City of Tucson

JULY 1, 2017 – JUNE 30, 2018

EMPLOYEE & RETIREE

INSURANCE HANDBOOK

Live Well, Be Well

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Overview

Life happens. Just when you think you have it figured out, something unexpected comes your way. Our insurance program is flexible. You choose the plans that meet your unique needs. . . and your budget. To ensure that you're getting the best value for the money you spend, we encourage you to take an active role in understanding your options and the plans you choose.

The City reserves the exclusive right to terminate, amend or modify plans, coverage and premiums for all employee and retiree benefits. This guide is only a summary of your benefits. Where disparities exist between the Handbook and insurance contracts, the insurance contracts will dictate.

Summaries of Benefits and Coverage

The benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury. In accordance with law, our plan provides you with a **Summary of Benefits and Coverage or SBC** as a way to help you understand and compare medical plan benefits. The SBC summarizes and compares important information including, what is covered, what you need to pay for various benefits, what is not covered, and where to get answers to questions. SBC documents are updated when there is a change to the benefits information displayed on an SBC. To get a free copy of the most current Summary of Benefits and Coverage (SBC) documents for our medical plan options, go to www.tucsonaz.gov/insurance or for a paper copy, contact the City's Benefits Office at benefitquestions@tucsonaz.gov or 520-791-4597.

Benefits at a Glance

The City of Tucson's insurance program includes both City-paid and Employee-paid benefits.

Paid by the City of Tucson	Paid by You and the City of Tucson	Paid by You
▪ Basic Term Life ▪ Dependent Term Life * ▪ Basic Long-Term Disability * ▪ Employee Assistance Program (EAP) *	▪ Medical ** ▪ Dental ***	▪ Vision ▪ Employee Supplemental Term Life * ▪ Spouse Term Life * ▪ Employee Long-Term Disability Buy-up * ▪ Supplemental coverage through Colonial Life * ▪ Flexible Spending Accounts: Health and Dependent Care *

* *Offered only to employees (not to retirees)*

** *Some retirees are responsible for 100% of the medical premium. Any subsidy provided by the City will be applied only to group medical insurance sponsored by the City of Tucson; no other plans are eligible for the subsidy.*

*** *Some levels are fully paid by the City with no employee contribution. In general, retirees are responsible for 100% of the dental premium. See the Retiree Health Continuation Administrative Directive for details.*

Eligibility

Employees

You are eligible to enroll in the City of Tucson's insurance program if you are hired to work, on average, 30 or more hours per week (130 or more hours per month) on a permanent basis, or if you are an elected official. Permanent or appointed part-time employees who are recorded in the payroll system on June 30, 2017 as being scheduled to work 20-29 weekly are also eligible under a grandfathered status; however, once a grandfathered employee changes position or employment status going forward, grandfathered status is lost, and the 30+ hour requirement will apply. If you are a temporary or seasonal employee, and if your employment is intended to end before 90 days of employment, you generally won't be eligible for insurance. If you have questions about your eligibility, please contact your insurance benefits staff at 520-791-4597.

Variable Hour Employees

Under the Affordable Care Act (ACA), employees whose hours vary from week to week are referred to as

"variable hour" employees. While the City of Tucson measures all employees' hours to ensure compliance with the ACA, variable hour employees have a 12-month "measurement period" to determine the average number of hours they worked and whether or not they are eligible for insurance for the upcoming plan year. The City of Tucson's ongoing measurement period is May 1 – April 30 annually. May and June are considered the "administrative period" during which the City contacts employees who are eligible and makes sure they have the information they need to enroll for the upcoming plan year. In addition to this ongoing measurement period, newly hired employees are also measured in an initial 12-month measurement period that begins the first day of the month following the date they begin employment. If, after the initial measurement period, an employee is determined to be eligible for insurance, coverage will be offered and will begin the first day of the month following the initial 12-month measurement period.

Retirees

Administrative Directive (AD) 3.04-6 posted at www.tucsonaz.gov/insurance outlines **benefits-eligible retiree** criteria. See AD 3.04-6 and the Retiree section of this Handbook for details and requirements. Employees hired or rehired on or after January 1, 2016 are not eligible for retiree insurance continuation.

Dependents

If you are covered by the City's medical, dental and/or vision plans, in general, you may also cover your eligible dependents for the plan(s) in which you are enrolled. Active employees also may enroll eligible dependents in the City-paid Dependent Life and employee-paid Spouse Life insurance, subject to plan limitations. **Retirees** may **not** enroll dependents who **qualify** for Medicare (due to age or disability) in the City's medical plans, even if the dependent hasn't actually enrolled in Medicare.

Your eligible dependents include the following:

- **Spouse:** Your spouse (unless legally separated, divorced or annulled)
- **Children under age 26:** Your biological child, step-child, adopted child (including those placed for adoption), foster child, child named as an "alternate recipient" under a Qualified Medical Child Support Order (QMSCO), or child for whom you have full permanent legal guardianship. Coverage may last until the last day of the month during which your child turns age 26. However, in the case of guardianship, coverage lasts until the earlier of the date the full permanent legal guardianship ends or until the child reaches age 26. Most guardianships end at age 18. A permanent guardianship of an adult (age 18+) who is not the natural, adopted or step-child of the employee/retiree is not considered a dependent even if you have permanent guardianship.
- **Disabled Children:** Children age 26+ who live with you, provide less than one-half of their own support and maintenance, are incapable of self-sustaining employment due to a mental or physical disability and who have been insured continuously under the City's insurance program since they were less than age 26 may apply to remain on the City's insurance plans. The City's medical insurance carrier (currently Cigna) must receive the appropriate application **prior to** your child reaching age 26 and will make the determination of whether an individual qualifies to continue coverage under disabled or handicapped status. Annual re-certification may be required. It is your responsibility to meet deadlines and requirements for disability determination. Children age 26+ who have not been continuously insured since they were less than age 26 through the City of Tucson insurance program may not be added to coverage. Once an age 26+ disenrolls from a plan, he/she may never re-enroll; you must notify the Benefits Office immediately if the individual no longer meets City eligibility criteria in order to remove the individual from coverage.

Online Dependent Verification and Dependent Audit

When you enroll in the online benefits system, you will attest that you understand the definitions for dependent eligibility and that you are enrolling only eligible dependents. We may conduct an audit requiring you to provide documentation proving their eligibility. If you're audited, you'll receive a list of acceptable documentation based upon the type of dependent you've enrolled. If sufficient documentation isn't received within the allowable period, coverage for your dependent(s) will be dropped and/or denied**. Providing dependent information that is false and inaccurate can result in disciplinary action, up to and including termination of coverage and/or employment, and may result in you having to repay City-paid premiums and insurance-paid claims.**

Dependents' Social Security Numbers (SSN)

Social Security Numbers (SSN) are required for enrollment in the medical plan, unless your dependent is a non-US citizen. You must provide a newborn's SSN no later than 90 days after the date of birth. Employers are required by law to provide SSNs for each medical plan participant to the IRS and to make at least two attempts each year to gather missing SSNs. If your qualifying dependent doesn't have a SSN, you can request one at http://www.socialsecurity.gov/online/ss-5.pdf. Applying for a Social Security card is free.

When Coverage Begins

Initial Enrollment

Insurance for newly hired and rehired employees begins the first day of the month following 30 days of employment. Insurance for employees who have a status change that makes them newly eligible for insurance also begins the first day of the month following 30 days in their newly benefits-eligible position.

You must complete your online enrollment via the City's online enrollment system, accessible via www.tucsonaz.gov/insurance, before the date your insurance is scheduled to begin. If you don't complete your enrollment by your benefits start date, you'll be enrolled automatically in Basic Life, Basic long term disability and the Employee Assistance Program. You'll have to wait until the next annual open enrollment to enroll in other coverage unless you have a qualifying life event. (See "Changes During the Plan Year".)

If you enroll during your initial eligibility period in Supplemental Employee Life, Spouse Life, Long-Term Disability Buy-Up and certain voluntary coverage (such as Short-Term Disability), you are guaranteed the coverage, but pre-existing condition exclusions may apply. If you decline these options when you're first eligible and later want to apply for them during Open Enrollment, the insurance carriers will require proof of good health (evidence of insurability), which may require examinations, tests or medical documentation – at your own expense. The insurance carriers have the right to accept or deny your request for coverage based on the evidence of insurability you provide.

To enroll in Colonial Life voluntary benefits, you must meet with a Colonial Life representative before your benefits start date.

Rehires

If you are rehired as an insurance-eligible employee within 30 days after the date your employment ended, you may reinstate only elections that were in place on the date you left employment, unless you had a qualifying life event - other than separation and rehire - during the time between the date your insurance ended previously and the date your coverage will begin as a rehired employee. If you are rehired as an insurance-eligible employee more than 30 days after your prior City insurance elections ended, you may make new elections, subject to IRS regulations and the provisions of the insurance contracts in effect at the time of your separation and rehire. If you had previously continued City life insurance through portability, you may be required to forfeit the portability policy upon rehire; contact the insurance carrier for confirmation. You would not be eligible to re-apply for portability if your rehire date is January 1, 2016 or later.

ONLINE ENROLLMENT

The City of Tucson's online enrollment system gives you access to your insurance information 24/7:

- ☑ Enroll
- ☑ Request changes due to qualifying life events
- ☑ Add or change life insurance beneficiaries
- ☑ Print a confirmation statement of your benefits

Visit **www.tucsonaz.gov/insurance**.

