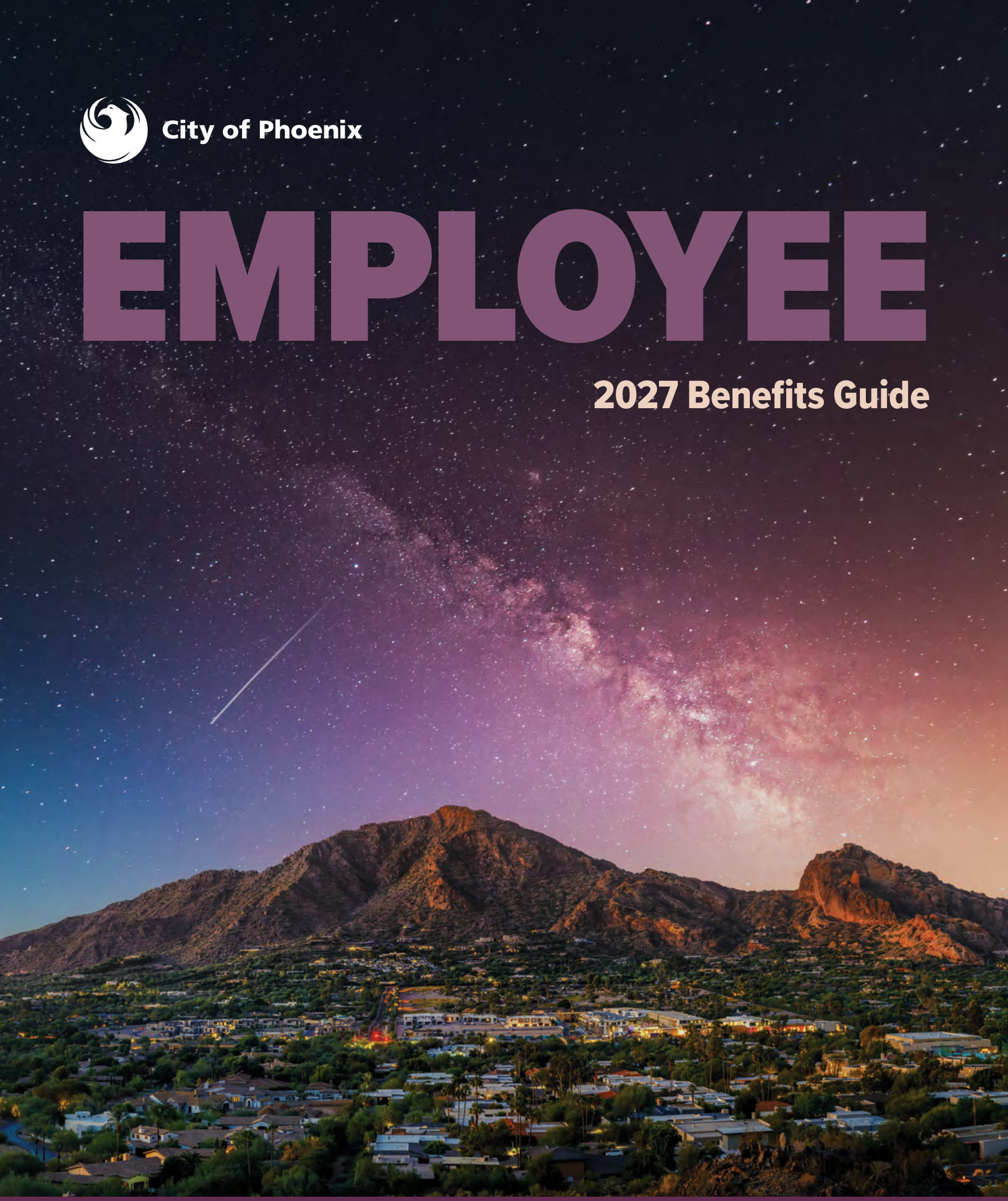
City of Phoenix

EMPLOYEE

2027 Benefits Guide



Annual Open Enrollment is October 9 through November 6, 2026, at 11:59 **p.m. MST**

Table of Contents

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Welcome

ANNUAL OPEN ENROLLMENT

Annual Open Enrollment is October 9–November 6, 2026, at 11:59 p.m. MST. If you have questions about your benefit choices or how to enroll, call the City's Benefits Office at **602-262-4777** or email benefits.questions@phoenix.gov. For more information, visit phoenix.gov/benefits.

Please note: Benefits Office staff will be available to answer questions until 5 p.m. MST on November 6, 2026. Any changes made during Annual Open Enrollment are final once the Annual Open Enrollment period ends. You cannot make changes after Annual Open Enrollment unless you experience a qualified life event (QLE).

OUR BENEFITS PROGRAM

- Three medical plans: Saver's Choice HDHP, PPO, and HMO
- Three dental plans: Dental PPO, Dental PPO Plus, and Dental HMO
- A buy-up vision plan
- A Health Savings Account (HSA) when you enroll in the Saver's Choice HDHP
- Flexible Spending Accounts (FSAs)
- A wellness incentive that can add up to $60 per month
- An Employee Assistance Program (EAP) with 12 free counseling visits per incident
- Two legal insurance plans: value and buy-up
- Qualified domestic partner coverage
- Post-Employment Health Plan (PEHP)
- Employee Loan Program
- Pet insurance

The 2027 Employee Benefits Guide includes important information and updates about City of Phoenix employee benefits. It does not include all plan rules, details, limitations, and exclusions.

Summary plan descriptions, coverage certificates, policies, contracts, and similar documents will govern if questions of coverage arise. The City of Phoenix reserves the right to change or discontinue its employee benefit plans at any time.

MESSAGE FROM THE CITY MANAGER

Each year, the City of Phoenix conducts a thorough review of our employee Benefits package in collaboration with the employee-driven Health Care Task Force (HCTF) and the independent Health Care Benefits Trust Board (HCBTB). We want to ensure that our benefits are sustainable, competitive, and aligned with the long-term financial health of the Health Care Benefits Trust. Preserving these important benefits is critical to City employees' well-being. Rising health care costs continue to require premiums and plan design changes for the upcoming year to keep our benefits available.

As Annual Open Enrollment begins, all employees are encouraged to attend a virtual information session hosted by the HR Benefits Team to explain all updates going into effect.

Thank you for your continued service to the City of Phoenix.

When to Review This Guide

When You Are Hired

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

During Annual Open Enrollment

During Annual Open Enrollment to see what's new before deciding whether to make changes or let your current elections roll forward, except for the health and dependent care FSAs and the Health Savings Account, which require an annual election.

When a Qualified Life Event Occurs

Whenever a qualified life event (QLE) occurs, such as marriage, birth, adoption, legal guardianship, divorce, or loss of other group coverage. See the Benefits website for a list of QLEs.

Innovative Features

The City's health plans offer innovative features to save you time and money. For example, when it's appropriate, you can control costs by using virtual health visits instead of visiting your PCP in person.

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

This guide provides highlights of the City of Phoenix employee benefit plans, effective January 1, 2027. Summary plan descriptions, coverage certificates, policies, and contracts prevail.

2027 Benefit Highlights

Here are a few highlights of the benefits designed to offer support to you and your family in 2027.

Reminder: During Annual Open Enrollment, review your address in eCHRIS, dependent documentation requirements, HSA elections, and FSA changes. Details are included in the relevant sections of this guide.

> It is the employee's responsibility to update their address in eCHRIS.

PERSONIFY HEALTH WELLNESS PLATFORM

The Fit4Phoenix Employee Wellness Program helps employees thrive in every area of health. Through Personify Health, employees and their families have access to wellness services, resources, and the City's wellness incentive.

Action required: To receive the wellness incentive starting in January 2027, complete the Health Assessment and the PCP Visit Attestation by **December 13, 2026**. These wellness incentive requirements cannot be completed between December 14 and December 31, 2026.

For more information about the wellness incentive, see page 14.

EMPLOYEE HEALTH CLINIC

The City of Phoenix Employee Health Clinic will permanently close on December 31, 2026, when our current contract with Banner Employer Solutions ends. This decision comes after a review showing that employee use of the clinic has remained very low, while operating costs have continued to rise. Because these costs draw directly from the City's Health Care Benefits Trust, continuing to fund a low-use service would increase pressure on the health plan and future premiums. To learn more, visit phoenix.gov/benefits.

High-Quality Medical Coverage

The City is committed to continuing to provide high-quality medical coverage through the same plans you know and rely on.

In 2027, you will see small medical plan design changes and a rate increase. As health care costs continue to rise, rate increases help support sustainable, high-quality medical benefits for years to come.

Your medical ID card can be used at the pharmacy. On the back of your medical ID card, you will find your pharmacy information for MedImpact.

BLUE CROSS BLUE SHIELD PPO PLAN

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

2027 Changes:

Monthly premium increases: $49.12 individual; $155.96 family

Out-of-pocket maximum increases: in-network increased to $600 individual / $1,800 family; out-of-network increased to $1,200 individual / $3,600 family

Introducing:

Telehealth from AZ Blue provides virtual visits by phone, tablet, or computer for medical care 24/7, plus counseling and psychiatry by appointment. Use it for non-emergency needs, such as colds, flu, sinus infections, rash, stress, anxiety, depression, and other common physical or behavioral health concerns.

BANNER | AETNA HMO PLAN

The HMO Plan provides you access to the Banner Health Network, including Honor Health.

2027 Changes:

Monthly premium increases: $15.21 individual; $48.29 family

Introducing:

Transcarent, powered by 98point6: Get the same on-demand, text-based care 24/7 from a smartphone or tablet for common non-emergency health needs. Through the 98point6 by Transcarent app, eligible members can ask health questions, start a visit anytime, and receive care guidance. When appropriate, providers can order labs or send prescriptions to a local pharmacy.

SAVER'S CHOICE HDHP + HSA PLAN

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

2027 Changes:

Monthly premium increases: $8.72 individual; $28.44 family

Deductible increases: in-network deductible increased to $2,000 individual / $4,000 family; out-of-network coverage is not available except in emergencies

Action Required

Saver's Choice HDHP + HSA Plan

You are not automatically enrolled in an HSA when you elect the Saver's Choice HDHP. To receive the City's HSA contribution, you must elect an HSA.

For more information about HSA eligibility and enrollment, see the Health Savings Account (HSA) section.

If adding a dependent during Annual Open Enrollment, both the elections and applicable dependent verification documentation must be received before the close of Annual Open Enrollment.

Eligibility

Eligible Employees

To be eligible for benefits, you must be a full-time, benefits-eligible City employee. Benefits are effective the first of the month following your date of hire. Please see plan documents for specific eligibility requirements for each benefit plan. Missed premiums will be deducted from your paycheck.

Eligible Dependents

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

- Your legal spouse
- Your qualified domestic partner (QDP) (approval process required)
- Your biological or adopted child, up to the month in which they attain age 26
- Your disabled child age 26 or older with confirmed disabled dependent certification and recertification by the health insurance carrier before turning 26
- Your stepchildren up to age 26 (so long as you are legally married to their parent)
- Your QDP's biological children up to age 26, as long as the qualified domestic partnership is approved and intact
- Children for whom you have legal custody or court-approved guardianship until age 18 or as specifically stated in the custody or guardianship order

INELIGIBLE DEPENDENTS FOR HEALTH COVERAGE

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

- Your ex-spouse or former qualified domestic partner (QDP)
- Your parents or your spouse's or QDP's parents
- Children of your ex-spouse or former QDP who are not your biological or adopted children
- A spouse or domestic partner who is actively serving in the military
- A dependent who is currently incarcerated in prison

The City conducts periodic audits to verify dependent eligibility. That process and associated actions and impacts are detailed on page 8.

Part-Time Eligibility

Hourly-paid members who have averaged at least 30 hours weekly in a calendar year are entitled to the same benefits as regular full-time unit members. Continued participation in these plans will be determined every calendar year in October by reviewing the average hours worked in the prior 12-month period. This qualifying period will determine eligibility for the following benefit year, effective January 1. Regardless of benefits eligibility, all part-time employees are eligible for commuter life insurance beginning on the date of hire.

UNIT 001 PART-TIME ELIGIBILITY

Hourly-paid Unit 001 members who have worked at least 50 hours in each pay period for 26 consecutive weeks are entitled to the same benefits as regular full-time Unit 001 members. Continued participation in these plans will be determined every calendar year on October 1 by reviewing the average hours worked in the prior 12-month period. This qualifying period will determine eligibility for the following benefit year, effective January 1.

Unit 001 part-time employees are allowed an hours reduction of up to two weeks in one pay period during the 26-week qualifying period and each period thereafter, without affecting their eligibility to participate in the part-time employees' benefits programs.

Moving from full-time to part-time will continue benefits eligibility through the end of the benefit year

Enrolling Dependents

DOCUMENTATION REQUIREMENTS FOR ENROLLING DEPENDENTS

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

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

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

Social Security numbers must be provided to the Benefits Office for all family members enrolled in City benefits coverage. This is required for federal reporting under the Patient Protection and Affordable Care Act (ACA). If you add a dependent during Annual Open Enrollment, both your benefit elections and applicable dependent verification documentation must be received before Annual Open Enrollment closes.

Refer to the table to the right for the required documentation based on dependent type.

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

Important Tax Information for Qualified Domestic Partner Coverage

Generally, the IRS does not recognize a domestic partner as being eligible for the same tax considerations as a legal spouse unless the domestic partner qualifies as your tax dependent under Internal Revenue Code Section 152. Payroll deductions for domestic partner coverage may not be taken from your paycheck on a pretax basis and the premium attributed to the domestic partner's coverage will be treated as imputed (additional) income resulting in an increase to the employee's tax liability, unless the employee completes the Certificate of Eligibility and Dependent Status for Health Coverage Form, and satisfies all requirements under the Internal Revenue Code Section 152, qualifying the Domestic Partner as a tax dependent. Changes to a tax status received after December 31 of the current calendar year will update at the beginning of the next calendar year. If you have questions about your domestic partner's tax status, contact your financial advisor.

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

A Health Savings Account (HSA) cannot be used to pay for a domestic partner's or their enrolled children's out-of-pocket health care expenses unless they are recognized as a tax-qualified dependent under applicable state law and the Internal Revenue Code. To learn more, please contact your financial advisor, or visit irs.gov.

QUALIFIED DOMESTIC PARTNER (QDP) COVERAGE

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

To request coverage:

- Go to phoenix.gov/benefits and click on **Documents and Forms**.
- Search for "Qualified Domestic Partner Application."

Contact the City's Benefits Office with questions at benefits.questions@phoenix.gov or **602-262-4777**.

