal Insurance	Oct. 11th - Nov. 8th, 2024 by 11:59 PM MT*

NON-MEDICARE MEDICAL, DENTAL, OR VISION PLAN

Complete the Retiree Enrollment Form on page 5. Call the Benefits Office
Phone number: (602) 262-4777 (open between 8 AM to 5 PM)
Email: benefits.questions@phoenix.gov

TO ENROLL (OR WAIVE) IN A MEDICARE MEDICAL OR PHARMACY PLAN:

Call AARP/UHC at (844) 488-3960

TO ENROLL (OR WAIVE) IN THE LEGAL INSURANCE PLAN:

Call ARAG at (800) 835-3425 (Access Code: 16922ret)
Pay monthly premiums directly to the vendor

TO ENROLL IN PET INSURANCE:

Call MetLife Pet Insurance at (855) 270-7387
Pay monthly premiums directly to the vendor

Reminder: Open Enrollment Form Required!

The City of Phoenix requires retirees seeking to change or waive Non-Medicare Medical, Dental, or Vision coverage for yourself or your spouse/family, to complete a Retiree Open Enrollment Form. This form can be found on page 5 of this guide. You can also complete this form electronically by visiting **phoenix.gov/benefitsretiree**.

*Please note that the Benefits Office staff will only be available through 5:00pm on November 8th.

Questions? Get Help From Our Benefits Vendors

FOR MORE INFORMATION ON	CONTACT	PHONE/WEBSITE/EMAIL
BENEFITS FOR MEDICARE RETIREES		
Medicare Supplement Plans **Medicare Pharmacy Plans**	UnitedHealthcare	Medicare Supplement: Pre-Enrollee Questions – (844) 488-3960 Post-Enrollee Questions – (800) 545-1797 Prescription Drug Plan: Pre-Enrollee Questions – (844) 488-3960 Post-Enrollee Questions – (888) 867-5575 10/1-3/31: 8am – 8pm local time, 7 days a week and 4/1 – 9/30: 8am – 8pm local time Mon. - Fri. www.myAARPmedicareplans.com AARP Membership Renewal Line: (888) 687-2277
BENEFITS FOR NON-MEDICARE RETIREES		
Medical	UnitedHealthcare	(844) 585-1273 Monday - Friday, 8:00a.m. - 8:00p.m. https://www.whyuhc.com/phoenix
Pharmacy	Elixir Solutions (Elixir to become Medimpact)	(833) 803-4402 elixirsolutions.com
BENEFITS FOR ALL RETIREES		
Dental	Cigna	(800) 244-6224 • www.mycigna.com
Vision	Davis Vision by MetLife	(833) EYE-LIFE www.metlife.com/mybenefits
Elder Care Resources	ComPsych	(844) 819-4775 or TDD (800) 697-0353 www.guidanceresources.com Download the app: GuidanceNow®
Legal Insurance	ARAG	(800) 835-3425 www.ARAGlegal.com/plans (Access Code: 16922ret)
Pet Insurance	MetLife	(855) 270-7387 • MetLifepetinsurance.com

Questions? Get Help From Our Benefits Team

FOR MORE INFORMATION ABOUT	CONTACT
Public Safety Retirees: Arizona State Retirement System (ASRS) Benefits	Arizona State Retirement System (ASRS) www.azasrs.gov
PSPRS State Subsidy	Public Subsidy Coordinator 602-262-4777 public.subsidy@phoenix.gov

FOR MORE INFORMATION ABOUT	CONTACT
Updating an Address or Phone Number	General city retirees should contact the City of Phoenix Employees' Retirement System (COPERS) office at (602) 534-4400 Sworn public safety retirees should contact the City of Phoenix Benefits Office at (602)262-4777 and PSPRS at (602) 255-5575
Resetting an eCHRIS Self-Service Password	**Help Desk** (602) 534-4357 Monday to Friday, 7:00 a.m. to 5:00 p.m.
Questions about: ■ **Ordering New ID Cards** ■ **Finding a Provider** ■ **Submitting a Claim** ■ **Updates About a Claim**	**Individual Benefits Vendors** (see contact information on previous page)
Questions about: ■ **Benefits Eligibility** ■ **Benefits Enrollment** ■ **Change in Benefits** ■ **Unresolved Problem with a Benefits Vendor**	**City Benefits Office** (602) 262-4777 Monday to Friday 8:00 a.m. to 5:00 p.m. benefits.questions@phoenix.gov

Glossary

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

- **Choice HSA Plan: Non-Embedded Deductible** – 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.
- **Catastrophic, Choice Plus PPO, and Navigate HMO Plans: Embedded Deductible** – 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.

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NOTICE OF SPECIAL ENROLLMENT RIGHTS FOR HEALTH PLAN COVERAGE

If you are declining enrollment in the City of Phoenix health plan for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward you or your dependents' other coverage). However, you must request enrollment within 31 calendar days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 calendar days after the marriage, birth, adoption, or placement for adoption.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or obtain more information, contact the City of Phoenix Benefits Office at benefits.questions@phoenix.gov or (602) 262-4777.

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, 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.

PROVIDER CHOICE NOTICE

The City of Phoenix health plan generally allows the designation of a Primary Care Provider (PCP). You have

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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.

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

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we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

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

Your Choices

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

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

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

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

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

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

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

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

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Run our organization

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

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

Pay for your health services

- We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

- We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

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

Help with public health and safety issues

We can share health information about you for certain situations such as:

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

Do research

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

Comply with the law

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

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

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

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

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- 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 PROTECTION 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 you have an emergency or when

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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.

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,

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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.

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;

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- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

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

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

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

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 the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

For more information about the Marketplace, visit www.HealthCare.gov.

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

City of Phoenix

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