Retirees Who Return to Employment

Retirees who are later rehired as insurance-eligible City employees must enroll in ***active employee*** insurance coverage. Those hired or rehired **before** January 1, 2016 may later **resume** their retiree coverage once active employee coverage ends. Those hired or rehired **on or after** January 1, 2016 are **not eligible for retiree insurance continuation**, retiree basic life insurance, or portability of supplemental life insurance; continuation of existing medical, dental, vision, Employee Assistance Program, and under certain circumstances health care Flexible Spending Account**,** will be offered in accordance with federal COBRA continuation laws.

Open Enrollment

Open Enrollment is your annual opportunity to make changes. During open enrollment you may:

- Elect or re-elect insurance from the options that are offered
- Add or remove dependents (continuous coverage requirements apply to retirees and their dependents for dental and vision – see the Retiree section at the end of this Handbook for details)
- Elect or re-elect personal contributions to a health savings account (HSA – active employees only; also available during the plan year)
- Apply for new or increased life or long term disability insurance, and voluntary insurance through Colonial (active employees only)
- Elect or re-elect contributions to a flexible spending account (FSA – active employees only)

Certain restrictions apply. For example:

- If you're enrolled in an HSA, you won't be allowed to enroll in the health care FSA, and vice versa.
- The HMO plans (medical and dental) require that your mailing address is within the list of eligible zip codes for those plans.
- Supplemental life and long-term disability buy-up coverage may require insurance carrier application and approval (active employees only – see applicable sections of this Handbook for additional information).

Medical, dental, vision, life, disability and Colonial insurance have a spring open enrollment (generally in May), becoming effective July 1 through June 30. Supplemental life and long term disability buy-up requests during Open Enrollment require evidence of insurability (also known as proof of good health) and insurance carrier approval before coverage will begin.

Unlike other benefits, the City's Flexible Spending Account program runs on a calendar year (January 1 – December 31). Open Enrollment for the FSAs occurs in the fall.

Making Changes During the Plan Year

Once you've enrolled, you generally may make changes during the Plan Year only if you experience a qualifying "life event" that affects your benefits. If you have a qualifying life event, you must complete your request for changes via the City's online enrollment system **and** the Benefits Office must **also** receive your required supporting documentation within ***31 days*** after the date of your life event (60 days under limited circumstances outlined below):

Event	Deadline to Request Change	Change Takes Effect
Birth or adoption	60 days after date of birth or adoption	The date of birth or adoption
You lose eligibility for state Medicaid or Children's Health Insurance Program (CHIP) coverage, or you become eligible for assistance with group health premium payment under a state Medicaid or CHIP plan	60 days after you lose eligibility for state Medicaid or CHIP coverage, or you become eligible for assistance with group health premium payment under a state Medicaid or CHIP plan	The first day of the month following the date you gained/lost CHIP coverage or premium payment assistance
All Other Life Events including but not limited to marriage, divorce, gain/loss of qualifying coverage elsewhere (see next page)	**31 days** after the date of the event	• On the date of the event, if the event occurs on the first day of the month • The first day of the following month *following* the event date, if the event occurs on the second or later day of the month

If you miss the deadline for submitting your change request and/or for providing required supporting documents, your next opportunity to make a change will be during Open Enrollment, with most changes taking effect the following July 1st.

Here are some important details you should know about making life event changes:

- Any changes you request must be consistent with the life event
- Subject to plan limitations (see Life Insurance), you may request Spouse Life and Dependent Life for *newly eligible* dependents (for example, if you get married or have a child), but requests for new or increased life insurance for *existing* dependents are considered only during Open Enrollment
- Significant change in dependent day care cost allows you to change your dependent day care flexible spending account contribution amount
- You may apply for new or increased Supplemental Employee Life, Long-Term Disability and Colonial Life coverage *only during Open Enrollment* and not when you have a qualifying life event

Qualifying Life Events include the following:

Events that allow you to ADD coverage mid-year	Events that allow you to DROP coverage mid-year
You gain a dependent (marriage, birth, adoption, court order reflecting full permanent legal guardianship or required coverage of a dependent).	You lose a dependent (divorce, legal separation, annulment, death). You may also drop coverage in the event of birth, adoption or court order reflecting full permanent legal guardianship or that someone else must cover your dependent *if you can provide acceptable documentation proving that your dependents have joined coverage through another qualifying plan.*
You or your dependents lose group or other creditable insurance elsewhere (due to a change in employment or a different open enrollment period/plan year). *Note:* Canceling individual insurance (for example, through the Health Insurance Marketplace) is NOT considered a qualifying life event that would warrant a mid-year addition of City coverage.	You or your dependent(s) become newly eligible for or gain group or other creditable insurance coverage elsewhere (due to a change in employment or a different open enrollment period/plan year). *Those dropping must join coverage through another qualifying plan in order to drop with the City.* *Note:* Enrollment in an individual insurance policy (for example, through the Health Insurance Marketplace) is NOT considered a qualifying life event that would warrant mid-year disenrollment.
Your dependent gains eligibility under the City's eligibility criteria.	Your dependent loses eligibility under the City's eligibility criteria.
You are not enrolled in the City's medical plan and you lose Medicaid or Children's Health Insurance Program (CHIP) coverage or you become eligible for the premium assistance subsidy. **Note:** You have 60 days in which to notify the City of this life event.	You or your dependents become eligible for Medicaid or the Children's Health Insurance Program (CHIP).
You may also make qualifying changes to certain plans if you or a dependent moves out of the plan's service area (example: you move to an area where the medical/dental HMO does not have providers or guesting privileges).	

Some changes may be made mid-year without a qualifying life event:

Change	How to make your request	Change Takes Effect
Drop supplemental employee life, spouse life or long term disability Buy-Up *(employees only)*	Via the online enrollment system accessible via www.tucsonaz.gov/insurance	First day of the month following the date you log your request
Change your personal HSA contribution *(employees only)*	Submit your completed HSA Change Form (on the Forms page at www.tucsonaz.gov/insurance) to the Benefits Office	See the form for details.
Drop **post-tax** voluntary Colonial Life coverage *Note:* Pre-tax Colonial Life coverage may be dropped only during Open Enrollment.	Contact Colonial Life: 1-800-433-8144	The pay period that Colonial Life sends notification to the Benefits Office
Retirees Only: Drop medical and/or dental	Submit your completed form to the Benefits Office. Form is available on the Retiree Information page at www.tucsonaz.gov/insurance.	First day of the month following the date the Benefits Office receives your properly completed form
Retirees Only: Drop vision	Send a cancellation request in writing to Avesis.	The date of your request or the date coverage is canceled due to non-payment

For additional information about qualifying life events, refer to the City's Section 125 Plan Document posted at www.tucsonaz.gov/insurance.

CAUTION: If You Decline Medical Plan Coverage Offered Through City of Tucson – or if you are not eligible for the City's medical plan– remember that you may pay a penalty when you file your personal income taxes if you don't have medical insurance. Visit https://www.healthcare.gov/fees-exemptions/fee-for-not-being-covered/ for details. If you choose not to be covered by City of Tucson medical when first eligible, your next opportunity to enroll is during the next spring annual open enrollment (provided that you are still eligible for coverage) unless you have a qualifying life event (see above). *If you enroll in coverage through the Health Insurance Marketplace, you may not drop City coverage in the middle of the plan year. Likewise, you are not able to join City insurance in the middle of the plan year in order to fulfill your requirement for having health insurance.*

IMPORTANT RETIREMENT REMINDERS!

- You may not change insurance plans when you retire unless you experience a qualifying life event (such as moving out of the HMO service area or getting married). Retirement itself is not considered a qualifying life event.
- HSA Plan Participants: **The City stops contributing money to your HSA fund upon retirement.** The deductible and other cost-sharing under the HSA medical plan remain unchanged, but the City will no longer provide you with money toward out-of-pocket costs.
- **The HSA medical plan is not considered Creditable Coverage for Medicare drug plans.** Because City coverage ends for retirees age 65+ and for Medicare-eligible dependents of retirees, please keep this in mind when choosing your medical plan. You may pay a higher cost for Medicare drug coverage if you don't have Creditable Coverage. Questions? Call Medicare at 1-800-MEDICARE (1-800-633-4227) or see the Non-Creditable Coverage Notice on our website at www.tucsonaz.gov/insurance.

When Coverage Ends

Medical, dental, vision, Employee Assistance Program (EAP) and life insurance end the last day of the month during which you separate from employment.

Long term disability, voluntary benefits through Colonial and Flexible Spending Accounts (FSAs) end on your last day of employment. FSA deadlines for incurring and submitting claims are outlined later in this Handbook.

COBRA is a federal law that allows you to continue existing medical, dental, vision, EAP, and in some cases health care FSA coverage, when you leave employment. Answers to commonly asked questions about COBRA, and the City of Tucson's Initial COBRA Notice, are posted at www.tucsonaz.gov/insurance.

Dual City of Tucson Coverage is Not Allowed

If you are married to or the child/parent of another City of Tucson employee or retiree, *dual coverage is not allowed.* You may each enroll independently, or you may enroll together, but you may not both cover each other under City insurance. In addition, you and your spouse may not each cover the same child. For example:

- You may not cover yourself for medical, dental or vision and also be covered under your spouse's /parent's City of Tucson plan
- You may not cover your spouse/child for the Basic Dependent or Supplemental Spouse Life insurance plans
- You must CHOOSE which one of you will cover eligible children; only ONE OF YOU may cover each eligible child for each type of insurance

You **are** permitted to designate your spouse or child as a **beneficiary** for your life insurance; AZ Community Property state rules apply.

It is your responsibility to comply with these rules. Failure to do so may result in you paying premium for benefits which are not payable at the time of a claim. Please contact the Benefits Office to correct any dual enrollment situations. *If the City Benefits staff or you discover dual enrollment, the Benefits Office is not able to reimburse you for premiums already deducted from your pay. Benefits Office staff will notify you – either via the phone or by email (provided contact information is available) – of changes being made to your coverage to correct dual enrollment issues.*

Have a Question About Your Benefits?