REMOVAL OF INELIGIBLE DEPENDENTS

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

IMPORTANT NOTE:

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

Enrollment Policies

If you and an eligible dependent are both City of Phoenix employees, the following enrollment rules apply:

- Employees and dependents cannot be enrolled in the same City benefit plan more than once.
- If you do not have eligible children enrolled in coverage, each employee must elect individual coverage.
- If you have eligible children, both employees and all eligible children must be enrolled under one family plan. One employee cannot elect individual coverage while the other elects family coverage.
- Each employee may elect either Employee Optional Life Insurance or Spouse Optional Life Insurance but cannot be covered under both options at the same time.

MAKING CHANGES MIDYEAR

Outside of Annual Open Enrollment, you can change your benefit elections only when you experience a qualified life event (QLE). A QLE chart is available on the Benefits website under Documents and Forms.

It is your responsibility to keep your address current in eCHRIS so the City has your correct mailing information.

Enrollment changes must be completed through eCHRIS Self-Service within the applicable time frame of the qualified life event. Coverage changes due to a life event are effective the first of the month following the date of the life event, except for birth or adoption of a child, which is effective on the date of the life event. Examples of QLEs include:

- Marriage
- Divorce
- Annulment
- Death of a spouse
- Birth*
- Adoption
- Placement for adoption
- Legal guardianship
- Change in legal custody
- Becoming covered by or losing other group coverage

*Newborns are not automatically added to your coverage. Employees have 60 days to add a newborn child through the QLE process.

Qualified Medical Child Support Order

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

Important Information

City Health Savings Account (HSA) Contributions Prorated for New Hires

City HSA contributions will be prorated monthly for the initial year of coverage for new hires or employees otherwise joining the Saver's Choice HDHP outside of Annual Open Enrollment.

How will this affect you? If you are enrolled in the Saver's Choice HDHP for all of 2027, this will not affect you at all. If you are joining the Saver's Choice HDHP at some point after January 1, 2027, either due to being a new hire or experiencing a qualified life event (QLE), the 2027 City HSA contribution will be prorated monthly based on the effective date of your enrollment in the Saver's Choice HDHP. See the table below for the prorated City HSA contribution amounts:

SAVER'S CHOICE HSA CITY CONTRIBUTION

SAVER'S CHOICE HDHP EFFECTIVE DATE	SINGLE	FAMILY	SINGLE TO FAMILY COVERAGE CHANGE ADD'L CONTRIBUTION*
January 1	$1,125	$2,250	N/A
February 1	$1,031	$2,062	$1,031
March 1	$938	$1,876	$938
April 1	$844	$1,688	$844
May 1	$750	$1,500	$750
June 1	$656	$1,312	$656
July 1	$563	$1,126	$563
August 1	$469	$938	$469
September 1	$375	$750	$375
October 1	$281	$562	$281
November 1	$188	$376	$188
December 1	$94	$188	$94

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

2027 Monthly Premium Rates

Medical Plan Premiums

FULL-TIME EMPLOYEES

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

	SAVER'S CHOICE HDHP WITH HSA		PPO		HMO	
	Employee	Family	Employee	Family	Employee	Family
Employee Monthly Premium	$143.80	$468.94	$236.30	$750.20	$167.67	$532.33
Per-Paycheck Deduction	$71.90	$234.47	$118.15	$375.10	$83.84	$266.17
City Monthly Contribution	$575.20	$1,875.75	$945.22	$3,000.78	$670.68	$2,129.32
Total Monthly Premium	$719.00	$2,344.69	$1,181.52	$3,750.98	$838.35	$2,661.65

JOB-SHARE EMPLOYEES

A deduction is taken from the first two paychecks of the month for that month's coverage (24 pay periods).
Job-share premiums are 60% employee paid and 40% employer paid.

	SAVER'S CHOICE HDHP WITH HSA		PPO		HMO	
	Employee	Family	Employee	Family	Employee	Family
Employee Monthly Premium	$431.40	$1,406.81	$708.91	$2,250.59	$503.01	$1,596.99
Per-Paycheck Deduction	$215.70	$703.41	$354.46	$1,125.29	$251.51	$798.50
City Monthly Contribution	$287.60	$937.88	$472.61	$1,500.39	$335.34	$1,064.66
Full Monthly Premium	$719.00	$2,344.69	$1,181.52	$3,750.98	$838.35	$2,661.65

2027 Monthly Premium Rates

Dental Premiums

FULL-TIME EMPLOYEES

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

	DENTAL HMO		DENTAL PPO		DENTAL PPO PLUS	
	Employee	Family	Employee	Family	Employee	Family
Paycheck Deduction	$0.00	$17.89	$0.00	$34.48	$14.74	$75.00
City Monthly Contribution	$25.96	$53.65	$50.00	$103.44	$50.00	$103.44
Full Monthly Premium	$25.96	$71.54	$50.00	$137.92	$64.74	$178.44

JOB-SHARE EMPLOYEES

One deduction is taken from the first paycheck of the month for that month's coverage. Job-share employees pay 50% for single coverage and 62.5% for family coverage for the HMO and PPO plans. The City contributes the same amount toward the PPO and PPO Plus plans, with the employee paying the difference.

	DENTAL HMO		DENTAL PPO		DENTAL PPO PLUS	
	Employee	Family	Employee	Family	Employee	Family
Paycheck Deduction	$12.98	$44.71	$25.00	$86.20	$39.74	$126.72
City Monthly Contribution	$12.98	$26.83	$25.00	$51.72	$25.00	$51.72
Full Monthly Premium	$25.96	$71.54	$50.00	$137.92	$64.74	$178.44

Buy-Up Vision Premium

ALL EMPLOYEES

Refer to the following table for all employees. A deduction is taken from the first two paychecks of the month for that month's coverage (24 pay periods).

DAVIS VISION BY METLIFE BUY-UP PLAN		
	Employee	Family
Paycheck Deduction	$5.54	$13.06

Optional Life Insurance Premiums

EMPLOYEES, SPOUSES, AND QUALIFIED DOMESTIC PARTNERS

Refer to the following table for all employees, spouses, and qualified domestic partners. One deduction per month is taken from the second paycheck of the month.

EMPLOYEE AGE	EMPLOYEE RATE PER $1,000 OF LIFE AND AD&D COVERAGE	SPOUSE OR QDP RATE PER $1,000 OF LIFE COVERAGE
Under 25	$0.057	$0.043
25–29	$0.064	$0.051
30–34	$0.080	$0.068
35–39	$0.088	$0.077
40–44	$0.095	$0.085
45–49	$0.137	$0.132
50–54	$0.211	$0.196
55–59	$0.350	$0.366
60–64	$0.527	$0.561
65–69	$0.997	$1.080
70+	$1.606	$1.080

CHILDREN

Refer to the following table for dependent children. One deduction per month is taken from the second paycheck of the month.

COVERAGE AMOUNT PER CHILD	$10,000	$15,000	$20,000	$25,000
Monthly Deduction	$1.00	$1.50	$2.00	$2.50

Legal Insurance Premium

ALL EMPLOYEES AND ELIGIBLE DEPENDENTS

Refer to the following table for all employees and their family members. One deduction is taken from the first paycheck of the month for that month's coverage.

	VALUE PLAN	BUY-UP PLAN
Coverage Level	Employee/Family	Employee/Family
Monthly Deduction	$11.65	$23.70

Understanding Medical Premiums

Who Sets the Medical Premiums?

For more than 15 years, the City has self-funded employee health plans to help manage the cost of group medical coverage. When an employer self-funds coverage, it sets annual premium rates based on the group's claims history, projected medical expenses, and the need to maintain adequate reserves.

The City of Phoenix Health Care Benefits Trust holds premium payments made by the City and employees. Trust funds can be used only for claims and plan administration. Plan administration includes necessary expenses, such as leasing provider networks, claims adjudication, appeals, drug formulary administration, stop-loss coverage, audits, and actuarial services. Because the plans are self-funded, more than 97% of every premium dollar goes directly to claim expenses.

Banner | Aetna and Blue Cross Blue Shield of Arizona (BCBS) were selected through competitive bidding processes to provide networks for doctors, hospitals, labs, and other medical services. Each network provider has a contract with Banner | Aetna and/or BCBS. These contracts determine how much is paid for services. Provider contracts are negotiated regularly and may change. Providers may apply to join a network at any time and may leave a network when their contract expires. The City does not control provider contracts or provider decisions to join or leave a network.

THE HEALTH CARE TASK FORCE

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

THE HEALTH CARE BENEFITS TRUST BOARD

The Health Care Benefits Trust Board provides financial oversight for the trust that holds premium payments from employees and the City. The Board includes four community members with benefits and/or financial backgrounds and one member representing COPCU (City of Phoenix Coalition of Unions).

The City's Contribution to Medical Premiums

The City pays 80% of eligible full-time employee medical premiums for both single and family coverage.

Wellness Incentive

Wellness Programs and Resources

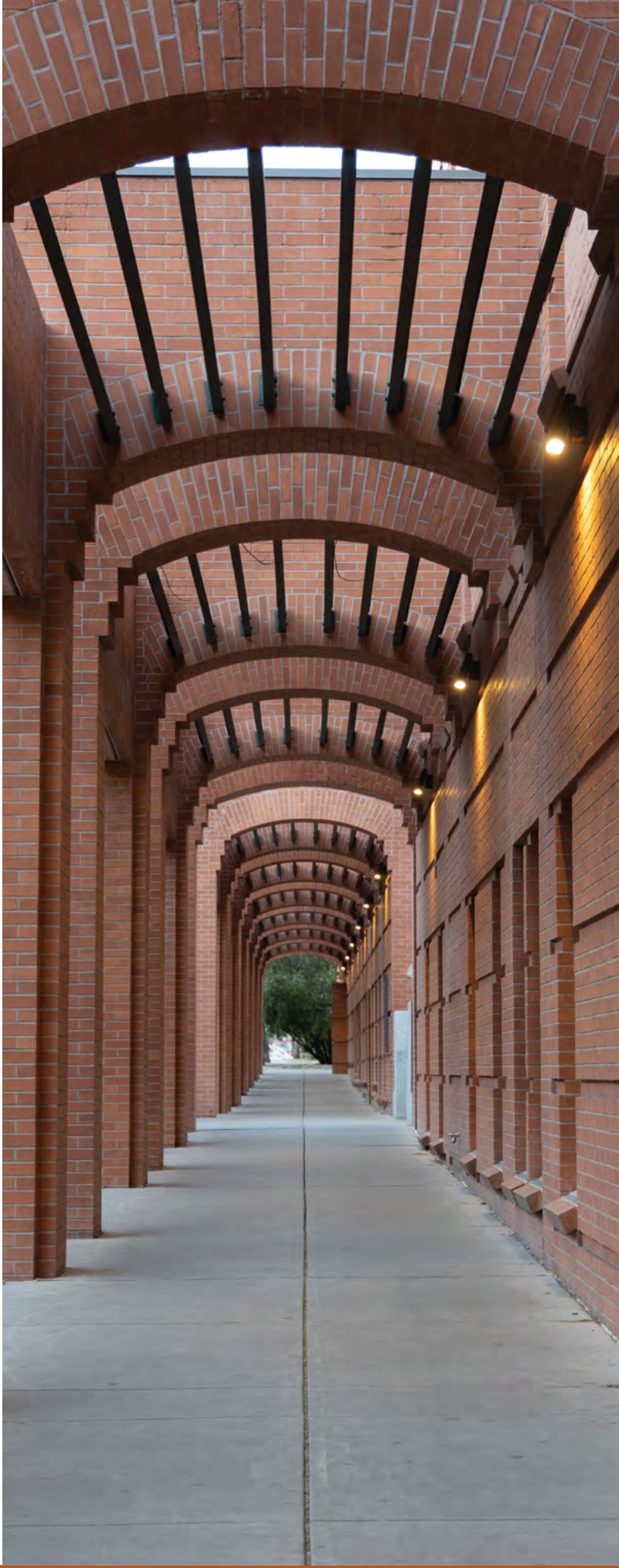
The City wants you to feel your best at work and at home. Good health is an important part of your overall well-being. Through the Fit4Phoenix Employee Wellness Program, you can find tools and resources to help you build healthy habits and manage everyday challenges.

The Fit4Phoenix Employee Wellness Program offers programs and resources in areas such as:

- Nutrition programs
- Fitness and step challenges
- Gym discounts
- Health coaching
- Wellness classes

INCENTIVE REQUIREMENTS ACHIEVED BY:	POTENTIAL EARNINGS*
Either employee or covered spouse / QDP	$40 per month
Both employee and covered spouse / QDP	$60 per month

*Earnings are paid biweekly and are subject to applicable federal and/or state tax withholdings.



Start Earning Your Wellness Incentive

STEP 1:

Visit Your Primary Care Provider (PCP)

A PCP is a family practice doctor, general practitioner, internist, or OB-GYN in your City of Phoenix employee plan network who can collect your biometric data: HDL cholesterol, total cholesterol, blood glucose, waist circumference, height, weight, and blood pressure.

STEP 2:

Create an Account

Employee: To create an account, visit join.personifyhealth.com/fit4phoenix. If you already have an account, visit login.personifyhealth.com.

Spouse or QDP: A spouse or QDP must create their own account and use their own user ID and password. To create an account, the spouse or QDP should use the employee's ID number with an S at the end. **Example:** 000000S.

STEP 3:

Health Assessment and PCP Visit Attestation

Complete the Health Assessment and PCP Visit Attestation within the same calendar year through the Wellness Incentive portal. You will need biometric data for yourself and your spouse or QDP, if applicable. For directions on how to complete Step 3, visit the City's Wellness website.

NOTE: The Health Assessment, PCP Visit, and PCP Visit Attestation must be completed and submitted in the same calendar year!

STEP 4:

Check Your Pay Stub

Once you and/or your covered spouse or QDP complete the Health Assessment and PCP Attestation within the same calendar year, your wellness incentive will appear on your paycheck under "Hours and Earnings" about 30 days after completion is reported.

To receive the first incentive of the year in 2027, you must complete both requirements by December 13, 2026. If you miss the deadline, you will not see the incentive on your first January 2027 paycheck. Your next opportunity to complete both requirements will be after January 1, 2027.

IMPORTANT

If you are or were enrolled as a spouse on another employee's City medical plan and then enroll in your own City medical plan, you must contact Personify Health to have your accounts merged within 30 days of this change.

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

Learn more about the Fit4Phoenix Wellness Program and Wellness Incentive by visiting the City's Wellness website. For questions about wellness programs, email be.healthy@phoenix.gov.

Medical Plan Highlights

All medical plans offer generous coverage and broad provider networks. You can choose from three medical plan options:

- Blue Cross Blue Shield (BCBS) Saver's Choice HDHP with Health Savings Account (HSA)
- BCBS PPO
- Banner | Aetna HMO

Review below for a quick guide to see which option may be right for you.