Your primary and quickest resource is contacting the insurance carrier. Contact information is at the end of this Handbook and at www.tucsonaz.gov/insurance. Our carriers' trained staff members can assist you with the following:

- Claims issues
- Coverage questions
- Ordering ID cards
- Finding or changing a doctor/dentist
- Filing a disability claim
- Checking on the status of a disability or life claim, or on your application for coverage
- Arranging for Employee Assistance Program visits

The City of Tucson's Employee Benefits Office is available to help you with questions about enrollment, what happens to your benefits when you leave the City, eligibility, mid-year changes, and filing life insurance claims. If you would like to visit us in person, **please make an appointment**. Our contact information – as well as contact information for the insurance carriers – is at the end of this booklet.

Medical

The City of Tucson offers three medical plans:

- HMO (Network plan)
- Health Reimbursement Arrangement (HRA) Choice Fund Open Access Plus
- Health Savings Account (HSA) Choice Fund Open Access Plus – *Not available to retirees*

HMO

- A **network** plan **(network is exclusively in Arizona)**
- You must select a primary care physician (PCP), who coordinates your care and provides referrals when needed. If your provider leaves the network, you may *not* change plans mid-year.
- $500 deductible for inpatient, outpatient and Advanced Radiology Imaging services
- Co-payments for doctor visits (higher for specialists than for your PCP)
- Care must be received **in-network**, except if you have a true medical emergency. **Emergency follow-up care must be coordinated with your PCP and provided in-network, or you will pay 100% of the cost yourself.**

IMPORTANT REMINDER IF YOU HAVE DEPENDENTS WHO LIVE OUTSIDE AZ

You and your covered dependents **must live inside the HMO service area (generally in Arizona) in order to have coverage** under the City of Tucson medical and dental **HMO plans**. If you have a family member who lives outside of AZ, contact CIGNA (800-244-6224) to make sure full coverage for that family member will be available under the HMO plans Be sure to ask about "Guesting", a CIGNA program which may provide full medical coverage during temporary absences. Guesting is not available in all areas, or for the dental HMO.

If you have a dependent who lives outside of AZ, you may need to enroll in the non-HMO plans in order to have full coverage.

HRA and HSA

- **National** plans with high-deductible ($2,000 single/$4,000 family)
- You may visit any provider you choose
- You'll generally pay less if you visit a provider in the network
- The City contributes money toward your expenses:
  - $1,000 single or $2,000 family (pro-rated if you join the plan after July 1st each year)
  - HSA funds become available throughout the plan year (see details later in this Handbook); HRA funds are available the date coverage begins.
  - If you leave employment or stop participating in the medical plan with HSA, your HSA bank account is yours! Funds in the account may be used to pay qualifying health expenses and insurance premiums, in accordance with IRS regulations.
  - If you leave employment or stop participating in the medical plan with HRA, you forfeit any funds left in your HRA account.
  - HRA funds are reduced by $1,000 if you reduce coverage tiers from covering family member(s) to covering only yourself.
- See Important Considerations for the HSA section of this Handbook for additional details.

Below are some features of the plans:

Plan Features	HMO	HRA	HSA
Preventive care is covered 100% if you visit a network provider (no deductible)	•	•	•
Some services are subject to a deductible	•	•	•
CIGNA automatically processes in-network claims	•	•	•
Lower premiums		•	•
Comprehensive medical coverage is available through the **national** CIGNA network		•	•
No referrals are required: You have the flexibility to see any provider in-network or out-of-network; however, you'll generally pay less if you visit Cigna network providers		•	•
You may file claims for out-of-network services		•	•
You receive money funded into the City's HRA to cover eligible medical expenses. HRA funds are available when you are an employee, continuing coverage under COBRA, or a retiree.		•	
You receive money deposited into your **personal** HSA bank account to cover your qualifying health expenses (including dental/vision). You may also contribute through pre-tax payroll contributions. **If you leave employment, the bank account is still yours!** You may use remaining funds for investment income accumulation, qualifying health expenses and to pay COBRA or Medicare premiums. Per IRS regulations, the City stops contributing additional funds after you leave employment or the medical plan with HSA, and you pay all banking fees.			•
Higher premiums	•		
You select a primary care provider (PCP) who coordinates and manages your care; **network plan (almost exclusively in Arizona)**	•		
Usually requires a referral from your PCP to see a specialist	•		

A Snapshot of How the HRA and HSA Work

- You pay nothing for preventive care received in-network. **Cigna pays 70% of allowable charges for preventive care received outside the network after you meet the plan's deductible.**
- The City provides funds equal to half of your deductible; funds are pro-rated if you join the plan after July 1st each year. See www.tucsonaz.gov/insurance for details.

HRA

- You pay a copayment for prescription drugs.
- You pay a share of the cost for all services except preventive care, which is covered 100% if received in-network.
- This plan comes with a City-owned account that has funds available to you if you have qualifying medical expenses. (Funds may not be used for dental or vision costs.)
- Funds for deductible and coinsurance (the percent of costs you pay after you've reached your deductible) are available on your first day of plan coverage. If you leave the City, the City will continue to contribute to your fund if you continue the plan either as a retiree or through COBRA.
    - If you leave the plan, you forfeit any remaining funds.
    - Accrued funds are reduced if you reduce coverage tiers and go from covering family members to covering only yourself.

City contributes $1,000 (single) or $2,000 (if you're covering at least one dependent) on the first day of the plan year or on your benefits start date (pro-rated if you join after July 1) to an account designated for your use

Qualifying medical claims are paid automatically from the account before you pay any share of claims costs

Funds roll over to the next plan year as long as you remain enrolled in the plan. The City contributes more funds each plan year so qualifying expenses can continue to be paid.

Account balance is reduced by $1,000 if you reduce coverage tiers and go from covering dependents to covering only yourself (employee only or retiree only)

Since HRA funds belong to the City, you forfeit the funds if you leave the plan.

- After you've spent all your funds, you pay 100% of claims with your own money until you reach the plan's annual deductible ($2,000 for Employee Only; $4,000 if you're covering family members)
- After you reach the annual deductible, most in-network services are covered 90% (you pay 10%), and most out-of-network services are covered at 70% *of allowable charges* (you pay 30% *plus any non-allowable charges*) until you reach your annual out-of-pocket maximum.
- After you reach your out-of-pocket maximum, most in-network charges are covered at 100% (you pay nothing). Out-of-network charges are covered at 100**%** *of allowable charges*. You pay all out-of-network non-allowable charges.

Non-allowable charges generally don't count toward the deductible or the out-of-pocket (OOP) maximum, which means that you'll pay them in addition to the deductible and OOP amounts.

HSA

- You pay 100% of prescription drugs until you reach your deductible. (You'll receive a discounted price if you use network pharmacies; compare costs between pharmacies at www.myCigna.com.)
- You pay a share of the cost for all services except preventive care, which is covered 100% if received in-network.
- This plan comes with a bank account that you can use to pay qualifying health expenses. You may use funds to pay qualifying dental and vision expenses, too! (The IRS dictates which expenses qualify.)
- If you enroll during Open Enrollment, the City contributes $500 to your HSA bank account approximately two weeks after the first pay day of the plan year (pro-rated for those who join the plan after July 1). The City contributes the remainder of its annual contribution over the remaining pay periods of the year ($20 per pay period for Employee Only coverage, $60 per pay period for all other coverage tiers).
  - **Each contribution is deposited into your account approximately two weeks after each pay day.**
  - You may also contribute your own money to your HSA bank account:
    - ▶ Contribute via pre-tax payroll deductions; biweekly limitations exist
    - ▶ Deposit money into your HSA account in a lump sum by working with HSA Bank; lump sum contributions are not available via payroll deduction
- **The bank account is yours!** You keep it even after you leave the plan, but you do pay all the bank fees and the City no longer contributes to your account after you leave the plan.
- You're responsible for all IRS reporting regarding your bank account; you'll need to file Form 8889 when you file your taxes.

City contributes $500 to your bank account shortly after the beginning of the plan year (pro-rated if you join after July 1)

City contributes biweekly to your bank account for each of the other 25 pay periods of the fiscal year: $20 single/ $60 if you cover family members

You have the option to make additional biweekly contributions to your bank account on a pre-tax basis up to prescribed limits

Use your bank account to pay eligible medical, dental and vision expenses for you and your tax dependents

You and the City continue contributing, and you may continue paying qualifying expenses from the funds in your account; money is yours if you leave the plan!