BCBS Saver's Choice HDHP with HSA

May be right for you if you want:

- The lowest medical premium costs
- 10% coinsurance after meeting your deductible
- A Health Savings Account (HSA) to pay for qualified health care expenses tax-free
- A City contribution to your HSA
- The ability to save and invest HSA funds tax-free for future health care expenses
- Access to HSA funds for qualified expenses even after you leave City employment

BCBS PPO

May be right for you if you want:

- The flexibility to see out-of-network providers at a higher cost
- Copays for primary care physician (PCP) and specialist visits with Patient-Centered Medical Home (PCMH) providers
- Pharmacy coverage with no deductible

Banner | Aetna HMO

May be right for you if you want:

- Medical coverage with no deductible
- Predictable costs through fixed copays
- A primary care physician (PCP) to help coordinate your care
- Specialist care without referrals

Features Included with All 3 Plans

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

Tip: Before choosing a plan, confirm that your providers participate in the plan's network. Providers may join or leave a network during the plan year.

Choosing Your Medical Plan

There are many questions that come to mind when choosing a medical plan for yourself and your family: How large is the plan's network? Am I required to use the plan's network of physicians, facilities, and other providers?

Learn what makes each plan distinct in this overview.

PLAN FEATURE	SAVER'S CHOICE HDHP WITH HSA	PPO	HMO
Provider Network	Large local and national network	Large local and national network	Large local and national network
Am I required to use the plan's network of physicians, facilities, etc.?	Yes, except in an emergency	No, but out-of-network providers may cost more	Yes, except in an emergency
Is a referral required to see a specialist?	No	No	No
Is there an annual deductible?	Yes. $2,000 individual / $4,000 family. Medical and prescription drug deductibles are combined.	Yes. $600 in-network or $1,200 out-of-network per covered member, up to the family maximum. Family maximum: $1,800 in-network or $3,600 out-of-network.	No
Is there coinsurance?	Yes	Yes	Yes. 10% coinsurance applies to home health care and skilled nursing.
Are there copays?	Only for prescriptions after the deductible is met	For some services, including prescriptions	Yes
What is the most I will pay out of pocket each year for covered in-network medical and prescription drug care?	$3,400 individual / $6,800 family	Medical: $1,500 individual / $4,500 family Pharmacy: $1,500 individual / $3,000 family	Medical—Performance Network: $1,500 individual / $3,000 family Medical—Broad Network: $2,500 individual / $5,000 family Pharmacy: $1,500 individual / $3,000 family
Can I enroll in a tax-free Health Savings Account (HSA)?	Yes. The City contributes $1,125 for individual coverage or $2,250 for family coverage each year.	No	No
What makes this plan distinctive?	The only plan with a tax-free Health Savings Account (HSA)	The only plan with out-of-network coverage	No deductible, fixed copays, and no-cost Transcarent virtual health visits

BCBS Saver's Choice HDHP with HSA

KEY FEATURES

Review the key features below to understand how the Saver's Choice HDHP works, including network access, premiums, deductibles, coinsurance, out-of-pocket costs, and HSA contributions.

KEY FEATURES OF SAVER'S CHOICE HDHP	
Provider Network	Large, national network (same as BCBS PPO) with 10,000 local physicians and more than 30 hospitals. Coverage is for in-network providers only, except in emergencies.
Lowest Premium Rates	Individual coverage: $143.80 per month Family coverage: $468.94 per month
Deductible	Individual coverage: $2,000 per calendar year Family coverage: $4,000 per calendar year
Coinsurance	10% coinsurance after the annual deductible is met. Hospital emergency room care is 20% coinsurance.*
Maximum Annual Out-of-Pocket Cost	Individual coverage: $3,400 Family coverage: $6,800. This amount includes the deductible and prescription drug copays.
Health Savings Account (HSA)	Individual coverage contribution:** $1,125 Family coverage contribution:** $2,250 The City contributes to your HSA to help cover eligible health care expenses.

*If admitted, inpatient hospitalization coinsurance will apply.

**City HSA contributions will be prorated monthly for the initial year of coverage for new hires or employees who join the Saver's Choice HDHP outside Annual Open Enrollment.

Retiring soon?

If you plan to retire soon, review the Saver's Choice HDHP with HSA carefully before enrolling. Medicare enrollment and Medicare Supplement plan coverage can prevent you from contributing to and using HSA funds. Please see IRS Publication 969 for details.

Contact our designated BCBS representative.

Visit the Benefits website for current contact information.

BlueCross BlueShield Arizona

CONTACT INFORMATION

BCBS of Arizona

- Call **602-864-4857**.
- Visit azblue.com.

Find a BCBS Provider

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

Health Savings Account (HSA)

The Health Savings Account (HSA) is part of the BCBS Saver's Choice HDHP and is administered by HealthEquity. The HSA provides you with potential savings.

HSA Benefits

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

Note: You cannot use an HSA to pay for health care expenses incurred by a domestic partner unless your domestic partner is a tax-qualified dependent.

ENJOY TAX SAVINGS

When you use your HealthEquity HSA, you can save on taxes in three ways:

- Pay for qualified health care expenses tax-free.
- Contribute to your HSA tax-free.
- Earn interest on unused HSA funds tax-free once your account reaches the $1,000 required balance.
- Investment options are available for account balances over $1,000.

Note: You cannot contribute to an HSA when you are enrolled in Medicare. If you have to (or choose to) enroll in Medicare Part A, the coverage is retroactive for up to six months, but no earlier than your eligibility date. Because of this, you should plan to stop HSA contributions around six months before enrolling in Medicare.

If you continue to contribute to your HSA after you enroll in Medicare, there may be potential tax penalties depending on your situation. One such penalty may include a 10% income tax penalty on the amount of funds you have contributed.

The City of Phoenix does not provide tax or legal advice. You should consult with your own tax or accounting advisor for your specific situation.

Important Note About Customer Identification Program (CIP) Failure: If you fail to meet CIP requirements within 60 days or by December 12, 2027, whichever is sooner, HSA contributions will be returned to the City. If CIP is not verified within the same calendar year, employer contribution funds will be forfeited for that year, and any employee contributions will be refunded to the employee.

TAKE IT WITH YOU INTO YOUR FUTURE

Money left in your HSA at the end of each year rolls over to the next year, including the City's contribution. You can save your HSA funds to use for your health care costs when you retire or leave the City. The money is yours to take with you. You can also use your HSA as another retirement vehicle: Once you turn 65 years of age, funds can be used for non-medical purposes (regular income taxes apply).

HSA Enrollment Information

You must be enrolled in the BCBS Saver's Choice HDHP to be eligible for the HSA. You are NOT automatically enrolled in the HSA when you elect the Saver's Choice HDHP. In order to receive the employee HSA seed, you have to elect the HSA, and then you'll receive a free debit card from HealthEquity for your HSA.

You have until December 1, 2027, to enroll in the HSA for this plan year. If you do not enroll by December 1, 2027, you will not receive the employer contribution for the 2027 plan year.

There is no fee for this account while you are enrolled in the Saver's Choice HDHP. If you do not enroll in the Saver's Choice HDHP for the following plan year, you may lose employer sponsorship and may be responsible for a small monthly account administration fee. If you close your HSA account, you may be responsible for an account closure fee.

You cannot enroll in the HSA if:

- You are enrolled in other non-HSA-eligible health coverage, including a spouse's group health plan, a Flexible Spending Account (FSA), or Medicare.
  - If you elect an FSA while enrolled in an HSA, your FSA election will automatically be converted to a Limited Purpose Health Care FSA.
- You are claimed as a dependent on someone else's tax return.

How the Health Savings Account Works

STEP 1:

Enroll in the BCBS Saver's Choice HDHP, and attest that you are eligible for the HSA. Per IRS rules, this is the only health plan the City offers with an HSA. You will then receive an HSA welcome kit and HSA debit card from HealthEquity.

STEP 2:

Activate the debit card. Use the debit card to pay for out-of-pocket expenses, such as copays, coinsurance, and deductibles. Pay with the HealthEquity app on your smartphone, or pay online at **myhealthequity.com**.

STEP 3:

At Annual Open Enrollment time, select the amount of your voluntary contributions to your HSA.* The HSA contribution limits for 2027 (including the City's annual HSA contribution) are $4,500 for single coverage and $9,000 for family coverage. In addition, there is a $1,000 catch-up amount for employees 55 or older.

STEP 4:

Check your HSA account for the City's contribution, given in a lump sum within 30 days of electing your HSA and generally during the first month of the plan year (January). The current City contribution is $1,125 for single coverage and $2,250 for family coverage. Note that the amount given by the City will be prorated for new hires and those otherwise enrolling in the Saver's Choice HDHP outside of Annual Open Enrollment (see page 9 for proration table).

STEP 5:

Review your pay stub. Your HSA contributions are deducted from your first two paychecks each month on a pretax basis. You can change your contribution at any time during the year using **eCHRIS Self-Service**.

STEP 6:

Use your HSA account to conveniently pay for qualified health care expenses, or save your HSA dollars to pay for expenses in future years. Your money never expires.

(See **IRS Publication 969**.)

*Important Note: An employee can contribute to their HSA on a pretax basis only while enrolled in the BCBS Saver's Choice HDHP. If you later switch to the HMO or PPO plan, you can no longer contribute to the HSA.

HSA ENROLLMENT REQUIRED

Your HSA pretax paycheck election amount must be elected each year. For instructions on how to enroll, visit our website at **phoenix.gov/benefits**. Indicate your desired contribution amount each year at Annual Open Enrollment.

You can change your contribution amount at any time throughout the year.

Contact HealthEquity

HealthEquity®

You'll receive a comprehensive welcome packet in the mail from our HSA administrator, HealthEquity, when you enroll in the BCBS Saver's Choice HDHP. You can manage your HSA account securely online. HealthEquity offers 24-hour customer service phone support and web access to track and manage your funds and provider payments. You are encouraged to attend webinars or to view videos about HSAs at **info.healthequity.com/virtual-events**.

Review the HSA qualified medical expenses (QME) list.

- Call **877-582-4793**.
- Visit **healthequity.com**.

BCBS PPO

The PPO provides in-network and out-of-network coverage. You can see the doctor of your choice, but you will pay more out of pocket when you go outside the network.

The plan has separate deductibles for in-network and out-of-network care, plus coinsurance. Once you reach the deductible, you pay coinsurance until you meet the out-of-pocket maximum. After that, the plan pays 100% of covered services.

IMPORTANT INFORMATION

When you use out-of-network physicians, labs, facilities, or other providers, you may be billed for the difference between what BCBS pays as the allowed amount and what the provider charges. This is called balance billing.

You are responsible for paying this difference to the out-of-network provider when billed. This amount is in addition to your out-of-pocket costs for the deductible and coinsurance.

KEY FEATURES OF PPO PLAN	
Provider Network	A large, national network (same as BCBS Saver's Choice HDHP) that contains 10,000 local physicians and 30 hospitals.
Highest Premium Rates (monthly paycheck deduction)	Individual Coverage: $236.30 per month Family Coverage: $750.20 per month
Deductible	In-Network: Individual: $600 per calendar year Family: $600 per covered member to a maximum of $1,800 per family Out-of-Network: Individual: $1,200 per calendar year Family: $1,200 per covered member to a maximum of $3,600 per family
Coinsurance	In-Network: 20% Out-of-Network: 30% 30% for hospital emergency room*
Maximum Annual Out-of-Pocket Cost	In-Network: Medical: $1,500 per covered member to a maximum of $4,500 per family Pharmacy: $1,500 per covered member to a maximum of $3,000 per family Out-of-Network: Medical: $3,000 per covered member to a maximum of $9,000 per family Pharmacy: Not covered
*If admitted, the coinsurance for inpatient hospitalization will be applied.	

You must pay all medical costs up to the deductible before coverage begins. If you have family coverage, each covered member has a deductible until the individual or family deductible is met.

After the member or family deductible is met, the member pays coinsurance until the member or family out-of-pocket limit is reached.

The out-of-pocket limit is the most you could pay for medical and prescription drug costs in one year. Keep in mind: You pay nothing for in-network preventive care—it's covered in full.

Patient-Centered Medical Home (PCMH) providers are available to members at a lower cost.

BlueCross BlueShield Arizona

CONTACT INFORMATION

Contact BCBS of Arizona

- Call **602-864-4857**.
- Visit azblue.com.

Find a BCBS PPO Provider

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

Contact our designated BCBS representative.

Visit the Benefits website for current contact information.

Telehealth from AZ Blue

Virtual Care When and Where You Need It

Telehealth from AZ Blue gives you access to virtual visits with board-certified physicians, counselors, and psychiatrists by phone, tablet, or computer. Medical visits are available 24/7, and counseling and psychiatry visits are available by appointment.

When to Use Telehealth

- Use medical telehealth for common non-emergency illnesses and injuries, such as colds, flu, fever, cough, sinus infections, sore throat, pinkeye, rash, ear infections, migraines, sprains, and strains.
- Schedule counseling or psychiatry visits for behavioral health needs, such as stress management, anxiety, depression, grief, insomnia, panic attacks, PTSD, OCD, and life transitions.
- Telehealth can be especially helpful when you are traveling, working remotely, or need care outside normal office hours.

How to Start a Visit

1. Log in to your AZ Blue Member Portal, click **Find Care**, then **Telehealth**.
2. Choose a provider type: **Medical**, **Counseling**, or **Psychiatry**.
3. Pay your cost share with a credit card, FSA, or HSA card.
4. Choose a pharmacy if medication is needed.
5. See the provider, or schedule an appointment and receive a visit summary.

Important: Virtual visits do not provide emergency care. If you have an emergency or possible emergency, seek emergency care right away.

CONTACT INFORMATION

Contact Telehealth from AZ Blue

- Call **844-606-1612**.
- Visit azbluetelehealth.com.

Banner | Aetna HMO

The HMO health plan is administered by Banner | Aetna. If you prefer predictable health care expenses, consider the HMO plan. You can save money by seeing a primary care physician (PCP) in the Performance Network. Services received outside the network are not covered, except for emergency services.

KEY FEATURES OF THE HMO PLAN	
Provider Network	National and local provider network that includes almost 4,100 primary care physicians, more than 33,850 specialists, 195 urgent care centers, 53 hospitals, and 18 Banner Health Centers offering primary and specialty care under one roof. There is no out-of-network coverage.
Reasonable Premium Rates	Individual coverage: $167.67 per month Family coverage: $532.33 per month
Deductible	None
Coinsurance	10% coinsurance applies to home health care and skilled nursing received from a Broad Network provider
Maximum Annual Out-of-Pocket Cost	Individual coverage: Medical: $1,500 or $2,500, depending on network Pharmacy: $1,500 Family coverage: Medical: $3,000 or $5,000, depending on network Pharmacy: $3,000

Contact our designated Banner | Aetna representative

Visit the Benefits website for current contact information.

CONTACT INFORMATION

Contact Banner | Aetna

- Call **855-220-6506**.
- Visit aetna.com/cityofphoenix.