- You pay 100% of claims expenses until you reach the plan's annual deductible ($2,000 for Employee Only; $4,000 if you are covering family members).
- After you reach the annual deductible, most in-network services are covered 90%, and most out-of-network services are covered at 70% *of allowable charges* until you reach your annual out-of-pocket maximum. You pay the remaining percentage *plus any out-of-network non-allowable charges.*
- After you reach your out-of-pocket maximum, most in-network charges are covered at 100%. Out-of-network charges are covered at 100**%** *of allowable charges*. You pay all out-of-network non-allowable charges.
- **Also note that non-allowable charges generally don't count toward the deductible or the out-of-pocket (OOP) maximum, which means that you'll pay them in addition to the deductible and OOP amounts.**

How Do the HRA and HSA Differ?	HRA	HSA
Below is a highlight of some of the plan differences. See plan documents for full plan details.		
Who owns the money in the account?	City's money	Your money
When is money contributed to the account?	Up front: You have access to the City's contribution the first day of plan coverage	Over time: • About a month after you join the plan, the City contributes $500 (pro-rated if you join after July 1) • Additional funds are deposited approximately 2 weeks after each pay day for the remainder of the plan year: $20 single / $60 if you're covering dependents
Fund reduction	The fund reduces by $1,000 if you go from covering dependents to covering only yourself.	Your fund balance isn't reduced, but the City will contribute $20 each pay period going forward instead of $60.
May I use fund money to pay IRS-qualified dental and vision expenses?	No	Yes
May I make personal contributions to the fund?	No	Yes
Do I need to file forms with my tax return reporting about the fund to the IRS?	No	Yes
What if I have a dependent on the plan who isn't my tax dependent?	You may use your HRA account to help pay for their expenses.	HSA funds may <u>not</u> be used to pay for their expenses.
What if I or my dependent has other medical coverage?	No issue (unless you're a retiree – see the Retiree section later in this Handbook)	IRS rules don't allow HSA plan participation if you or your spouse have other coverage including but not limited to: • A plan that doesn't meet IRS requirements for a high deductible health plan • Medicare • Tricare • A health care flexible spending account that will pay for medical expenses (One that will pay only for dental and vision expenses is OK.)
How do prescriptions work?	You pay a copay	You pay 100% of the cost until you reach your deductible; then you pay a percentage of the cost.

Important Considerations for the HSA

- **Your HSA bank account must be opened within 60 days after the date your insurance coverage begins.** If it's not, you'll forfeit any City contributions made to date. If you later re-open your account, you may request to have the City begin contributing the biweekly contribution, but prior contributions that were lost won't be restored. Any personal contributions made prior to when your account opened would be refunded to you.
- **The City stops contributing money to your HSA fund and you pay the bank fees when you leave employment (including retirement), or if you stop participating in the plan.** The deductible and other cost-sharing under the HSA medical plan remain unchanged.
- **The HSA medical plan is not considered Creditable Coverage for Medicare drug plans.** Because City coverage ends for retirees age 65+ and for Medicare-eligible dependents of retirees, please keep this in mind when choosing your medical plan. You may pay a higher cost for Medicare drug coverage if you don't have Creditable Coverage. Questions? Call Medicare at 1-800-MEDICARE (1-800-633-4227) or see the Non-Creditable Coverage Notice on our website at www.tucsonaz.gov/insurance.
- **You are responsible for all tax consequences and reporting**, including the filing of Form 8889 with your personal tax return
- **Make Sure You Qualify to Contribute to a Health Savings Account.** The Internal Revenue Service has eligibility requirements for opening and contributing to a Health Savings Account (HSA). If you enroll in the HSA but later learn that you are ineligible for the account, you may have to pay financial penalties to the IRS. It is **your responsibility** to make sure that you meet eligibility requirements. Some (but not all) of the requirements are listed below. Refer to the HSA Terms and Conditions posted at www.tucsonaz.gov/insurance for additional information.
    - You may **not** enroll in the HSA medical plan if you have medical coverage elsewhere that doesn't meet the requirements for a qualifying high deductible health plan, including but not limited to a general purpose health care flexible spending account, other group/individual insurance, Tricare, Medicare or state-assisted medical coverage, or if you receive health benefits (including prescription drugs) from the Veterans Administration or one of their facilities.
    - You may not be claimed as a dependent on someone else's tax return.
    - You may **not** participate in the Health Care FSA if you enroll in the Medical HSA plan.
    - You may **not** enroll in the HSA medical plan if your spouse is enrolled in a Health Care FSA, unless it is a limited use FSA that reimburses only dental and vision expenses.
    - The IRS doesn't allow people to open HSA bank accounts after December 1st of each calendar year. If your coverage will begin December 2nd through the end of the calendar year, you may still enroll in the HSA plan, but understand that contributions to your bank account will be delayed to the next calendar year.
    - If you make personal contributions to your HSA account, it is your responsibility to make sure not to exceed IRS limits.
    - If you are enrolling dependents who do not qualify as your tax dependents, under most circumstances, IRS regulations don't allow you to use HSA bank account funds to pay for their expenses, even if the expenses would normally be considered "eligible" expenses. States and other local jurisdictions may impose similar restrictions.

Medical Opt-Out Program

The City offers a medical opt-out incentive of $36.92 per pay period to those employees who waive City medical coverage via the online enrollment system ***and*** provide acceptable proof of medical coverage through a plan that's not sponsored by the City of Tucson. To participate, you must be an active, insurance benefits-eligible employee of the City, and the Benefits Office must receive your opt-out form and proof of non-City medical coverage by the date your benefits begin or, if during Open Enrollment, by the end of Open Enrollment. For more information about the opt-out program, contact the Benefits Office. *You will not receive retroactive Medical Opt-Out credit if your paperwork is received late; however, you will receive the credit starting the pay period in which the Benefits Office receives your properly completed paperwork.*

The City reserves to right to request new medical opt-out incentive paperwork periodically. If you don't supply the paperwork when requested, participation in the program will end.

CAUTION: If You Decline Medical Plan Coverage Offered Through City of Tucson – or if you are not eligible for the City's medical plan coverage – remember that you must maintain medical plan coverage elsewhere, or you can purchase health insurance through a Marketplace (www.healthcare.gov). See the section of this Handbook entitled, "Making Changes to Your Coverage" for additional information.

Medical Preventive Reminder:

When you see the doctor for your annual wellness visit, if you also need treatment for a health condition (new or previously diagnosed), the provider has the right to bill your visit as **diagnostic** and **not preventive**, and you will be responsible for the office visit charges.

Your Benefits at a Glance

	HMO Plan	Health Reimbursement Account Open Access Plus Plan		Health Savings Account Open Access Plus Plan	
Benefits	**In-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
City contribution	N/A	$1,000 – Employee $2,000 **–** Family		$1,000 – Employee $2,000 **–** Family *The City will contribute $500 shortly after the beginning of the Plan Year. You accrue the remainder during the remaining pay periods of the year.*	
Lifetime maximum	Unlimited	Unlimited		Unlimited	
Annual deductible	$500/Individual $1,000/Family *Deductible applies for inpatient hospital services, outpatient hospital facility services and Advanced Radiology Imaging services*	$2,000/Individual[1] $4,000/Family	$2,000/Individual[1] $4,000/Family	$2,000/Individual[1] $4,000/Family	$2,000/Individual[1] $4,000/Family
Out-of-pocket maximum	$6,350/Individual $12,700/Family	$3,000/Individual[2] $6,000/Family	$5,000/Individual[2] $10,000/Family	$3,000/Individual[2] $6,000/Family	$5,000/Individual[2] $10,000/Family
PCP Office Visit	$25 co-pay	10% coinsurance*	30% coinsurance**	10% coinsurance*	30% coinsurance**
Specialist Office Visit	$45 co-pay	10% coinsurance*	30% coinsurance**	10% coinsurance*	30% coinsurance**
Routine Preventive Exam **Well Woman Exam**	No charge – If you receive non-preventive services, copay/deductible will apply	No charge for preventive services. If you receive non-preventive services, 10% coinsurance / deductible will apply	30% coinsurance** $500 maximum per contract year	No charge for preventive services. If you receive non-preventive services, 10% coinsurance / deductible will apply	30% coinsurance** $500 maximum per contract year
Urgent care	$75 co-pay *(Waived if admitted)*	10% coinsurance*	10% coinsurance* *(unless not a true emergency, then 30%**)*	10% coinsurance*	10% coinsurance* *(unless not a true emergency, then 30%**)*
Emergency room	$200 co-pay *(Waived if admitted)*	10% coinsurance*	10% coinsurance* *(unless not a true emergency, then 30%**)*	10% coinsurance*	10% coinsurance* *(unless not a true emergency, then 30%**)*
Inpatient and outpatient hospital	No charge after plan deductible	10% coinsurance*	30% coinsurance** **Precertification required for inpatient**	10% coinsurance*	30% coinsurance** **Precertification required for inpatient**
Inpatient mental health and substance abuse	No charge after plan deductible	10% coinsurance*	30% coinsurance* **Precertification required**	10% coinsurance*	30% coinsurance* **Precertification required**
Outpatient mental health	$25 co-pay / No charge after plan deductible for facility	10% coinsurance*	30% coinsurance**	10% coinsurance*	30% coinsurance**
Outpatient substance abuse	$25 co-pay / No charge after plan deductible for facility				

	HMO Plan	Health Reimbursement Account Open Access Plus Plan		Health Savings Account Open Access Plus Plan	
Benefits	**In-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Prescription Drugs – Retail* **					
Generic	$15 co-pay	$15 co-pay	40%**	30%*	40%**
Brand	$40 co-pay	$40 co-pay	40%**	35%*	40%**
Non-preferred brand	$60 co-pay	$60 co-pay	40%**	40%*	40%**
Prescription Drugs – Mail Order* **					
Generic	$30 co-pay	$30 co-pay	40%**	30%	40%**
Brand	$80 co-pay	$80 co-pay	40%**	35%	40%**
Non-preferred brand	$120 co-pay	$120 co-pay	40%**	40%	40%**

[1] All family members contribute toward the family deductible. An individual cannot file a claim for covered services until the total family deductible has been satisfied.

[2] All family members contribute toward the family out-of-pocket maximum. Once the out-of-pocket maximum has been satisfied, benefits are covered at 100%.

* Services are subject to contract year deductible.

** Out-of-network services are subject to the contract year deductible and maximum reimbursable charge limitations. Providers may bill you for the difference between their billed charge and the maximum reimbursable charge as determined by the plan.