To Find a Provider

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

Transcarent Virtual Health Visits

On-demand health care services through Transcarent are available to employees and dependents. Transcarent gives you 24/7 access to U.S.-based, board-certified doctors from your phone. Transcarent visits are available at no cost to Banner | Aetna HMO members. Here's how to get started:

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

Transcarent also provides on-demand diagnosis and treatment from board-certified physicians by secure in-app messaging, including:

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

transcarent

CONTACT INFORMATION

Contact Transcarent

- Download Transcarent mobile app.

Health Plans at a Glance

All three medical plans provide comprehensive coverage, access to broad provider networks, and preventive care benefits. Use the comparison below to review key plan features—including network access, deductibles, out-of-pocket costs, virtual care options, and maternity benefits—to help determine which plan best meets your health care and financial needs.

FEATURE	BCBS SAVER'S CHOICE HDHP IN-NETWORK ONLY	BCBS PPO IN-NETWORK	BCBS PPO OUT-OF-NETWORK	BANNER | AETNA HMO IN-NETWORK ONLY
Networks	BCBS PPO	BCBS PPO	Not applicable	Banner | Aetna HMO
Local or National Network?	National	National	Not applicable	National
Out-of-Network Coverage?	For emergency services	For emergency services	Yes, with out-of-pocket costs	For emergency services
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited
Calendar-Year Deductible	$2,000 for single, $4,000 for all covered family members combined	$600 per covered member to a maximum of $1,800 per family	$1,200 per covered member to a maximum of $3,600 per family	No deductible
Coinsurance	10%	20%	30%	10% applicable to home health care and skilled nursing
Calendar-Year Out-of-Pocket Maximum for Medical Services	Single Coverage: $3,400 (deductible plus pharmacy copays) Family Coverage: $6,800 (deductible plus pharmacy copays)	Medical: $1,500 per covered member to a maximum of $4,500 per family Pharmacy: $1,500 per covered member to a maximum of $3,000 per family	Medical: $3,000 per covered member to a maximum of $9,000 per family Pharmacy: Not covered	Medical Performance Network — Single: $1,500; Family: $3,000 Broad Network — Single: $2,500; Family: $5,000 Pharmacy — Single: $1,500; Family: $3,000
Virtual Health Care	Telehealth from AZ Blue: $20 copay per visit until deductible is met, and then is available at 10% coinsurance	Telehealth from AZ Blue: $0	N/A	Transcarent: $0
Health Savings Account?	Yes	No	No	No
Prenatal Office Visits	Plan pays 90% of the contracted rate after the calendar-year deductible is met.	PCMH providers: $10 copay, deductible does not apply Other providers: $30 copay, deductible does not apply, or 20% coinsurance	Plan pays 70% of the BCBS allowed amount after the calendar-year deductible is met. The difference between the allowed amount and the billed amount is your responsibility to pay	No charge for office visits. Maximum copay for additional maternity tests and services: Performance Network $600 per year; Broad Network $900 per year
Office Visit, Primary Care	Plan pays 90% of the contracted rate after the calendar-year deductible is met.	PCMH providers: $10 copay, deductible does not apply Plan pays 80% of the contracted rate after the calendar-year deductible is met.	Plan pays 70% of the BCBS allowed amount after the calendar-year deductible is met. The difference between the allowed amount and the billed amount is your responsibility to pay.	Performance Network: $25 Broad Network: $50

FEATURE	BCBS SAVER'S CHOICE HDHP IN-NETWORK ONLY	BCBS PPO IN-NETWORK	BCBS PPO OUT-OF-NETWORK	BANNER | AETNA HMO IN-NETWORK ONLY
Office Visit, Specialist	Plan pays 90% of the contracted rate after the calendar-year deductible is met.	PCMH providers: $10 copay, deductible does not apply Other providers: Plan pays 80% of the contracted rate after the calendar-year deductible is met.	Plan pays 70% of the BCBS allowed amount after the calendar-year deductible is met. The difference between the allowed amount and the billed amount is your responsibility to pay.	Performance Network: $50 Broad Network: $80
Office Visit, Mental Health	Plan pays 90% of the contracted rate after the calendar-year deductible is met.	Plan pays 80% of the contracted rate after the calendar-year deductible is met.	Plan pays 70% of the BCBS allowed amount after the calendar year deductible is met. The difference between the allowed amount and the billed amount is your responsibility to pay.	Performance Network: $25 Broad Network: $50
Outpatient Procedure	Plan pays 90% of the contracted rate after the calendar-year deductible is met.	Plan pays 80% of the contracted rate after the calendar year deductible is met.	Plan pays 70% of the BCBS allowed amount after the calendar year deductible is met. The difference between the allowed amount and the billed amount is your responsibility to pay.	$200
Inpatient Hospitalization	Plan pays 90% of the contracted rate after the calendar-year deductible is met.*	Plan pays 80% of the contracted rate after the calendar-year deductible is met.	Plan pays 70% of the BCBS allowed amount after the calendar year deductible is met. The difference between the allowed amount and the billed amount is your responsibility to pay.	Performance Network: $200 per admit, $600 max per year Broad Network: $300 per admit, $900 max per year
Lab and X-Rays (medically necessary)	Plan pays 90% of the contracted rate after the calendar-year deductible is met.	Plan pays 80% of the contracted rate after the calendar year deductible is met.	Plan pays 70% of the BCBS allowed amount after the calendar year deductible is met. The difference between the allowed amount and the billed amount is your responsibility to pay.	Covered 100%
Physical Therapy / Occupational Therapy*	Plan pays 90% of the contracted rate after the calendar-year deductible is met.	Plan pays 80% of the contracted rate after the calendar year deductible is met.	Plan pays 70% of the BCBS allowed amount after the calendar-year deductible is met.	Plan pays 100% with no deductible or copay
Home Health Care / Skilled Nursing	Plan pays 90% of the contracted rate after the calendar-year deductible is met.	Plan pays 80% of the contracted rate after the calendar year deductible is met.	Plan pays 70% of the BCBS allowed amount after the calendar year deductible is met. The difference between the allowed amount and the billed amount is your responsibility to pay.	Plan pays 90%
Hearing Aids	Plan pays 90% of the contracted rate after the calendar-year deductible is met.	Plan pays 80% of the contracted rate after the calendar year deductible is met.	Plan pays 70% of the BCBS allowed amount after the calendar year deductible is met. The difference between the allowed amount and the billed amount is your responsibility to pay.	One hearing aid per ear every 2 years

Health Plans at a Glance

FEATURE	BCBS SAVER'S CHOICE HDHP IN-NETWORK ONLY	BCBS PPO IN-NETWORK	BCBS PPO OUT-OF-NETWORK	BANNER | AETNA HMO IN-NETWORK ONLY
Urgent Care Facility	Plan pays 90% of the contracted rate after the calendar-year deductible is met.	Plan pays 80% of the contracted rate after the calendar year deductible is met.	Plan pays 70% of the BCBS allowed amount after the calendar year deductible is met. The difference between the allowed amount and the billed amount is your responsibility to pay.	$75
Hospital Emergency Room	Plan pays 80% of the contracted rate after the calendar-year deductible is met.*	Plan pays 70% of the contracted rate after the calendar-year deductible is met.*	Plan pays 70% of the BCBS allowed amount after the calendar-year deductible is met. The difference between the allowed amount and the billed amount is your responsibility to pay.	$500 ER copay waived if admitted as inpatient hospitalization. Inpatient Hospitalization Copay applies.**
Eye Exam with Optometrist (once every plan year)	See pages 35–37.	See pages 35–37.	See pages 35–37.	See pages 35–37.
Chiropractic	36 visits per year paid at 100% of the contracted rate after the calendar-year deductible is met	36 visits per year covered at 100% with no member cost share	Plan pays 70% of the BCBS allowed amount after the calendar-year deductible is met. The difference between the allowed amount and the billed amount is your responsibility to pay.	36 visits per year
Generic Drugs	$10, after deductible	$10	Not covered	$10
Brand-Name Drugs	$40, after deductible	$40	Not covered	$40
Non-Formulary Drugs	$80, after deductible	$80	Not covered	$80
Specialty Drugs	$150, after deductible	$150	Not covered	$150
Options for Maintenance Medication (3 months for 2 months copay)	Mail-order maintenance medications covered for 3 months at Birdi mail or retail pharmacies, CVS, Target, or Fry's	Mail-order maintenance medications covered for 3 months at Birdi mail or retail pharmacies, CVS, Target, or Fry's	Mail-order maintenance medications covered for 3 months at Birdi mail or retail pharmacies, CVS, Target, or Fry's	Mail-order maintenance medications covered for 3 months at Birdi mail or retail pharmacies, CVS, Target, or Fry's

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

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

Add your medical ID card to your digital wallet. Log in to your plan's member portal or mobile app to access your digital medical ID card. If available, select **Add to Apple Wallet** or **Add to Google Wallet**, and follow the prompts to save it to your phone.

Pharmacy Benefits

Your prescription drug benefits are administered by MedImpact and help reduce the cost of covered medications. What you pay depends on the medication prescribed, where you fill it, and whether it is classified as a maintenance medication. The information below outlines drug tiers, maintenance medication requirements, cost-saving opportunities, and available pharmacy resources.

Drug Tiers

The cost of your prescription medications under the City's pharmacy plan is based on the medication tier:

- Generic drugs contain the same active ingredients as their brand-name equivalents and meet the same federal safety standards but typically cost less.
- Preferred brand drugs are brand-name medications selected by the plan, based on their effectiveness and cost.
- Non-preferred brand drugs are brand-name medications that are generally covered at the highest copay level.
- Non-formulary drugs are not included on the plan's formulary due to effectiveness and cost considerations. Coverage may require prior authorization or approval of a non-formulary exception.
- Specialty drugs are typically high-cost injectable medications that may require special handling, storage, or administration. These medications are often available only through specialty pharmacies and are generally limited to a 30-day supply.

To determine whether a brand-name medication is classified as non-preferred, contact MedImpact. Preferred brand medications may be reclassified as non-preferred if a generic equivalent becomes available during the plan year. Medications newly approved by the FDA are not covered until they have been reviewed by the MedImpact Pharmacy and Therapeutics (P&T) Committee. Not all medications are covered under every prescription drug benefit program. Coverage may be subject to formulary requirements, utilization management programs, prior authorization, quantity limits, step therapy, or other coverage criteria.

MedImpact

MEDIMPACT CONTACT INFORMATION

Pharmacy Customer Care

- Call **833-803-4402**.
- Email **ctyphoenixsupport@medimpact.com**.

To contact your designated MedImpact representative, visit **phoenix.gov/benefits** for current contact information.

Maintenance Medication Requirements

The City's prescription drug plan includes maintenance medication requirements. Maintenance medications are medications taken on an ongoing basis to manage chronic conditions, such as high blood pressure or high cholesterol. Maintenance medications may be filled up to three times, in quantities of no more than a 30-day supply, at any MedImpact participating retail pharmacy.

Beginning with the fourth fill and for all subsequent fills, these medications are covered as a three-month supply (84 to 90 days) through the Birdi mail-order pharmacy or at participating retail pharmacies, including CVS, Target, and Fry's. Mail order is not required. Medications used to treat ADHD are considered maintenance medications but are not required to follow the three-month maintenance medication requirement.

Short-term medications, such as antibiotics, may be filled at any participating retail pharmacy.

MedImpact's nationwide pharmacy network includes more than 60,000 pharmacies, including Bashas', Costco, Safeway, Sam's Club, Walmart, and Walgreens.

You can save by paying only two copays for a 90-day supply of medication when you use a 90-day retail pharmacy (CVS, Target, or Fry's) or Birdi mail order. Set up mail-order prescriptions by calling Birdi mail order or by visiting **medimpact.com**.

SAVE MONEY ON PRESCRIPTIONS

You can help lower your prescription drug costs by filling a three-month supply (84 to 90 days) of eligible maintenance medications through CVS, Target, Fry's, or Birdi mail-order pharmacy. A three-month supply is available for the cost of two copays, providing savings compared to filling three separate 30-day prescriptions. When available, consider choosing generic medications. Generic drugs contain the same active ingredients as their brand-name counterparts and meet the same federal safety standards, while often costing significantly less.

Preventive Drug List

In some cases, covered prescription medications may be available at no cost to members, as required by applicable laws and regulations, including the Patient Protection and Affordable Care Act (PPACA). Coverage and cost-sharing requirements are determined in accordance with plan provisions and applicable regulatory guidelines.

Behavioral Health Benefits

Your mental and emotional health are important parts of your overall well-being. Your medical plan covers office visits with licensed psychiatrists, psychologists, and counselors, as well as certain outpatient and inpatient programs. Learn more about behavioral health benefits through each medical plan.

BCBS Saver's Choice HDHP

- Behavioral health services are available through a national BCBS network. There is no out-of-network coverage.
- Covered services and precertification requirements are the same as for the PPO. The deductible and coinsurance apply for in-network providers.

BCBS PPO Plan

- Behavioral health services are available through a national BCBS network and from licensed and accredited out-of-network providers. The City has a broad network of providers and facilities to meet your needs.
- Precertification is required for non-emergency inpatient behavioral and mental health admissions. The PPO deductible and coinsurance apply for in-network and qualified out-of-network providers.

Banner | Aetna HMO Plan

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

EXCLUSIONS

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

Virta Health— Type 2 Diabetes Reversal

Virta is a guided nutrition program designed to help lower blood sugar, reverse type 2 diabetes,* and reduce the need for certain diabetes medications. The program is available at no cost to eligible employees and adult dependents.† Virta is personalized and flexible to your lifestyle, helping you learn to eat foods that are right for you—without injections, fad diets, or extra gym visits. Virta provides ongoing expert support, including:

- One-on-one support from a health coach and medical provider
- A digital weight scale and connected meter that sync with your phone
- A personalized nutrition plan backed by clinical research

*Reversal on Virta is defined as reaching an HbA1c below 6.5% without the use of diabetes medications beyond metformin. Diabetes and related conditions can return if lifestyle changes are not maintained.

†Virta is available to City of Phoenix employees and eligible adult dependents who are enrolled in a health plan through BCBSAZ or Banner | Aetna, including those covered under COBRA. This benefit is currently offered to individuals with type 2 diabetes who are ages 18 through 79. Some medical conditions may exclude patients from Virta treatment.

Claim your fully covered Virta benefit at virtahealth.com/join/cityofphoenix.

Employee Assistance Program

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

ComPsych GuidanceResources

The City's Employee Assistance Program (EAP) is offered through ComPsych GuidanceResources, where you can find care, information, and resources to support mental and emotional wellness.

SHORT-TERM COUNSELING

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

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

Twelve free counseling sessions are available per person, per incident. Counseling sessions are available face-to-face through a large network of local and national providers. With supervisory approval, you may use up to three EAP visits per year on City time.

Telephonic counseling is available, and counseling can also be accessed by web video for added convenience.

ELDER CARE SERVICES

One phone call connects you with a credentialed care manager who specializes in medical care for older adults. The care manager will come to your loved one's home to learn more about their situation and needs.

After an assessment, the care manager will work with family members to develop a customized support plan. Together, you can consider housing options, home health services, safety management, health management, social engagement, nutritional counseling, cognitive monitoring, mental health and grief counseling, and more.

ONLINE INFORMATION

Receive digital access through your mobile phone, tablet, or computer, and get expert information on thousands of topics, including wellness, relationships, work, education, legal, financial, lifestyle, and more. You can also:

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

Long-Term Counseling

All three medical plans offer behavioral health services. The EAP can provide medical plan participants with in-network referrals so you can get the support you need. See the "Behavioral Health Benefits" section to learn more.

ComPsych

CONTACT INFORMATION

ComPsych GuidanceResources

- Call **844-819-4775**.
- Visit guidanceresources.com.
- Download GuidanceNow®.

Eligibility for EAP Services

The Employee Assistance Program (EAP) offers confidential counseling and support services for employees and their eligible family members. All persons living in the same household as the full-time or part-time employee or retiree are eligible for the same benefits as the member with whom they live. With supervisory approval, you can have up to three EAP visits per year on City time. Available services vary by employee group, as shown below.

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

PHOENIX FIRE DEPARTMENT EMPLOYEES

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

Traumatic Event Counseling (ARS 38-672 and 38-673)

ComPsych

Police officers, crime scene technicians, digital forensic technicians, firefighters, 911 dispatchers, and other positions covered by the City's contract, who experience a traumatic event on duty and need counseling, have access to 36 free counseling sessions per incident. Sessions must be completed within 12 months of the initial session. If you have questions about eligibility, contact the Benefits Office.

To learn more about the six qualifying categories of traumatic events, visit the City's internal employee wellness site. Additional questions can be emailed to the Benefits Office at tec.benefits@phoenix.gov.

To confirm your provider's coverage, contact ComPsych at _COPTigerActRequest@compsych.com or **844-819-4775**.

Cigna Dental Plans

We value your smile. It is one of the best ways to communicate to our community that the City of Phoenix is a great place to live, work, and play. We encourage you and your family to use your dental benefits to help protect your smile for years to come.

Review each and decide which meets your and your family's needs.

You have three plans available to you:

- Dental PPO Plan
- Dental PPO Plus
- Dental HMO Plan

Compare Dental Plans

DENTAL PPO

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

- All preventive services received in-network are covered at 100%.
- There is no deductible for preventive exams, cleanings, and X-rays. Most other services are covered at 80%.
- There is a calendar-year deductible of $50 for individuals and a maximum of $150 for families, meaning you pay 100% of the deductible for non-preventive covered services.
- The maximum annual benefit per member is $2,000 per calendar year for general services and a $4,000 lifetime benefit for orthodontia for members up to age 19.

You have coverage when using licensed out-of-network dentists, but your out-of-pocket cost may be higher when you use an out-of-network dentist. Contact Cigna if you need a full list of in-network providers in the United States and Mexico.

DENTAL PPO PLUS PLAN

This is the same Dental PPO Plan described above, with the following enhancements:

- Adult and child orthodontia are covered under this plan.
- The maximum annual benefit per member is $3,000 per calendar year instead of $2,000.
- Implant coverage is included and paid at 80%.
- Paid benefits apply to the maximum annual benefit. Exclusions may apply.

The premium rates for this plan are higher than the Dental PPO Plan. Both the PPO and PPO Plus plans have a missing tooth limitation. For more information, contact Cigna before enrolling.

DENTAL HMO PLAN

The Dental HMO Plan has the lowest dental plan premiums and no annual maximum.

- There is no deductible and no out-of-pocket cost for preventive services.
- There is no out-of-network coverage, and you have a smaller network of dentists.
- A fee schedule determines the amount you pay for dental treatment.

Every person enrolled must choose a primary dentist from the HMO network directory to manage their care. Every person enrolled must have a dentist of record on file with Cigna Dental. Initially, a dentist is assigned, and you can change to a different in-network dentist by contacting Cigna.

Before choosing this plan, make sure the dentist or dentists you want to use are in the network. HMO plans are not available in all states. Contact Cigna for a current list of states where the HMO plan is not available.

Note: The following states and U.S. territories do not currently offer HMO plan options: Alaska, Guam, Maine, Montana, New Hampshire, New Mexico, North Dakota, Puerto Rico, South Dakota, Vermont, Wyoming, and the U.S. Virgin Islands.

Dental Benefits at a Glance

All three dental plans help cover preventive, basic, and major dental services, but they differ in provider networks, out-of-network coverage, annual maximums, and orthodontia benefits. Use the comparison below to review key plan features, and choose the option that best meets your dental care needs.

Go to phoenix.gov/benefits for detailed dental coverage information. Information in plan documents on the website supersedes information in this guide.

FEATURE	DENTAL HMO	DENTAL PPO (IN-NETWORK)	DENTAL PPO (OUT-OF-NETWORK)	DENTAL PPO PLUS (IN-NETWORK)	DENTAL PPO PLUS (OUT-OF-NETWORK)
Dentist Network	Cigna Dental Care Access Plus Network	Cigna Total DPPO Network	Any licensed dentist	Cigna Total DPPO Network	Any licensed dentist
Deductible	None	$50 per calendar year for single coverage and $150 for family coverage. Deductible does not apply to preventive or orthodontia services.	$50 per calendar year for single coverage and $150 for family coverage. Deductible does not apply to preventive or orthodontia services.	$50 per calendar year for single coverage and $150 for family coverage. Deductible does not apply to preventive or orthodontia services.	$50 per calendar year for single coverage and $150 for family coverage. Deductible does not apply to preventive or orthodontia services.
Cleanings, Exams, and X-Rays	No charge	Plan pays 100% of covered charges.	Plan pays 80% of reasonable and customary charges.	Plan pays 100% of covered charges.	Plan pays 80% of reasonable and customary charges.
Extractions, Fillings, Crowns, Dentures, Bridges, Root Canals, and Oral Surgery	See the HMO Dental Coverage and Fee Schedule.	Plan pays 80% of covered charges after deductible.	Plan pays 80% of reasonable and customary charges after deductible.	Plan pays 80% of covered charges after deductible.	Plan pays 80% of reasonable and customary charges after deductible.
Implant Benefit	None	None	None	Plan pays 80% of covered charges after deductible.	Plan pays 80% of reasonable and customary charges after deductible.
Maximum Annual Benefit	No maximum	Up to $2,000 per member per calendar year for covered services	Up to $2,000 per member per calendar year for covered services	Up to $3,000 per member per calendar year for covered services	Up to $3,000 per member per calendar year for covered services
Lifetime Orthodontia Benefit	See the HMO Dental Coverage and Fee Schedule.	$4,000 per child dependent (up to age 19)	$4,000 per child dependent (up to age 19)	$4,000 per person	$4,000 per person

PEDIATRIC DENTISTRY

For a dependent child under age 13, you may select a network pediatric dentist as the Network General Dentist by calling Cigna Customer Service at **800-CIGNA24** for a list of network pediatric dentists in your service area. If your Network General Dentist refers your child under age 13 to a network pediatric dentist, the network pediatric dentist's office will have primary responsibility for your child's care. Your Network General Dentist will provide care for children age 13 and older. If your child continues to visit the pediatric dentist after their 13th birthday, you will be responsible for the pediatric dentist's usual fees. Exceptions for medical reasons may be considered on a case-by-case basis.

Cigna Dental Oral Health Integration Program

Additional coverage may be available for certain health conditions, including but not limited to those listed below. To learn more, contact Cigna at **800-564-7642**, and view the Oral Health Integration Program flyer.

COVERED SERVICE	HEART DISEASE	STROKE	DIABETES	MATERNITY	CHRONIC KIDNEY DISEASE	ORGAN TRANSPLANTS	HEAD & NECK CANCER RADIATION
Periodontal Treatment & Maintenance	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Periodontal Evaluation	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Oral Evaluation				Yes			
Emergency Palliative Treatment				Yes			
Topical Application of Sealants					Yes	Yes	Yes
Sealant Repair					Yes	Yes	Yes

Vision Benefits

Because seeing clearly is important, vision benefits are automatically included in your medical plan. Coverage levels vary by plan. Use the comparison below to review covered services, eyewear allowances, and provider networks.

VISION BENEFIT	BANNER	AETNA HMO / BCBS PPO	SAVER'S CHOICE HDHP WITH HSA
Maximum Annual Benefit	N/A		$500 maximum for eyewear (glasses and contacts combined)
Standard Contact Lens Fit and Follow-Up	Not covered		Not covered
Eye Exam (once per calendar year)	$25 copay		100% after deductible
Frames (once per calendar year) Exclusions apply*	$30 credit		$500 maximum after deductible (frames and contacts combined)
Single-Vision Lenses (once per calendar year)	$20–$40 credit		$500 maximum after deductible (frames and contacts combined)
Contact Lenses	$75 credit		$500 maximum after deductible (frames and contacts combined)
Vision Provider Network	Banner | Aetna Vision Network Blue Cross Network		Blue Cross Network

*Excludes frames such as Meta glasses, Google AI glasses, Google intelligent eyewear, Google smart glasses, Oakley Meta Vanguard, and Lucyd Reebok Optical.

Davis Vision by MetLife Buy-Up Plan

You can purchase additional vision benefits through payroll deduction. The buy-up plan provides a low-cost comprehensive eye exam each year, plus coverage for eyeglasses or contact lenses.

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

- Employees: $5.54
- Family: $13.06

VISION CARE SERVICE	IN-NETWORK BENEFIT	OUT-OF-NETWORK REIMBURSEMENT
Eye Exam, Glasses	$10 copay	Up to $40
Standard and Premium Contact Lens Fit and Follow-Up	Included	Up to $175
MATERIALS		
Frame Allowance*	Davis Vision Network Collection fashion, designer, and premier frames are covered in full. Non-collection frames are covered up to the $175 allowance, including at participating Walmart, Costco, Sam's Club, Warby Parker, and Target locations.**	Up to $50
Single-Vision Lenses	Included	Up to $40
Progressive (Standard/Premium) or Bifocal Lenses	Included	Up to $60
Trifocal, Lenticular Lenses	Included	Up to $80

*Note: The $175 standard allowance can be applied to either glasses or contacts, but not both, within the same plan year.

** Providers listed are not guaranteed to be in-network also for an eye exam.

The table below outlines additional vision benefits available through the vision plan, including lens enhancements, contact lens coverage, out-of-network reimbursement amounts, and service frequency limits.

DavisVision® By MetLife

CONTACT INFORMATION

MetLife

- Call **833-EYE-LIFE** (393-5433).
- Visit metlife.com/mybenefits.

Did you know?

The Buy-Up Vision Plan includes a $200 LASIK reimbursement, available from any provider, in-network or out-of-network, once per lifetime. All members also have access to discounts of up to 50% for LASIK-related services when they use a provider through the QualSight program. Contact QualSight for help finding a provider and scheduling services. Members are eligible for the discounts in addition to the $200 benefit.

VISION CARE SERVICE	IN-NETWORK BENEFIT	OUT-OF-NETWORK REIMBURSEMENT
Polycarbonate Lenses (adults and children)	Included	Up to $40
Standard Scratch-Resistant Coating	Included	Up to $40
Standard Tint (all gradients)	Included	Up to $40
Standard Anti-Reflective Coating	Included	Up to $40
Transitions® Lenses	Included	Up to $40
CONTACT LENSES		
Elective*	$175 allowance	Up to $175
Medically Necessary	Included with prior approval	Up to $250 (prior approval required)
Standard and Premium Contact Lens Fit and Follow-Up	Included	Up to $175
Specialty or First-Time Contact Lens Fit and Follow-Up	$60 allowance plus 15% discount on overage	Up to $175
FREQUENCY		
Eye Examination	Once per calendar year	
Lenses and Contact Lenses	Once per calendar year	
Frames	Once per calendar year	
Sunglasses at Prime Eye Care	Members can now get full coverage for the Davis Vision Exclusive Collection of Frames only, at all Arizona Prime Eye Care locations. This is in addition to an everyday eyewear benefit that provides benefits for prescription glasses or contacts. Sunglasses dispensed at Prime Eye Care are available every calendar year in conjunction with an eye exam. Lenses can be prescription or non-prescription. Some restrictions apply. Eye exam MUST take place at any Prime Eye Care location.	

*Note: The $175 standard allowance can be applied to either glasses or contacts, but not both, within the same plan year.

Flexible Spending Account (FSA)

Now is the time to make the most of your hard-earned dollars! Enrolling in a Flexible Spending Account (FSA) can help you to save and pay for eligible health care and dependent care expenses with pretax dollars.

Learn more about the types of FSAs:

FSA Enrollment Required

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

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

Health Care FSA

When you enroll in the Health Care FSA, available through Flexible Benefit Administrators (FBA), you will receive a debit card preloaded with your annual FSA health care contribution. You can be reimbursed by using the FBA online participant portal or the mobile phone app, or by submitting claims via fax or mail. When you set up direct deposit, your reimbursement will appear in your account within five to seven business days of Flexible Benefit Administrators receiving your claim and documentation.

Eligible expenses must be incurred on or before March 15, 2028, for calendar year 2027. When you have a qualifying event, such as marriage, birth, adoption, divorce, or a new daycare provider, you can make a correlating change to your FSA amount when you contact the Benefits Office within the applicable time frame.

Review the Qualified Life Events Chart on the Benefits website under Documents and Forms.

General Purpose FSA

If you are enrolled in a general purpose FSA in 2026 and electing the Saver's Choice HDHP in 2027, you must spend your FSA dollars down to $0 before December 31, 2026, to be eligible for the City HSA contribution in January 2027. If more than a $0 balance exists in your General Purpose FSA, your City HSA contribution will be postponed until after the FSA grace period of March 15, 2027.

Use Your 2026 Funds

For 2026 Health Care FSA and Dependent Care FSA funds, the standard two-and-a-half-month grace period will apply, and you have until March 15, 2027, to incur claims and until March 31, 2027, to submit claims using your FBA FSA card or via reimbursement through the FBA portal. Unused 2026 funds will be forfeited.

Expense Reimbursement

Find an alphabetical list of eligible expenses at the FBA Participant Portal. Submit your expenses for reimbursement online, by fax, by mail, or via the FBA mobile app.

Set up direct deposit through the FBA Participant Portal to have your reimbursement automatically deposited. A check will be mailed if direct deposit is not established. Find account information and claim forms at the FBA Participant Portal. You can submit claims without using a claim form when you submit online or via the mobile app. Find the mobile app by searching your app store for FBA Mobile.