*** HRA pharmacy charges do not count toward satisfying your deductible or out-of-pocket maximum. There is no separate out-of-pocket maximum for pharmacy charges and **HRA funds cannot be used to pay for pharmacy charges.**

Note: HRA fund can be used to cover expenses covered under the HRA Open Access Plus medical plan only. HSA funds can be used to cover all IRS section 213D expenses.

CIGNA Extras (FREE!)

Visit www.tucsonaz.gov/insurance for important information about FREE CIGNA programs including:

- **Healthy Pregnancies, Healthy Babies:** Get the personal support you need throughout your pregnancy and receive free money when you deliver. Call 1-800-615-2906 to enroll.
- **Your Health First:** You don't want your chronic health condition to control your life. Neither do we. Learn how you can better manage your chronic health condition and get one-on-one support. Call 1-866-797-5833.
- **Lifestyle Management Programs:** Lose weight, manage stress, stop smoking, take control of your health! Call 1-866-417-7848 to enroll.
- **24-Hour Nurse Line:** Have a medical question? Call the Nurse Line at 1-800-244-6224 or 1-800-564-8982.

CIGNA Discounts (Save Money!)

Visit www.tucsonaz.gov/insurance for important information about ways you can save money including:

- Save on Urgent Care or Emergency Room costs and visit a CVS or Walgreen's clinic — open extended hours and weekends.
- When possible, save by visiting a free-standing lab for your lab work instead of visiting a hospital or outpatient facility.
- Get three months of prescriptions for the price of two through Mail Order. Call 1-800-TEL-DRUG (1-800-835-3784), and choose option 2.
- Get Healthy Rewards Discounts on gym memberships, acupuncture, massage therapy, vision/hearing care, and more! Call 1-800-870-3470.

Live Well, Be Well

Both the City and CIGNA offer wellness programs and tools to help you live a healthy lifestyle. For more information, visit www.tucsonaz.gov/wellness, www.tucsonaz.gov/insurance, or www.mycigna.com.

Dental

The City offers two Cigna dental plan options: Dental HMO (DHMO) and Dental PPO.

The **Dental HMO** (DHMO) plan offers comprehensive dental benefits through a network of dentists. When you need care, you must visit a dentist in the CIGNA Dental network, which is restricted mainly to AZ. There are no deductibles to pay, no annual or lifetime maximums, and no claim forms to submit. To enroll, you must live in a zip code serviced by the DHMO.

With the **CIGNA PPO Plan**, you may see any dentist, anywhere in the world. If you visit an in-network dentist, you generally pay less. If you visit an out-of-network dentist, your coverage is limited to "reasonable and customary" charges. If you receive care from an out-of-network dentist who charges more than the amount CIGNA considers reasonable and customary, you pay the extra portion of the bill. You must meet a deductible before most plan benefits begin, and you pay coinsurance (a percentage) for most services you receive. The plan limits the total dollar amount of services that CIGNA will pay each plan year.

DID YOU ADD A CHILD TO YOUR FAMILY IN THE LAST FEW YEARS?

Remember, newborns aren't eligible to enroll in dental or vision at the time of birth. If you added a newborn to medical and/or dependent life coverage in the last few years and you would like your child to have dental and/or vision coverage, you must enroll him or her in dental and/or vision during a subsequent Open Enrollment.

To review plan documents of all covered services, visit www.tucsonaz.gov/insurance.

Retirees and Dental Coverage

Once you retire, you and your dependents must maintain continuous dental insurance coverage in order to be covered under a City of Tucson dental plan. Please see the Retiree section of this Handbook for more details.

IMPORTANT REMINDER IF YOU HAVE DEPENDENTS WHO LIVE OUTSIDE OF ARIZONA

You and your covered dependents **must live inside the HMO service area (generally in Arizona) in order to have coverage** under the City of Tucson medical and dental **HMO plans**. If you have a family member who lives outside of AZ, please contact the CIGNA at 800-244-6224 to make sure full coverage for that family member will be available under the HMO plans. Be sure to ask about "Guesting", a CIGNA program which may provide full medical coverage during temporary absences. Guesting is not available in all areas, or for the dental HMO.

If you have a dependent who lives outside of AZ, you may need to enroll in the non-HMO plans in order to have full coverage.

Your Dental Benefits at a Glance

	CIGNA DHMO	CIGNA PPO	
		In-Network	Out-of-Network
General Information	You must select a Primary Care General Dentist from CIGNA's Dental HMO provider list.	You may go to any provider you choose. In-network dentists have agreed to lower rates, so you will generally pay less if you visit an in-network dentist.	
Allowable Charges	The dollar amounts listed on the Patient Charge Schedule are only applicable to treatment performed by your selected Network General Dentist. If you receive care from a Network Specialty Dentist, you are responsible for paying for that care. You are entitled to pay at the Contract Fees negotiated by CIGNA Dental rather than the Network Specialty Dentists' usual fees. Under this plan, referrals and preauthorization for payment by CIGNA Dental are not necessary for care received at a Network Specialty Dentist. CIGNA Dental will not make payments toward this treatment.	If you visit an out-of-network dentist, you are responsible for coinsurance (percentage of charges) PLUS any non-allowable charges. Your total cost may exceed the percentages listed below.	
Deductible	N/A	$25 Individual/$75 Family	$50 Individual/$150 Family
Plan Year Maximum	N/A	$2,000 Individual	$1,500 Individual
Lifetime Maximum	N/A	N/A	N/A
Diagnostic	**YOU PAY THIS AMOUNT*** **	**THE PLAN PAYS THIS PERCENTAGE**	
Visit	$5 co-pay	100%, no deductible	80%, no deductible
Exam/X-rays	No charge	100%, no deductible	80%, no deductible
Preventive			
Cleaning	No charge	100%, no deductible	80%, no deductible
Fluoride Application	No charge	100%, no deductible	80%, no deductible
Basic/Restorative			
Routine Fillings	$16 - $32 co-pay	90%, after deductible*	80%, after deductible**
Oral Surgery			
Routine Extractions	$100 co-pay	90%, after deductible*	80%, after deductible**
Impactions – Soft Tissue	$110 co-pay	90%, after deductible*	80%, after deductible**
Impactions – Complete Bony	$220 co-pay	90%, after deductible*	80%, after deductible**
Periodontics			
Perio Prophy – Partial	$78 co-pay	90%, after deductible*	80%, after deductible**
Perio Scaling – Complete	$61 - $110 per quadrant	90%, after deductible*	80%, after deductible**
Gingival Care/Quadrant	$120 - $240 per quadrant	90%, after deductible*	80%, after deductible**
Surgical Treatment of Gums	$155 - $295 per quadrant	90%, after deductible*	80%, after deductible**
Osseous Surgery	$310 - $595 per quadrant	90%, after deductible*	80%, after deductible**
Missed Appointment	Not covered	Not covered	Not covered
Prosthetics			
Full Upper or Lower Dentures	$550 each	60%, after deductible*	50%, after deductible**
Partial Upper or Lower Dentures	$410 - $640 co-pay	60%, after deductible*	50%, after deductible**
Adjustments to Dentures	$33 co-pay	60%, after deductible*	50%, after deductible**
Inlays	$410 - $460 co-pay	60%, after deductible*	50%, after deductible**
Porcelain Crown	$405 - $505 co-pay	60%, after deductible*	50%, after deductible**
Bridgework	$405 - $460 co-pay	60%, after deductible*	50%, after deductible**

	CIGNA DHMO	CIGNA PPO	
		In-Network	Out-of-Network
Denture Repair	$65 - $82 co-pay	60%, after deductible*	50%, after deductible**
Implants	Not covered	60%, no deductible	50%, no deductible****
Endodontics			
Root Canal – One Root	$315 - $505 co-pay	90%, after deductible*	80%, after deductible**
Root Canal – Two Roots	$315 - $505 co-pay	90%, after deductible*	80%, after deductible**
Root Canal – Three Roots	$315 - $505 co-pay	90%, after deductible*	80%, after deductible**
Apicoectomy with Retrograde Fill	$375 - $430 co-pay for first root, $145 each additional root; $100 per root for retrograde filling	90%, after deductible*	80%, after deductible**
Orthodontics			
Orthodontics	$2,304 for children up to 19th birthday; paid in 24 monthly payments of $96.00.; $3,120 for adults; paid in 24 monthly payments of $130.00	60%, no ortho deductible (coverage for both eligible adults and children)	60%, no ortho deductible (coverage for both eligible adults and children)
Lifetime Maximum	N/A	$2,000	$1,500
Nitrous Oxide Analgesia			
Nitrous Oxide Analgesia	$73 - $160 per unit	90%, after deductible*	80%, after deductible**

**The plan pays the percentage shown after you meet the plan deductible.*
***The plan pays the percentage shown after you meet the plan deductible. Percentages are based on reasonable and customary charges. You are responsible for the applicable percentage plus any charges the plan considers in excess of "reasonable and customary." As such, the percentage you pay may exceed the amount shown.*
**** Please refer to your Dental HMO Patient Charge Schedule for full detailed copayment listing.*
***** Percentages are based on reasonable and customary charges. You are responsible for the applicable percentage plus any charges the plan considers in excess of "reasonable and customary." As such, the percentage you pay may exceed the amount shown.*

Vision

The City offers a voluntary, 100% employee- or retiree-paid vision plan through Avesis that includes coverage for eye exams and vision hardware (glasses, contact lenses), as well as additional discounts. Under the plan, you have the option of visiting any provider you choose; however, you generally pay less when using network providers. For complete vision coverage and rate information, please visit the Vision page at www.tucsonaz.gov/insurance, or contact Avesis (800-828-9341 or www.avesis.com).