Submit Claims Information

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

FEATURE	HEALTH CARE FSA	LIMITED PURPOSE HEALTH CARE FSA	DEPENDENT CARE FSA
Who Can Participate?	Employees not enrolled in an HSA	Employees enrolled in an HSA	All employees
What Does It Pay For?	Eligible medical, vision, dental, and other approved health care expenses. See IRS Publication 502 for a list of eligible expenses.	Eligible dental and vision expenses only. See IRS Publication 502 for a list of eligible expenses.	Eligible daycare expenses for children up to age 13 (childcare must be for care while you are working; if married, your spouse must also work or attend school full-time). Eligible care expenses for dependent adults. See IRS Publication 503 for a list of eligible expenses.
How Much Can I Contribute?*	Up to $3,400*	Up to $3,400*	Up to $7,500 ($3,750 if married and filing separate tax returns)*
When Do I Enroll?	Every year during Annual Open Enrollment, when newly hired, or when you experience an eligible life event	Every year during Annual Open Enrollment, when newly hired, or when you experience an eligible life event.	Every year during Annual Open Enrollment, when newly hired, or when you experience an eligible life event
How Does the FSA Affect My Paycheck?	Existing employees: Annual contributions are divided into equal deductions over 24 paychecks. Your full annual election amount is available after your first contribution. Newly eligible employees: Contributions are divided over the remaining paychecks through the end of the year (not more than two paychecks per month).	Existing employees: Annual contributions are divided into equal deductions over 24 paychecks. Your full annual election amount is available after your first contribution. Newly eligible employees: Contributions are divided over the remaining paychecks through the end of the year (not more than two paychecks per month).	Contributions are available only after the payroll deduction occurs.
What Happens if I Don't Use It?	For 2027 FSA and Dependent Care FSA funds, the standard two-and-a-half-month grace period applies. You have until March 15, 2028, to incur claims and until March 31, 2028, to submit claims for reimbursement. Unused 2027 funds will be forfeited.	For 2027 FSA and Dependent Care FSA funds, the standard two-and-a-half-month grace period applies. You have until March 15, 2028, to incur claims and until March 31, 2028, to submit claims for reimbursement. Unused 2027 funds will be forfeited.	For 2027 FSA and Dependent Care FSA funds, the standard two-and-a-half-month grace period applies. You have until March 15, 2028, to incur claims and until March 31, 2028, to submit claims for reimbursement. Unused 2027 funds will be forfeited.
How Do I Get Reimbursed?	Use your FBA Benefits Card, or submit reimbursement requests at fba.wealthcareportal.com.	Use your FBA Benefits Card, or submit reimbursement requests at fba.wealthcareportal.com.	Submit reimbursement requests at fba.wealthcareportal.com.
Unsubstantiated Claims	Unsubstantiated claims in the current plan year may result in your FBA Benefits Card being turned off. You have until March 31 of the following plan year to substantiate year-end claims. Claims not substantiated will be imputed as income in the current year.	Unsubstantiated claims in the current plan year may result in your FBA Benefits Card being turned off. You have until March 31 of the following plan year to substantiate year-end claims. Claims not substantiated will be imputed as income in the current year.	Unsubstantiated claims in the current plan year may result in your FBA Benefits Card being turned off. You have until March 31 of the following plan year to substantiate year-end claims. Claims not substantiated will be imputed as income in the current year.

*Maximum contribution amounts are subject to change once 2027 contribution limits are announced by the IRS. If you elect the maximum amount for 2026, the City will automatically increase your contribution to the 2027 maximum amount once it is released.

FlexibleBenefit ADMINISTRATORS

Flexible Benefit Administrators

- Call **602-325-9418**.
- Visit fba.wealthcareportal.com.
- Download FBA Mobile.

DON'T FORGET

The IRS imposes a use-it-or-lose-it rule. In other words, if you do not spend all the money in your FSA by the deadline, any unused dollars in your account(s) after the deadline are forfeited.

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

Life Insurance

Basic Life and AD&D Coverage

Basic Life Insurance coverage is provided at no cost to you. This coverage is automatic, and you do not need to enroll in another health or protection program to receive it.

Please note: Under IRS rules, the City of Phoenix is required to tax you on the value of coverage above $50,000 per year. The life insurance benefit itself is not taxable, but the premium value for coverage above $50,000 is taxable.

Designate or update your beneficiary in eCHRIS. You can change your beneficiary; however, beneficiary information cannot be deleted because of recordkeeping policies. You can find instructions for updating your beneficiary at phoenix.gov/benefits. Instructions for how to add a trust as your beneficiary are located on the Benefits website.

The AD&D benefit matches your Basic Life coverage amount and follows a benefit schedule for dismemberment. It also includes additional benefits for felonious assault, bereavement and trauma counseling, permanent disfigurement or critical burns, seat belt, coma, and airbag coverage.

BASIC LIFE INSURANCE COVERAGE	
Unit 1	$15,000
Unit 2	The greater of $25,000 or 1x base salary
Unit 3	The greater of $25,000 or 1x base salary
Unit 4	$15,000
Unit 5	1x base salary
Unit 6	1x base salary
Unit 7	The greater of $25,000 or 1x base salary
Unit 8	1.5x base salary
Middle Managers (General City, Sworn Police, and Sworn Fire)	1.5x base salary (up to $500,000)
Executives (General City, Sworn Police, and Sworn Fire), Mayor, and City Council Members	1.75x base salary (up to $500,000)
Executive	2x base salary (up to $500,000)

When your child is no longer eligible for insurance, you may elect to convert their coverage to an individual policy without answering health questions. This must be elected with Securian within 31 days of the child losing eligibility.

securian FINANCIAL®

Additional Information

Basic Life Insurance includes an option to receive an accelerated benefit if your life expectancy is 12 months or less. Contact the Benefits Office to apply.

The aggregate limit payable under commuting AD&D will not exceed $3 million.

Occupational Accidental Death and Dismemberment

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

OCCUPATIONAL INSURANCE COVERAGE	
Unit 1	$75,000
Unit 2	$75,000
Unit 3	$75,000
Unit 4	$100,000
Unit 5	$75,000
Unit 6	$100,000
Unit 7, Unit 8, Middle Managers (General City and Fire)	The greater of $25,000 or 1x base salary
Executives (General City and Fire), Mayor and City Council Members	$75,000
Middle Managers and Executives (Police)	$100,000
Police Reservists	$25,000

Commuter Life Insurance

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

All employees, including part-time employees, are eligible for Commuter Life Insurance. Police reservists are not eligible for commuter life AD&D.

Learn More

Visit Securian at securian.com/phoenix-insurance for additional resources and more information about your life insurance benefits.

Optional Life Insurance

You can add to your Basic Life coverage by purchasing Optional Term Life Insurance. The employee coverage includes Optional AD&D coverage equal to your Optional Term Life Insurance coverage. Coverage is available at group rates for you, your spouse or qualified domestic partner (QDP), and your children. You pay 100% of the premium through after-tax payroll deductions. It may be subject to underwriting.

NEW EMPLOYEES

As a new hire, you have a one-time opportunity to elect up to $150,000 in employee coverage and up to $50,000 in spouse or QDP coverage without evidence of insurability (EOI).

For Optional Life Insurance only, you have an additional 14 days after your 31-day new hire enrollment period to enroll. Contact the Benefits Office for enrollment assistance during this 14-day period.

IMPORTANT INFORMATION

Check your life insurance beneficiary every year in eCHRIS to make sure it is accurate and up to date. You can change your beneficiary, but beneficiary information cannot be deleted because of recordkeeping policies. Sign in to eCHRIS Self-Service, and click the Benefits tile to review your beneficiaries for each insurance policy.

Submission of Evidence of Insurability (Underwriting)

Evidence of insurability (EOI): Enroll in life insurance coverage through eCHRIS first. If the coverage amount you elect requires EOI, you will also need to complete Securian's EOI process by providing the required health information. Coverage that requires EOI will not take effect unless Securian approves your application. For more information, visit securian.com/phoenix-insurance.

CONTACT INFORMATION

- Visit lifebenefits.com/submitEOI.
- Find Group Policy #34390.
- Enter Access Key: Phoenix.

Optional Life Insurance at a Glance

Use the table below to compare Optional Life Insurance coverage options for employees, spouses or qualified domestic partners (QDPs), and eligible children, including available coverage amounts, beneficiary requirements, evidence of insurability (EOI) rules, and Annual Open Enrollment opportunities.

FEATURE	EMPLOYEE	SPOUSE OR QUALIFIED DOMESTIC PARTNER (QDP)	CHILD(REN)
Available Coverage Amounts	Increments of $10,000 up to $250,000 Increments of $50,000 from $250,000 to $500,000	Increments of $10,000 up to $300,000 Spouse or QDP coverage cannot exceed the employee's combined Basic Life Insurance and Optional Life Insurance coverage amount (Arizona State Statute §20-1257). If you elect Optional Life Insurance for an employee spouse, your employee spouse cannot also elect their own Optional Life Insurance.	$10,000, $15,000, $20,000, or $25,000 One election covers all eligible children at one premium rate.
How Do I Request an Increase or Cancel Coverage?	Request Optional Life Insurance changes through eCHRIS Self-Service	Request Optional Life Insurance changes through eCHRIS Self-Service.	Request Optional Life Insurance changes through eCHRIS Self-Service.
When Is Evidence of Insurability (EOI) Required?	EOI is required outside newly eligible, Annual Open Enrollment, or qualified life event (QLE) periods. EOI is required for coverage amounts over $150,000 or when coverage is under $150,000 and the requested increase exceeds $20,000.	EOI is required for spouse or QDP coverage amounts over $50,000 when newly eligible. EOI is required if coverage is under $50,000 and the requested increase exceeds $20,000 during Annual Open Enrollment. EOI is required to enroll for the first time outside the newly eligible period.	Not required
Do I Need to Name a Beneficiary?	Employee must name a beneficiary.	Employee is automatically named as the beneficiary.	Employee is automatically named as the beneficiary.
When Does Approved Coverage Become Effective?	First of the month following underwriting approval, or January 1 of the following year when elected during Annual Open Enrollment	First of the month following underwriting approval, or January 1 of the following year when elected during Annual Open Enrollment	First of the month following election, or January 1 of the following year when elected during Annual Open Enrollment
When Is Coverage Reduced or Stopped?	Employee Optional Life and AD&D coverage is automatically reduced to: ■ 65% at age 70 ■ 45% at age 75 ■ 30% at age 80	Coverage ends when the spouse or QDP reaches age 70.	Contact the Benefits Office if you no longer have eligible dependents covered under Optional Child(ren) Life Insurance. Coverage termination will be processed prospectively.
What Can I Do During Annual Open Enrollment?	Enroll for up to $20,000 or increase existing coverage up to $20,000; not to exceed a new total of $150,000.	If currently enrolled, coverage may be increased by up to $20,000, provided total coverage does not exceed $50,000. If not currently enrolled or requesting coverage above $50,000, EOI is required.	Elect coverage for dependent children. No Annual Open Enrollment EOI requirements apply.

Optional Life Insurance includes an option to receive an accelerated benefit if your life expectancy is 12 months or less. Contact the Benefits Office to apply.

Additional Benefits

ARAG Legal Insurance

ARAG legal insurance gives you support when legal challenges arise. For example, if a contractor does not complete a home remodel or you buy a lemon car, a network attorney is just a phone call away to provide legal advice and representation for these situations and more. When you work with a network attorney, their fees are paid in full for most legal issues that are included in your plan.

ARAG legal insurance provides affordable coverage with more than 100 ways to use your plan. It is available to you, your spouse or qualified domestic partner (QDP), and eligible children.

You can elect legal insurance during Annual Open Enrollment or as a new hire during your 31-day initial eligibility enrollment window. Select from two options:

- Value Plan: $11.65 per month for the most common personal legal services
- Buy-Up Plan: $23.70 per month for added protection:
  - Child custody and support
  - Divorce
  - Identity theft protection
  - Services for parents and grandparents
  - Trusts

*Limitations and exclusions apply.

CONTACT INFORMATION

ARAG

- Call **800-835-3425**.
- Visit araglegal.com/plans and use access code: 16922phx.

BeneMoney Employee Loan Program

BeneMoney is your financial safety net when you need it most. Establish or rebuild your credit by repaying a safe, regulated bank loan through automatic payroll deductions. BeneMoney provides loans from $1,000 to $5,000 with no credit check to determine eligibility. You are eligible after 12 months of continuous employment. Loans have a 19.99% annual percentage rate (APR) and are intended to cover immediate cash needs when other resources are not available.

You can apply online, with no fees or prepayment penalties. Visit benemoney.com/apply to apply for a loan.

CONTACT INFORMATION

BeneMoney

- Call **651-265-5688**.
- Visit benemoney.com/apply.

Additional Benefits

Pet Insurance

MetLife Pet Insurance can help you manage the cost of care for your dogs and cats. You have the freedom to visit any U.S. veterinarian, and exam fees are covered for accidents and illnesses. Plans are flexible, with no breed exclusions, so you can choose coverage that fits your pet's needs and your budget.

Coverage options may include:

- Optional preventive care coverage to help with routine wellness expenses
- Multi-pet savings and a Family Plans option with one policy and a shared deductible for up to three dogs and cats
- Discounts of up to 30%, where available
- 24/7 live vet chat through the MetLife Pet app
- Additional benefits, where available, such as a healthy pet incentive, automatic annual coverage increases, loss or theft coverage, and mortality benefits

If you are switching from another pet insurance provider, coverage may be available for preexisting conditions that were previously covered, as long as you had active pet insurance and enroll in MetLife Pet Insurance through the City's group benefit offering.

Important: Availability, discounts, coverage options, and plan features may vary. Review the MetLife Pet Insurance materials for full details, limitations, and exclusions.

MetLife | Pet Insurance

CONTACT INFORMATION

MetLife Pet Insurance

- Call **800-GET-MET8 (800-438-6388)**.
- Visit metlife.com/getpetquote.

Paid Parental Leave

You don't have to choose between growing a career or growing a family. Paid parental leave provides flexibility for employees to take leave so they can bond with and care for a new child, without exhausting their accrued leave time.

ELIGIBILITY

You experienced one of the qualified events:

- Have given birth to a child
- Spouse or partner of someone who has given birth to a child
- Have adopted a child
- Received placement of a foster child

Paid parental leave will only be available to an employee during the 12-month period immediately following the birth, adoption, or placement of a child.

You meet the program requirements if you:

- Have been employed with the City of Phoenix for at least 12 months prior to the requested date of leave
- Have worked at least 1,250 hours during the 12 months preceding the date the leave would begin

Eligibility and duration of approved paid parental leave are subject to change. For current program information, visit Employee Leave Programs on hr.phoenix.gov.

Long-Term Disability Benefits

The City provides no-cost long-term disability (LTD) coverage to help protect your income if a serious illness or injury keeps you from working for more than 90 days.