Retirees and Vision Coverage

Similar to the City's dental plan, the vision plan has a continuous coverage requirement for retirees and their dependents. Retirees pay premiums directly to the insurance carrier (Avesis). Please visit the Retiree section of this Handbook for additional information.

Flexible Spending Accounts (FSAs)

Pay your health care and dependent care expenses with tax-free money from an FSA.

An FSA lets active employees (but not retirees) set aside money from each paycheck before taxes to pay for eligible health care and dependent care expenses. (The IRS sets the rules for what's considered an eligible expense.) Participation is voluntary, and you must re-enroll every year to continue participating. **Unlike our other insurance benefits, the City's FSA program runs on a calendar year (January 1 – December 31).** Open Enrollment for the FSAs occurs annually each fall.

Eligibility

- **Because the City's Health Care FSA is a general purpose FSA** and allows for reimbursement of qualifying medical care costs **AND** qualifying dental and vision costs, IRS regulations say that **you may not participate in the Health Care FSA if you enroll in the City's Medical HSA plan.**
- **If you are married, there may be IRS rules that say you're not allowed to enroll in the Health Care FSA if your spouse makes pre-tax contributions to an HSA (Health Savings Account).**
- In order to enroll in the health care FSA, you MUST be enrolled in a medical plan that meets the Affordable Care Act requirements for minimum coverage. All City of Tucson medical plans meet the requirements.
- **It is your responsibility to make sure that you meet the eligibility requirements.** Please consult a tax professional if you have eligibility questions.

Annual Non-Discrimination Testing

Each year, the IRS rules require that the Flexible Spending Accounts undergo nondiscrimination testing to make sure that the plan doesn't discriminate in favor of certain individuals known as "highly compensated" and "key" employees. If the City discovers that the plan is at risk for not passing the testing, highly compensated and/or key individuals may be removed from the plan with possible reversal of contributions and claims.

Use-It-Or-Lose-It

If you enroll in an FSA, budget wisely. Under federal tax rules, if you don't have enough qualifying expenses to claim all your contributions, or if you don't submit your claims by the deadlines, you lose the money you contributed. ***Choose wisely, and submit your claims on time!***

Health Care FSA

Eligible Expenses

Funds may be used for you and your qualifying tax dependents. Eligible expenses include out-of-pocket expenses for qualifying:

- Doctor visits
- Prescription drugs
- Prescription glasses
- Contact lenses
- Dental work (including orthodontia)

The IRS says which expenses qualify. See a list at www.asiflex.com.

To be reimbursed for the cost of over-the-counter drugs, you must have a written prescription. Check with the IRS or our FSA administrator, ASI Flex, for details.

You may not use FSA dollars for expenses related to general well-being or cosmetic improvement, expenses that are not medically necessary, or insurance premiums.

Health Care FSA Plan Limits

You may contribute between $7.70 and $100.00 per pay period (subject to change January 1 if IRS rules or limitations change and the City adopts allowable changes).

If You Are Married and If You or Your Spouse is Enrolled in the City's or Any Other HSA

- According to the IRS, if you or your spouse are contributing - or having contributions made - to a Health Savings Account (HSA), you **may not** participate in the City's health care FSA program.
- If you're enrolled in the City's HSA medical plan and your spouse has the opportunity to enroll in a health care FSA, your spouse may enroll in the health care FSA only if it is specifically designated as a **"limited use" FSA that reimburses only dental and vision expenses**.
- Call ASI Flex at 1-800-659-3035 or contact the IRS for additional information about restrictions.

If You Leave the City

If you leave the City during the plan year, you may:

- **End your participation** – You may claim reimbursement for any eligible expenses incurred before your last day of employment; deadlines exist!
- **Continue participating under COBRA** – Under certain circumstances, you may be eligible to continue participation on an after-tax basis through COBRA, allowing you to extend the date through which you may incur and claim eligible expenses.

Stockpiling

Under IRS regulations, you may not purchase an unusually large amount of a qualifying product at the end of the plan year in an effort to use up your FSA dollars so they are not forfeited.

Dependent Care FSA

Dependent care is a large expense for families with children. A dependent care FSA allows you to pay for qualifying dependent care expenses with pre-tax dollars. We encourage you to consult with the IRS or your tax attorney for information about rules, limitations and exclusions, including but not limited the following:

- The day care provider can be a licensed day care facility or a private individual
- The day care must allow both you (and your spouse, if you're married) to work, actively look for work, or attend school full time
- Your dependent must live with you and must be age 12 or younger; a dependent age 13 or older can be eligible if you provide proof the dependent cannot physically or mentally care for himself/herself
- The day care provider cannot be a dependent on your tax return or your child under the age of 19
- You can reimburse yourself only up to the amount available in your account
- Expenses **not** eligible for reimbursement include the following:
  - Tuition for school at the kindergarten level or above, overnight camps, nursing home expenses, activity/supply fees and transportation costs
  - Tuition for Montessori school (Montessori school for preschool, and before and after school care are allowed)
- You must complete Form 2441 when filing your federal tax return

Dependent Care FSA Plan Limits

You may contribute between $7.70 and $192.30 per paycheck (subject to change January 1 if IRS rules or limitations change and the City adopts allowable changes). The $5,000 annual IRS limit is a **combined limit for married couples** so if you are married, you may need to split the $5,000 between your contribution and your spouse's, if your spouse also has the option to participate in a dependent care FSA. Consult with the IRS or your tax attorney for information about this and other limitations. It is your responsibility to make sure you do not exceed IRS limits. **(Note:** If your spouse is a full-time student, review Publication 503 located on the IRS website at www.irs.gov for other limitations.)

If You Leave the City

If you leave the City during the plan year, your participation in the dependent care FSA will end. You are still required to submit your claims before the deadline.

FSA Election Errors

If you make an FSA election during Open Enrollment or when you first enroll during your initial eligibility period that is clearly an error (for example, if you elect Dependent Care FSA coverage and you have no legal tax dependents in dependent care), you must notify the Benefits Office **before the second pay day of the calendar year** (or second pay day after your insurance eligibility begins for newly eligible employees)**.** Your situation will be reviewed and, if it can be clearly determined that your election was made in error, your deduction will be stopped and money deducted will be refunded.

If you notify the Benefits Office of an error **later than the second pay day of the calendar year** (or second pay day after your insurance eligibility begins for newly eligible employees), your situation will be reviewed, and if it can be clearly determined that your election was made in error, the deduction will be transferred to a health care FSA account. Refunds and stopping of deductions will not be permitted. Even if you accidentally elect both the Health Care FSA and the Dependent Care FSA in the same dollar amount, if it is past the second pay day of the plan year, the amount of both your elections will be **combined** under the Health Care FSA.

FSA Deadlines

- Since City FSAs are on a calendar year (January 1 – December 31), open enrollment occurs annually in the fall. **You MUST re-enroll every year to continue participating.**
- The City's FSAs have adopted the 2 ½ month grace period, as allowable under IRS regulations. The City has not adopted the $500 carry-over because IRS regulations allow for *either* the grace period *or* the carry-over.
- Below are important deadlines:

	Health Care FSA	Dependent Care FSA
Plan Year Begins	January 1	January 1
Plan Year Ends	December 31	December 31
Incur Claims By *	March 15 (2 ½ months after the plan year ends)	March 15 (2 ½ months after the plan year ends)
Submit Claims for Reimbursement By *	March 31 (3 months after the plan year ends)	March 31 (3 months after the plan year ends)

* ***If you separate from employment, you must incur claims by your last date of work and submit claims no later than 90 days after your date of separation.*** *If you've claimed less than you've contributed to your Health Care FSA (i.e., if your account is "underspent"), you may continue your health care FSA coverage through COBRA, a federal law that allows you to continue certain benefits after leaving employment. Continuing the coverage through COBRA allows you to extend the dates through which you may incur and submit claims. Contact the Benefits Office (520-791-4597) or ASI Flex (1-800-659-3035) for details.*

FSA Claims

The City contracts with a third party administrator, currently ASI Flex, for FSA administration. Claims may be submitted by mail, fax, online or via phone app. ASI Flex processes reimbursements daily. The "Benny" card is available to make payment of qualifying medical expenses easier. **Questions?** Contact ASI Flex at 1-800-659-3035, or visit www.asiflex.com.

Employee Assistance Program (EAP)

Just when you think you have it figured out, along comes a challenge. Whether those challenges are big or small, your Employee Assistance & Work/Life Support Program is available to help you and your family find a solution and restore your peace of mind.

The Employee Assistance Program is a **free, voluntary, confidential** service, providing active employees and their household members with assessments, consultations, and referrals. It is designed to assist you in dealing with a variety of personal concerns such as depression, marital difficulties, concerns with children, alcoholism, and financial issues. **You do not need to be enrolled in the City's medical program to use the Employee Assistance Program. However, you must be a benefits-eligible employee.**

The EAP counselor, a licensed mental health professional, will listen to your concerns and identify key issues of your particular situation. The EAP counselor will then assist you with devising a plan of action. Your problem may be resolved through consultation, support, or information. However, if you need further assistance, you may be referred to a counselor, social service, consumer credit, or self-help group.

Through the Employee Assistance Program, you can find productive solutions to personal problems and improve your health and well-being. You and your household members are encouraged to call for appointments by dialing **1-877-622-4327**. An EAP counselor can assist you in selecting a convenient time for a confidential face-to-face meeting.