Note: LTD is a voluntary benefit. If you cannot work for more than 90 days, you must request and submit a completed LTD application packet to be considered.

ELIGIBILITY

You may qualify if you are:

- A full-time, benefits-eligible employee under age 75 with 12 consecutive months of full-time service and no unpaid leave during that period
- An elected official with one full year of service
- In a job-share position and have completed 12 months of full-time equivalent hours or 24 consecutive months in a job-share role
- Past the preexisting-condition waiting period, if applicable, which may be up to 24 months

WHEN BENEFITS BEGIN

Benefits begin after a 90-day waiting period, which may be paid or unpaid, and once all accrued leave—including sick, vacation, comp time, and donated leave—has been fully exhausted.

Limitations and Exclusions

LTD does not cover disabilities related to:

- Self-inflicted injury
- Felony or violent acts
- Acts of war
- Unmet preexisting-condition waiting periods
- Substance abuse

Additional limitations may apply.

HOW TO APPLY

Contact the LTD Program as soon as you think you may qualify. You will receive an application packet that includes an Attending Doctor's Statement, which must be completed by the provider treating you for your condition. Your primary care physician cannot complete this form unless they are the provider treating that specific condition.

CONTACT US

City of Phoenix LTD Program

- Call **602-534-5583**
  Monday–Friday, 8 a.m.–5 p.m.
- Email: employee.ltd@phoenix.gov.

Saving for Retirement

You work hard and deserve a relaxing and rewarding retirement! The City provides you with opportunities to save for retirement so that you can look forward to a secure and satisfying future once your employment with the City has ended.

Deferred Compensation Plan

The Deferred Compensation Plan (DCP) program is administered by the City's Retirement Department. These retirement savings options are in addition to your pension plan:

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

Nationwide Retirement Solutions is the recordkeeper for the DCP program. Nationwide provides the platform, tools, and services to help you plan for retirement at no additional cost, such as:

- Local Nationwide representatives
- Retirement Planning Specialist support from a CERTIFIED FINANCIAL PLANNER
- Free online investing advice tools
- Retirement tracking tools, including **My Interactive Retirement Planner**
- **Workshops and webinars**

Nationwide can help you set up your online account, request a loan, sign up for workshops and webinars, and learn more about your retirement savings options.

CITY OF PHOENIX DEFERRED COMPENSATION PLANS *Building your future together.* | Nationwide®

CONTACT INFORMATION

Nationwide Retirement Solutions

- Call **800-891-4749**.
- Visit **phoenixdcp.com**.

Post-Employment Health Plan (PEHP)

Since 2007, the City has provided a $150-per-month contribution.

Eligible employees are those who:

- Were hired as of August 1, 2007, or later
- Were more than 15 years away from pension eligibility as of August 1, 2007
- PEHP-eligible City spouse enrolled in City medical coverage

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

A variety of investment options are available for PEHP funds. As a new hire, your contributions are automatically defaulted to an American Funds Target Retirement Date Fund that correlates to your 65th birthday. Employees cannot contribute to their PEHP account. Employees enrolled as a child dependent of another City employee are not eligible for PEHP, nor when enrolled under COBRA. The Saver's Choice Health Savings Account is another vehicle to help you save for future medical costs. Learn more on page 19 of this guide.

Viewing Your DCP Accounts

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

The 401(a) Plan

All benefits-eligible employees receive a City contribution to their 401(a) accounts each pay period. The contribution percentage is negotiated with each bargaining unit during each contract period and may change every two years. See the table for City contribution percentages.

NEW EMPLOYEES

During your first 31 calendar days of employment, you have a one-time opportunity to choose whether to make an ongoing, irrevocable contribution from your paycheck to your 401(a) account.

Your investment will default to the target retirement date fund that most closely matches the year you turn 65.

To enroll in or change your 401(a) investment election, log in to your Nationwide account, or contact Nationwide Retirement Solutions.

BENEFIT CATEGORY	CITY CONTRIBUTION TO YOUR 401(A) ACCOUNT
001	0.45%
002	3.62%
003	2.36%
004	2.56%
005	4.42%
006	1.50%
007	6.50%
008	1.92%
009	9.0% or $9,500 annually (whichever is greater)
010	9.0% or $9,500 annually (whichever is greater)
011	9.0% or $9,500 annually (whichever is greater)
016	9.0% or $9,500 annually (whichever is greater)
017	9.0% or $9,500 annually (whichever is greater)
018	9.0% or $9,500 annually (whichever is greater)
019	9.0% or $9,500 annually (whichever is greater)

The 457(b) Plan

The City does not contribute to the 457(b) plan, but you can choose to contribute a percentage or dollar amount from your paychecks anytime. You can direct your contribution to pretax (traditional) or post-tax (Roth). The benefits of a traditional 457(b) include:

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

The Roth 457(b) Plan

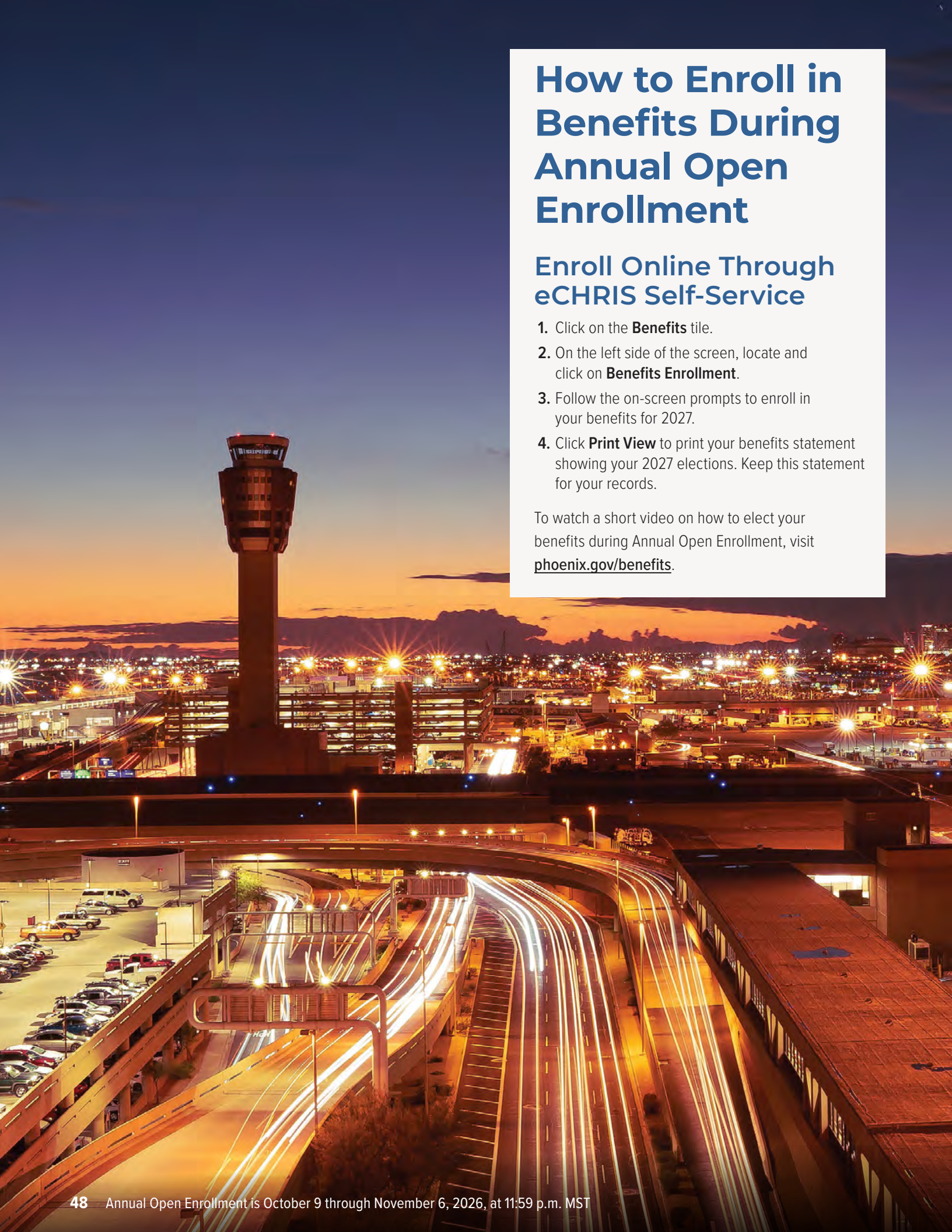
With a Roth 457(b), you pay taxes up front when you make contributions into the plan. Then your money grows tax-free, and you'll also enjoy tax-free withdrawals, as long as:

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

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

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

Build that safety net now — you can access it during and after your employment with the City of Phoenix. As a new hire, your contributions are automatically defaulted to an American Funds Target Retirement Date Fund that correlates to your 65th birthday. To enroll in the 457(b) or change your contribution amount, log in to your account at phoenixdcp.com. Contribution elections are not made on eCHRIS.



How to Enroll in Benefits During Annual Open Enrollment

Enroll Online Through eCHRIS Self-Service

1. Click on the **Benefits** tile.
2. On the left side of the screen, locate and click on **Benefits Enrollment**.
3. Follow the on-screen prompts to enroll in your benefits for 2027.
4. Click **Print View** to print your benefits statement showing your 2027 elections. Keep this statement for your records.

To watch a short video on how to elect your benefits during Annual Open Enrollment, visit phoenix.gov/benefits.

Whom to Contact

Contact the City of Phoenix Benefits Office

- You have a question about benefits eligibility.
- You have a question about Annual Open Enrollment.
- You have a question about making a change in your benefits enrollment.
- You have a question about the Fit4Phoenix Employee Wellness Program.
- You have an unresolved problem with one of our benefits vendors.

City of Phoenix Benefits Office

- Visit: phoenix.gov/benefits
- Email for benefits: benefits.questions@phoenix.gov
- Email for wellness: be.healthy@phoenix.gov
- Call **602-262-4777**.

Contact the Benefits Vendors

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

Whom to Contact

Use the contact information below to reach your medical plan vendors for member services, registration assistance, or plan-specific questions.

Benefits vendors are subject to change.

BENEFITS VENDOR	CONTACT INFORMATION
Banner | Aetna	Employee website: aetna.com/cityofphoenix To contact your designated representative, see the Benefits website for current contact information: phoenix.gov/benefits Banner | Aetna Health Concierge: **855-220-6506**
Transcarent	transcarent.com/members
Blue Cross Blue Shield of Arizona	Registration and password reset: **602-864-4844** Member website: azblue.com To contact your designated BCBS representative, see the Benefits website for current contact information: phoenix.gov/benefits Member Services: **602-864-4857**

Use the contact information below to connect with your benefits providers for questions about coverage, claims, account access, enrollment, and support services.

BENEFITS VENDOR	BENEFIT/SERVICE	CONTACT INFORMATION
Telehealth from AZ Blue	Virtual Visits	Website: azbluetelehealth.com Member Services: **844-606-1612**
HealthEquity	Health Savings Account (HSA) for Saver's Choice HDHP	Website: healthequity.com/phoenix Member Services: **877-582-4793**
MedImpact	Pharmacy Benefits	Website: medimpact.com To contact your designated MedImpact representative, visit the Benefits website for current contact information: phoenix.gov/benefits Customer Service: **833-803-4402** (24-hour assistance, including holidays)
ComPsych GuidanceResources	Employee Assistance Program (EAP)	Website: guidanceresources.com Web ID: PhoenixEAP App: GuidanceNow Member Services: **844-819-4775**
Cigna	Dental Benefits	Website: mycigna.com Member Services: **800-244-6224** Registration Questions and Password Reset: **800-853-2713**
Davis Vision by MetLife	Vision Buy-Up Plan	Vision Line: **833-EYE-LIFE (833-393-5433)** Website: metlife.com/mybenefits
DCP Program	457(b) / 401(a) / PEHP	Email: dcp.benefits@phoenix.gov
Flexible Benefit Administrators	Flexible Spending Accounts (FSAs) and COBRA	FSA Website: fba.wealthcareportal.com COBRA Website: cobrapoint.benaissance.com Member Services: **602-325-9418**
Securian Financial	Life Insurance Plan	Website: securian.com/phoenix-insurance
ARAG	Legal Insurance Plan	Website: ARAGlegal.com/plans Access Code: 16922phx Member Services: **800-835-3425**
MetLife	Pet Insurance Plan	Website: MetLifePetInsurance.com Member Services: **800-GET-MET8** or **800-438-6388**
Nationwide Retirement Solutions	Retirement Planning Services	Website: phoenixdcp.com Phoenix Nationwide Office: **602-266-2733**
Personify Health	Employee Wellness Vendor	Email: support@personifyhealth.com Member Services: **888-671-9395**
City of Phoenix	Long-Term Disability Program	Email: employee.ltd@phoenix.gov Call: **602-534-5583** Monday–Friday, 8 a.m.–5 p.m.
AbsenceResources®	Paid Parental Leave	Website: absenceresources.com Member Services: **855-749-3652**

Benefits vendors are subject to change.

Glossary

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

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

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

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

Out-of-Pocket Maximum (Medical or 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; this 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 that your network provider might use an out-of-network provider for some services (such as lab work). Before you get services, check with your provider to confirm their network status.

Legal Notices

MEDICARE NOTICE OF CREDITABLE COVERAGE REMINDER

If you or your eligible dependents are currently Medicare eligible, or will become Medicare eligible during the next 12 months, you need to be sure that you understand whether the prescription drug coverage that you elect under the Medical Plan options available to you are or are not creditable with (as valuable as) Medicare's prescription drug coverage.

To find out whether the prescription drug coverage under the medical plan options offered by your employer are or are not creditable, you should review the Plan's Medicare Part D Notice of Creditable Coverage available from the City and provided in full at the end of these Legal Notices.

NOTICE OF QUALIFIED LIFE EVENT 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. You must request enrollment within 60 calendar days after the 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**.

DEPENDENTS INELIGIBLE FOR HEALTH COVERAGE

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

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the deductibles and coinsurance listed in this Guide (and/or your health plan's Summary Plan Description) apply. If you would like more information on WHCRA benefits, contact your plan administrator at benefits.questions@phoenix.gov or **602-262-4777**.

NEWBORN'S AND MOTHER'S HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

PROVIDER CHOICE NOTICE

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

You do not need prior authorization from the health plan or from any other person (including a PCP) in order to obtain access to obstetrical or

gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the City of Phoenix Benefits Office at **benefits.questions@phoenix.gov** or **602-262-4777**.

CITY OF PHOENIX HIPAA PRIVACY NOTICE

EFFECTIVE JANUARY 1, 2027

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

Your Rights

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

Get a copy of health and claims records

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

Ask us to correct health and claims records

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

Request confidential communications

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

Ask us to limit what we use or share

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

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

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

Get a copy of this privacy notice

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 3.
- 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, SW, Washington, DC 20201, calling **877-696-6775**, or visiting **hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you for filing a complaint.