Voluntary Benefits (Colonial Life)

Colonial Life offers individual voluntary benefits to active employees, including Short Term Disability, Accident, Life, Hospital Confinement, and Cancer and Critical Illness insurance. Most coverage is available for you and your family. You can continue coverage - with no increase in premiums - when you retire or change jobs. With most plans, you receive benefits regardless of any other insurance you may have with other insurance companies. Guaranteed issue for Short-Term Disability or other types of coverage, where applicable, is available only during your initial eligibility period as a new hire. Evidence of insurability (EOI) may be required if you enroll outside of this initial period. During Open Enrollment, coverage may be offered without EOI, depending on the type and level of coverage you choose. For the 2016-17 Plan Year, Colonial is offering ***FREE*** Accidental Death and Dismemberment (AD&D) coverage for any employee who meets with the City's Colonial representatives during their new hire eligibility period. For information about the plans offered, including coverage options and premiums, contact Colonial Life at the number listed in the back of this Handbook. Accrued time off does not need to be exhausted in order to receive benefits under a Colonial Life Short Term Disability policy; however, City policies regarding leave without pay when accruals exist still apply.

Long-Term Disability (LTD) Insurance

LTD Insurance, provided through MetLife, is available to active employees.

- The City of Tucson provides a 60% benefit with a maximum payment of $4,000 per month for five years* after meeting the criteria for disability for 180 days**.
- You may purchase a buy-up option that increases your monthly maximum benefit to $6,000 and reduces the elimination period from 180 to 90 days**.
- If you choose to purchase supplemental long-term disability (buy-up coverage) within your initial benefit eligibility period, you don't need to show proof of insurability. However, pre-existing condition limitations exist.
- Rates for the buy-up option are based on base salary and age and are posted at www.tucsonaz.gov/insurance and display in the enrollment system when you enroll.
- If you choose not to elect coverage when you are first eligible, and want to apply for it during a later open enrollment, you'll need to submit Evidence of Insurability – at your own expense – and the insurance carrier may either approve or deny your request for buy-up coverage. Premium deductions begin once you are approved for coverage.
- LTD benefits are offset by disability retirement, Worker's Compensation and Social Security benefits paid to you or your family as a result of your disability. To receive benefits for a pre-existing condition, you must be continually insured under the City's LTD planfor 365 days and have not received Medical Care for the condition for 90 days on the Basic option and 180 days on the Buy-Up option. Payment of LTD benefits is limited to 24 months for disabilities due to mental illness and to 12 months for disabilities due to substance abuse.

**The five-year maximum coverage period varies if disability begins after you turn age 61 – See below.*
*** Regardless of which plan you have, you must exhaust all your accumulated time off before benefits will be paid.*

Maximum Duration of LTD Benefits

Basic LTD:

Age When Disabled	Benefits Payable
Prior to Age 61	60 months
Age 61	54 months
Age 62	48 months
Age 63	42 months
Age 64	36 months
Age 65	30 months
Age 66	27 months
Age 67	24 months
Age 68	21 months
Age 69 and over	18 months

Buy-up LTD:

Age When Disabled	Benefits Payable
Prior to Age 62	To Age 65, or 48 months, if greater
Age 62	48 months
Age 63	42 months
Age 64	36 months
Age 65	30 months
Age 66	27 months
Age 67	24 months
Age 68	21 months
Age 69 and over	18 months

Life Insurance

Basic Term Life Insurance

Basic Term Life Insurance is provided to you at no cost; the City pays the premium.

Active Employees

This insurance provides a cash benefit to your designated beneficiary(ies) in the event of your death equal to your base annual salary, rounded up to the nearest thousand dollars, to a maximum of $50,000. *The amount of your basic insurance decreases 50% on your 70th birthday.*

Retirees

Eligible retirees hired before January 1, 2016 receive a City-paid $7,500 term life insurance policy. The benefit amount does not reduce with age.

Dependent Life Insurance *(Active Employees Only)*

If you elect this coverage, Dependent Life term insurance is paid by the City and provides a cash benefit of $5,000 to active employees if your spouse or qualifying child passes away. (Insurance for infants who are 15 days to 6 months of age pays a benefit equal to $100. No coverage exists for infants younger than 15 days.) Only your qualifying dependents whom you identify and enroll via the online benefits enrollment system are covered.

If you gain a new dependent mid-year, you must enroll your new dependent via the online enrollment system within 31 days of the date the dependent becomes eligible (60 days for birth/adoption of a child). You may also elect coverage during Open Enrollment.

Supplemental Life Insurance *(Active Employees Only)*

As an active employee, you may supplement the Basic and Dependent Life insurance coverage that the City provides by purchasing supplemental life insurance for yourself and/or your spouse (but not for your children). Your cost for coverage is deducted from your pay. Rates are posted at www.tucsonaz.gov/insurance and in the online enrollment system when you enroll.

DUAL CITY OF TUCSON COVERAGE IS NOT ALLOWED!

If you are married to or the child/parent of another City of Tucson employee or retiree, *dual coverage is not allowed.*

You may be covered **either** as the employee/retiree **or** as a dependent for medical, dental, vision **and life** insurance. This means…

- You may not cover yourself for medical, dental or vision and also be covered under your spouse's /parent's City of Tucson plan
- **You may not cover your spouse /child for the Basic Dependent or Supplemental Spouse Life insurance plans**
- You must CHOOSE which of you will cover eligible children. **Only ONE OF YOU may cover each eligible child for each type of insurance**
- You are permitted to designate your spouse or child as a **beneficiary** for your life insurance; AZ Community Property state rules apply

It is your responsibility to comply with these rules. Failure to do so may result in you paying premium for benefits which are not payable at the time of a claim. Please contact the Benefits Office to correct any dual enrollment situations.

If the City discovers dual enrollment, the Benefits Office is not able to reimburse you for premiums already deducted from your pay. Benefits Office staff will notify you – either via the phone or by email (provided contact information is available) – of changes being made to your coverage to correct dual enrollment issues.

Employee Supplemental Life Insurance

Employees may purchase supplemental life insurance for yourself in the amount of two, four or six times your basic annual earnings, not to exceed the maximum listed below:

TIER	COVERAGE AMOUNT	MAXIMUM
1	2 x your basic annual earnings	$100,000
2	4 x your basic annual earnings	$200,000
3	6 x your basic annual earnings	$300,000

Examples:

1	*Employee Earning $30,000*		*Employee Earning $60,000*	
TIER	**COVERAGE AMOUNT**	**MAXIMUM**	**COVERAGE AMOUNT**	**MAXIMUM**
1	2 x $30,000	$60,000	2 x $60,000 with $100,000 max	$100,000
2	4 x $30,000	$120,000	4 x $60,000 with $200,000 max	$200,000
3	6 x $30,000	$180,000	6 x $30,000 with $300,000 max	$300,000

Beginning on your 65th birthday, the amount of your supplemental life insurance decreases. The percentage of the amount otherwise payable is as follows:

- Age 65 to 70: 65%
- Age 70 to 75: 50%
- Age 75 and older: 30%

If you choose to purchase supplemental employee life insurance within your initial benefit eligibility period, you do not need to provide proof of insurability to the insurance company. This means no medical examination is required, and you are guaranteed the coverage. If you do not enroll during your initial benefit eligibility period or if you would like to increase a coverage level after you are first eligible, you may apply to do so during a subsequent Open Enrollment by requesting the coverage via the online benefits enrollment system **and** submitting the necessary application and required documentation to the insurance company. The insurance company may require a medical examination or records at your own expense. The insurance company then determines whether to approve or deny the request for additional coverage. If approved, coverage and premium deductions become effective on the date of approval.

Rates are based on base salary and age and are posted at www.tucsonaz.gov/insurance and in the online enrollment system when you enroll.

Spouse Supplemental Life Insurance

As an employee, you may purchase supplemental life insurance for your spouse in the amounts shown in the table below. However, the amount of your spouse's insurance coverage (Dependent Life *plus* Supplemental Spouse Life) may not be more than the amount of your own insurance coverage (Employee Basic Life *plus* Supplemental Employee Life).

Rates are posted at www.tucsonaz.gov/insurance and in the online enrollment system when you enroll.

TIER	COVERAGE AMOUNT
1	$7,500
2	$15,000
3	$22,500

If you choose to purchase supplemental spouse life insurance within your initial benefit eligibility period or during the first 31 days after you gain a newly qualified spouse, you do not need to provide proof of insurability to the insurance

company. This means no medical examination is required and coverage is guaranteed. If you do not enroll during your initial benefit eligibility period or when your spouse is first eligible, or if you would like to increase a coverage level after your spouse is first eligible, you may apply to do so during a subsequent Open Enrollment by requesting the coverage via the online benefits enrollment system **and** submitting the necessary application and required documentation to the insurance company. The insurance company may require a medical examination or records at your own expense. The insurance company then determines whether to approve or deny the request for additional coverage. If approved, coverage and premium deductions become effective on the date of approval.

Portability of Supplemental Life Insurance

Current contracts allow you to continue your coverage if you leave employment with the City if you (1) were hired or rehired before January 1, 2016, (2) are under the normal Social Security retirement age, (3) have been employed by the City for at least one year and insured under the current level of coverage for at least one year, and (4) meet any additional criteria outlined in the contract. If you elect to port your coverage, you make your payments directly to the insurance provider. Your elections and first quarterly payment must be made directly to the insurance carrier within **31 days** of terminating active employment and must be done in accordance with the procedures outlined by the insurance carrier, or coverage will not be granted. Rates are outlined on the portability application, which you'll receive from the insurance carrier upon request and **are not guaranteed and may change annually.**

For additional information, see the Supplemental Life insurance booklet posted at www.tucsonaz.gov/insurance.

Conversion of Basic Life Insurance

Current policy allows you or your covered dependent to convert to an individual life insurance plan if you leave employment with the City, provided you meet all criteria outlined in the insurance contract. Your elections must be made within **31 days** of terminating active employment and must be done in accordance with the procedures outlined by the insurance carrier, or coverage will not be granted. Rates are outlined on the conversion application. **Rates are not guaranteed and may change annually.** Under an individual life insurance plan, you make your payments directly to the insurance carrier. For additional information, see the insurance booklet posted at www.tucsonaz.gov/insurance.