Your Choices

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

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

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

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

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

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

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

Help manage the health care treatment you receive

- We can use your health information and share it with professionals who are treating you.

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

Run our organization

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

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

Pay for your health services

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

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

Administer your plan

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

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

How else can we use or share your health information?

We are allowed or required to share your information in other ways—usually [em dash, no spaces] 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. In all cases, if we have substance use disorder patient records about you, subject to 42 CFR part 2, we cannot use or share information in those records in civil, criminal, administrative,
or legislative investigations or proceedings against you without (1) your consent or (2) a court order and a subpoena. For more information see: hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

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

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

Do research

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

Comply with the law

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

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

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

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

- We can use or share health information about you:
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services
  - Respond to lawsuits and legal actions. We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

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

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

Changes to the Terms of this Notice

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

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

Please contact:

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

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

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

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

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

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

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is the Plan's in-network cost-sharing amount (such as copayments and coinsurance).

You can't be balance billed for emergency services, including services you may receive after you're in stable condition, unless you give written consent and give up your protections not to be balance 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 **800-985-3059**.

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

NOTICE REGARDING WELLNESS PROGRAM

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

However, employees who choose to participate in the wellness program will receive an incentive of $40 or $60 per month for completing the HRA and visiting their PCP. If the employee or covered spouse (or qualified domestic partner) do this, the incentive is $40. If the employee and covered spouse (or qualified domestic partner) do this, the incentive is $60.

Although you are not required to complete the HRA or complete a PCP visit only, employees who do so will receive the incentive.

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

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

PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION

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

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

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

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

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

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

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

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

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

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

and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2026. Contact your State for more information on eligibility:

ALABAMA – MEDICAID

Website: myalhipp.com/
Phone: **1-855-692-5447**

ALASKA – MEDICAID

The AK Health Insurance Premium Payment Program
Website: **myakhipp.com/**
Phone: **1-866-251-4861**
Email: **CustomerService@MyAKHIPP.com**
Medicaid Eligibility: **health.alaska.gov/dpa/Pages/default.aspx**

ARKANSAS – MEDICAID

Website: **myarhipp.com/**
Phone: **1-855-MyARHIPP** (855-692-7447)

CALIFORNIA – MEDICAID

Health Insurance Premium Payment (HIPP) Program Website:
dhcs.ca.gov/services/health-insurance-premium-payment-program-cost-avoidance/
Phone: **916-445-8322**
Fax: 916-440-5676
Email: **hipp@dhcs.ca.gov**

COLORADO – HEALTH FIRST COLORADO (COLORADO'S MEDICAID PROGRAM) & CHILD HEALTH PLAN PLUS (CHP+)

Health First Colorado Website: **healthfirstcolorado.com/**
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+: **hcpf.colorado.gov/child-health-plan-plus**
CHP+ Customer Service: **1-800-359-1991**/State Relay 711
Health Insurance Buy-In Program (HIBI): **mycohibi.com/**
HIBI Customer Service: **1-855-692-6442**

FLORIDA – MEDICAID

Website: **flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html**
Phone: **1-877-357-3268**

GEORGIA – MEDICAID

GA HIPP Website: **medicaid.georgia.gov/health-insurance-premium-payment-program-hipp**
Phone: **678-564-1162**, Press 1
GA CHIPRA Website: **medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra**
Phone: **678-564-1162**, Press 2

ILLINOIS - MEDICAID

Illinois Medicaid Premium Assistance Information
Medicaid application website: **abe.illinois.gov**
HIPP Hotline Number: **217-524-8268**
HIPP Email: **mhfs.boc.hipp@illinois.gov**

INDIANA – MEDICAID

Health Insurance Premium Payment Program
All other Medicaid
Website: **in.gov/medicaid/**
in.gov/fssa/dfr/
Family and Social Services Administration
Phone: **1-800-403-0864**
Member Services Phone: **1-800-457-4584**

IOWA – MEDICAID AND CHIP (HAWKI)

Medicaid Website: **hhs.iowa.gov/medicaid**
Medicaid Phone: **1-800-338-8366**
Hawki Website: **hhs.iowa.gov/medicaid/plans-programs/hawki**
Hawki Phone: **1-800-257-8563**
HIPP Website: **hhs.iowa.gov/medicaid/plans-programs/fee-service/health-insurance-premium-payment-program**
HIPP Phone: **1-888-346-9562**

KANSAS – MEDICAID

Website: **kancare.ks.gov/**
Phone: **1-800-792-4884**
HIPP Phone: **1-800-967-4660**

KENTUCKY – MEDICAID

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: **chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx**
Phone: **1-855-459-6328**
Email: **KIHIPP.PROGRAM@ky.gov**
KCHIP Website: **kynect.ky.gov**
Phone: **1-877-524-4718**
Kentucky Medicaid Website: **chfs.ky.gov/agencies/dms**

LOUISIANA – MEDICAID

Louisiana Medicaid Website: **ldh.la.gov/healthy-louisiana**
Medicaid Customer Service Line: **1-888-342-6207**
Louisiana Medicaid email: **healthy@la.gov**
Louisiana Health Insurance Premium Program (LaHIPP) Website:
ldh.la.gov/lahipp
LaHIPP phone: **1-877-697-6703**
LaHIPP email: **La.HIPP@la.gov**
LaHIPP fax: 1-888-716-9787
LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000, Tucker, GA 30084

MAINE – MEDICAID

Enrollment Website: **mymaineconnection.gov/benefits/s/?language=en_US**
Phone: **1-800-442-6003**
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
maine.gov/dhhs/ofi/applications-forms
Phone: **1-800-977-6740**
TTY: Maine relay 711

MASSACHUSETTS – MEDICAID AND CHIP

Website: **mass.gov/masshealth/pa**
Phone: **1-800-862-4840**
TTY: 711
Email: **masspremassistance@accenture.com**

MINNESOTA – MEDICAID

Website: **mn.gov/dhs/health-care-coverage/**
Phone: **1-800-657-3672**

MISSOURI – MEDICAID

Website: **dss.mo.gov/mhd/participants/pages/hipp.htm**
Phone: **573-751-2005**

MONTANA – MEDICAID

Website: **dphhs.mt.gov/MontanaHealthcarePrograms/HIPP**
Phone: **1-800-694-3084**
Email: **HHSHIPPProgram@mt.gov**

NEBRASKA – MEDICAID

Website: **accessnebraska.ne.gov**
Phone: **1-855-632-7633**
Lincoln: **402-473-7000**
Omaha: **402-595-1178**

NEVADA – MEDICAID

Medicaid Website: **dhcfp.nv.gov**
Medicaid Phone: **1-800-992-0900**

NEW HAMPSHIRE – MEDICAID

Website: **dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program**
Phone: **603-271-5218**
Toll free number for the HIPP program: **1-800-852-3345**, ext. 15218
Email: **DHHS.ThirdPartyLiabi@dhhs.nh.gov**

NEW JERSEY – MEDICAID AND CHIP

Medicaid Website: **nj.gov/humanservices/dmahs/individuals-families/familycare/**
Phone: **1-800-356-1561**
CHIP Premium Assistance Phone: **609-631-2392**
CHIP Website: **njfamilycare.org/index.html**
CHIP Phone: **1-800-701-0710 (TTY: 711)**

NEW YORK – MEDICAID

Website: **health.ny.gov/health_care/medicaid/**
Phone: **1-800-541-2831**

NORTH CAROLINA – MEDICAID

Website: **medicaid.ncdhhs.gov/**
Phone: **919-855-4100**

NORTH DAKOTA – MEDICAID

Website: **hhs.nd.gov/healthcare**
Phone: **1-844-854-4825**

OKLAHOMA – MEDICAID AND CHIP

Website: **insureoklahoma.org**
Phone: **1-888-365-3742**

OREGON – MEDICAID

Website: **healthcare.oregon.gov/Pages/index.aspx**
Phone: **1-800-699-9075**

PENNSYLVANIA – MEDICAID AND CHIP

Website: **pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html**
Phone: **1-800-692-7462**
CHIP Website: Children's Health Insurance Program (CHIP) (**pa.gov**)
CHIP Phone: **1-800-986-KIDS (5437)**

RHODE ISLAND – MEDICAID AND CHIP

Website: **eohhs.ri.gov/**
Phone: **1-855-697-4347**, or
401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – MEDICAID

Website: **scdhhs.gov**
Phone: **1-888-549-0820**

SOUTH DAKOTA - MEDICAID

Website: **dss.sd.gov**
Phone: **1-888-828-0059**

TEXAS – MEDICAID

Website: **hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program**
Phone: **1-800-440-0493**

UTAH – MEDICAID AND CHIP

Utah's Premium Partnership for Health Insurance (UPP) Website: **medicaid.utah.gov/upp/**

Email: **upp@utah.gov**

Phone: **1-888-222-2542**

Adult Expansion Website: **medicaid.utah.gov/expansion/**

Utah Medicaid Buyout Program Website: **medicaid.utah.gov/buyout-program/**

CHIP Website: **chip.utah.gov/**

VERMONT– MEDICAID

Website: **dvha.vermont.gov/members/medicaid/hipp-program**

Phone: **1-800-250-8427**

VIRGINIA – MEDICAID AND CHIP

Website: **coverva.dmas.virginia.gov/learn/premium-assistance/famis-select**

coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs

Medicaid/CHIP Phone: **1-800-432-5924**

WASHINGTON – MEDICAID

Website: **hca.wa.gov/**

Phone: **1-800-562-3022**

WEST VIRGINIA – MEDICAID AND CHIP

Website: **bms.wv.gov/**

mywvhipp.com/

Medicaid Phone: **304-558-1700**

CHIP Toll-free phone: **1-855-MyWVHIPP (1-855-699-8447)**

WISCONSIN – MEDICAID AND CHIP

Website: **dhs.wisconsin.gov/badgercareplus/p-10095.htm**

Phone: **1-800-362-3002**

WYOMING – MEDICAID

Website: **health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/**

Phone: **1-800-251-1269**

To see if any other states have added a premium assistance program since July 31, 2026, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration

dol.gov/agencies/ebsa

1-866-444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

cms.hhs.gov

1-877-267-2323,

PAPERWORK REDUCTION ACT STATEMENT

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, NW, Room N-5718, Washington, DC 20210, or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

GINA NOTICE AND AUTHORIZATION FOR WELLNESS PROGRAM

This Notice and Authorization is being provided because the City of Phoenix offers a voluntary wellness program available to spouses (or qualified domestic partners) of employees.

The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve health or prevent disease, including the Americans with Disabilities Act of 1990 (ADA), the Genetic Information Nondiscrimination Act of 2008 (GINA), and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as applicable, among others. Employees of the City of Phoenix will receive a separate Notice regarding the wellness program. Federal law requires that you provide knowing, written, and voluntary authorization prior to the City of Phoenix's wellness program (Fit4Phoenix) collecting your genetic information, which includes information about your current or past health status. By participating in the City of Phoenix's wellness program, you are agreeing that you have read and understood this notice and that you are knowingly and voluntarily providing information about the manifestation of your diseases and certain other conditions—considered genetic information—as part of the wellness program. This may include a medical questionnaire that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You may also be asked to visit your Primary Care Physician (PCP).

If you are unable to participate in any of the health-related activities, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the Wellness Coordinator at **602-262-4777**.

You are not required to complete the questionnaire or the PCP Visit. You are not required to provide genetic information; however, if you choose not to provide information regarding your own health status, you may not qualify for the full amount of wellness incentives ($40 or $60 per month). The wellness program cannot offer you a wellness incentive in return for you providing your own genetic information, including your family medical history, results of your genetic tests, or information about your children's health status or genetic information.

Regardless, you and/or your spouse (or qualified domestic partner) will not be denied access to the City of Phoenix's health plan (or any package of health plan benefits), or subjected to the City of Phoenix discrimination or retaliation if you choose not to participate in the wellness program.

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

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

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

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

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

CONTINUATION COVERAGE RIGHTS UNDER COBRA INTRODUCTION

This notice describes your rights once you have coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan.

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

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

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

WHAT IS COBRA CONTINUATION COVERAGE?

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

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

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

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

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

- You become divorced or legally separated from your spouse.

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

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

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

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

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

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 31 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 may permit a beneficiary to receive additional coverage, up to a maximum of 36 months. The ways in which this 18-month period of COBRA continuation coverage can be extended:

DISABILITY EXTENSION OF 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

COBRA Disability Extension Notice

Qualified beneficiaries may be eligible for an extension of their COBRA continuation coverage if they are determined to be disabled by the Social Security Administration (SSA). The extension allows COBRA coverage to continue for up to 29 months (an additional 11-month period beyond the standard 18-month coverage), provided all requirements below are met.

Eligibility for Disability Extension

A qualified beneficiary may receive the disability extension if:

- The SSA determines the individual is disabled under Title II or Title XVI of the Social Security Act at any time during the first 60 days of COBRA continuation coverage; or
- The SSA determined the individual was disabled under Title II or Title XVI of the Social Security Act before COBRA coverage began and the individual was not found to be no longer disabled before COBRA coverage started.

Notice Requirements

To receive the disability extension, the plan administrator must be notified, in writing, of the SSA disability determination:

- Within 60 days after the date the SSA issues the disability determination; and
- Before the end of the original 18-month COBRA continuation period.

Coverage During the Disability Extension

If the disability extension requirements are met:

- All qualified beneficiaries associated with the same qualifying event are eligible for the extension, not just the individual who is disabled.
- During the additional 11-month extension period, the plan may charge up to 150% of the premium cost for COBRA coverage.

Important Considerations

- Beneficiaries must continue to pay COBRA premiums on time to maintain coverage.
- If the SSA later determines the individual is no longer disabled, beneficiaries must notify the plan administrator within 30 days.

Notify the City of Phoenix Benefits Office (the plan administrator) at **602-262-4777** or benefits.questions@phoenix.gov with additional questions or concerns.

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 **healthcare.gov**.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area, or visit **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 **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
7th Floor
251 W. Washington Street
Phoenix, AZ 85003

602-262-4777
Benefits.questions@phoenix.gov

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

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

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

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

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **The City of Phoenix has determined that the prescription drug coverage offered by the City of Phoenix PPO Actives, Saver's Choice Actives, and Banner-Aetna HMO Health Plan (collectively, "City of Phoenix Health Plans") is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is, therefore, considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Drug Plan?

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

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

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

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

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

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

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

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

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

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

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: 08/19/2022

Name of Entity/Sender: City of Phoenix

Contact–Position/Office: City of Phoenix Benefits Office

Address: 251 W. Washington Street, 7th FL, Phoenix, AZ 85003

Phone Number: **602-262-4777**

City of Phoenix

Human Resources Department

251 W. Washington St.

Phoenix, AZ 85003