Designating a Beneficiary

When you enroll for your insurance benefits, you should designate a life insurance beneficiary via the online enrollment system. **Please keep your beneficiary designation up-to-date** to ensure that your life benefit is paid in accordance with your wishes in the event of your death. You may update your life insurance beneficiary at any time by logging into the online enrollment system, accessible via www.tucsonaz.gov/insurance. Community Property state rules apply.

Waiver of Life Insurance Premium Disability Benefit

If you are unable to work in any occupation as a result of injury or sickness for a minimum of six months, prior to age 60, premium may be waived for your life insurance benefit until you are no longer disabled or reach age 65, whichever occurs first. You must provide satisfactory written proof of total disability and complete a claim form within one year of the date your total disability begins to be eligible for the waiver of premium. **Your dependents are not eligible for this benefit.** Contact the Employee Benefits Office for more information.

Retirees

The City currently offers continuation of medical, dental and vision coverage plus a basic life insurance plan to eligible retirees. Retiree eligibility is defined in Administrative Directive 3.04-6, posted on the Retiree Information page at www.tucsonaz.gov/insurance. Employees hired on or after January 1, 2016 are not eligible for retiree insurance continuation, portability of supplemental life insurance or retiree life insurance.

No other employee benefits apply to retirees. Any subsidy provided by the City will be applied only to medical insurance sponsored by the City of Tucson; no other plans are eligible for this subsidy except in accordance with Administrative Directive 3.04-6. **All rules regarding dependent eligibility and audit, and when/how to enroll and make changes, do apply to retirees. (See applicable pages of this Handbook.)**

Retirees Who Return to Employment

Retirees who are later rehired as insurance-eligible City employees must enroll in ***active employee*** insurance coverage. If you had previously continued City life insurance through portability with Dearborn National, you must forfeit the portability policy upon rehire; you would *not* be eligible to re-apply for portability after active employee coverage ends if your rehire date is January 1, 2016 or later.

- Individuals hired or rehired **before** January 1, 2016 **may resume** their retiree coverage once active employee coverage ends.
- Individuals hired or rehired **on or after** January 1, 2016 **are not eligible for retiree insurance continuation, retiree life insurance, or for portability of supplemental life insurance;** continuation of existing medical, dental, vision, EAP, and under certain circumstances health care FSA, will be offered in accordance with federal COBRA continuation laws.

Retiree Medical

Non-Medicare Eligible Retirees

Non-Medicare group coverage is available until you:

- Become eligible for Medicare due to your age
- Do not pay medical premiums within 30 days of due date
- Enroll in group medical coverage through another employer. Your dependents are also ineligible for medical coverage if they enroll in medical through another employer. If medical coverage at the other employment ends, you may request enrollment in the City's group coverage if you: (a) submit the proper documentation and (b) follow the prescribed procedures for making your request within 31 days of the date other coverage is lost. Contact the Benefits Office for requirements.

See group medical benefit descriptions in the Medical section of this Handbook. Refer to City of Tucson Administrative Directive 3.04-6 for complete eligibility details.

Medicare-Eligible Retirees and Medicare-Eligible Dependents of Retirees

As a Medicare-eligible retiree (age 65+) or Medicare-eligible dependent of retiree (due to age **or** disability), you may not continue on the City's non-Medicare group medical coverage, except as described, below, under "Medicare-Eligible Retirees Under Age 65".

Coverage ends the last day of the month prior to the month during which you turn age 65. Your enrolled eligible dependents may continue under the group medical coverage by paying 100% of the applicable group premium.

- You must notify the Employee Benefits Office when you or a covered dependent becomes eligible for Medicare.

- When your enrolled eligible dependents become eligible for Medicare (due to either disability or age), they no longer qualify for City group medical coverage.
- Please note that numerous Medicare supplement plans are available in the Tucson area. Thoroughly investigate your options to ensure that you enroll in a plan that best meets your needs. For information about non-City offered plans, please contact Pima Council on Aging at 8467 E. Broadway Blvd., 520-790-7262, www.pcoa.org.
- Public Safety retirees should also contact the State regarding Medicare plan options.
- **Public Safety retirees who do not qualify for Medicare, refer to Administrative Directive 3.04-6 posted at www.tucsonaz.gov/insurance.**

Medicare-Eligible Retirees Under Age 65

If you become eligible for Medicare due to disability prior to age 65, you are currently eligible for a reduced rate for group medical, provided you enroll and remain enrolled in Medicare Parts A & B, and Medicare pays primary. Contact Employee Benefits for additional information. In accordance with the City's current medical contract, if you are eligible to enroll in Medicare, CIGNA will pay secondary, **even if you choose not to enroll in Medicare Part A and/or B, and you will be liable for any non-covered claims.** We strongly suggest you understand your options and enroll in Parts A **and** B in order to ensure maximum claim payment.

Retiree Dental and Vision

You may **continue** your coverage in the City's dental and vision plans. Refer to the benefit descriptions in the Dental and Vision sections of this Handbook and at www.tucsonaz.gov/insurance. You must maintain continuous dental and/or vision insurance coverage in order to be eligible for City of Tucson dental/vision coverage.

Continuous Coverage is Required

If you are a retiree and you want to add dental and/or vision coverage for yourself or your eligible dependents during an annual Open Enrollment or due to a qualifying life event, the Benefits Office must receive your acceptable proof of continuous insurance coverage through another dental/vision insurance plan for the immediately preceding 36 months for you and any dependents you wish to cover. This provision applies even if you were previously enrolled and coverage was dropped for any reason, including but not limited to being dropped due to lack of premium payment. Deadlines exist and are communicated annually at Open Enrollment or at the time a retiree contacts the Benefits Office regarding a qualifying life event.

Newborns and Dental/Vision (Retirees)

Since newborns may not be added to dental and/or vision at the time of birth, retirees wishing to add recently born children to these plans must request the enrollment during the first three open enrollments following the baby's birth date. If coverage is requested at any time after the first three open enrollments following the baby's birth date, the retiree continuous coverage provisions will apply.

Paying for Your Vision Coverage

Unlike retiree Medical and Dental premiums, retiree Vision premiums are not deducted from pension checks. Retirees pay premiums directly to the Vision insurance carrier on a quarterly, semiannual or annual basis.

Retiree Basic Life Insurance

Qualifying retirees currently have coverage under a City-paid $7,500 term life insurance policy. You may update your beneficiary information at any time by logging on the online enrollment system, accessible via www.tucsonaz.gov/insurance. Retiree Basic Life Insurance is not available to individuals hired or rehired on or after January 1, 2016.

Important Notices

Each year, the City of Tucson is required to provide you with certain Important Notices affecting your employee benefit programs. Please review these notices located on the Benefits Home Page at www.tucsonaz.gov/insurance.

Please see next page for vendor and Benefits Office contact information.

Contacts

WHO?	BENEFIT	PHONE NUMBER	WEB / EMAIL
CIGNA (Medical and Dental) **Group #3329224**	**MEDICAL** ▪ HMO medical ▪ Choice Fund OAP medical (HRA and HSA) ▪ HSA Bank Account Questions **DENTAL** ▪ DHMO ▪ PPO	Pre-enrollment Hotline: 1-800-401-4041 After enrollment: 1-800-CIGNA24 (1-800-244-6224) 24-Hour Nurseline: 1-800-564-8982 Local: 520-837-4180	www.cigna.com (prior to enrollment) www.mycigna.com (after you are enrolled in a CIGNA medical plan)
AVESIS	▪ Vision	1-800-828-9341	www.avesis.com
Employee Assistance Program (CIGNA)	▪ Employee Assistance and Work/Life Support Program	1-877-622-4327	www.CignaBehavioral.com Employer ID: cityoftucson
MetLife	▪ Long-Term Disability Insurance ▪ Employee Supplemental Long-Term Disability Insurance (Buy-Up)	1-800-638-2242	N/A **For claim information and status of EOI:** www.thehartfordatwork.com
Colonial Life and Accident Insurance Company	▪ Short-Term Disability ▪ Accident Insurance ▪ Cancer Insurance ▪ Critical Illness Insurance ▪ Hospital Confinement Indemnity Insurance ▪ Life Insurance	**Local** Phone: 1-800-456-4311 **Home Office** Phone: 1-800-325-4368	www.coloniallife.com *Note: You can download claim forms on this website.*
ASI Flex	▪ Health Care and Dependent Care Flexible Spending Accounts	800-659-3035	www.asiflex.com
The Hartford	▪ Questions about life insurance plan coverage ▪ To check on the status of a life claim ▪ To discuss life conversion, portability and waiver of premium policies and costs	Underwriting (EOI): 800-331-7234 Claims: 888-563-1124	
City of Tucson Employee Benefits Office	▪ Enrollment, separation from employment, life insurance claims, insurance deduction information	Phone: 1-520-791-4597 Fax: 1-520-791-5942 255 W. Alameda, 3rd Floor P.O. Box 27210 Tucson, AZ 85726-7210 *If you would like to visit us in person, please make an appointment.*	**E-mail:** benefitquestions@tucsonaz.gov **Website:** www.tucsonaz.gov/insurance
Medicare Plans		The City does not offer Medicare medical plans. Please visit www.tucsonaz.gov/insurance on the Retiree Information page for additional information.	

This Employee & Retiree Insurance Handbook is a summary of the City of Tucson's health and wellness benefits. For complete coverage details, please see the appropriate plan administrator's certificate of coverage.