

City of Tucson: Important Notices for Plan Participants

Updated April, 2020

To request enrollment or obtain more information, visit www.tucsonaz.gov/insurance, or contact the City's Benefits team: benefitquestions@tucsonaz.gov or (520) 791-4597.

MID-YEAR CHANGES TO YOUR HEALTH CARE BENEFIT ELECTIONS

IMPORTANT: After this open enrollment period is completed, generally you **will not** be allowed to change your benefit elections or add/delete dependents until next year's open enrollment, unless you have a Special Enrollment event or a Mid-year Change in Status as outlined below:

• **Special Enrollment Event:**

Loss of Other Coverage Event: If you decline enrollment for yourself, your spouse or qualifying child(ren) 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. However, you must request enrollment within 31 days after your or your dependents' other coverage ends.

Marriage, Birth, Adoption Event: 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 days after the marriage, or 60 days after birth, adoption, or placement for adoption.

Medicaid/CHIP Event: You and your dependents may also enroll in this plan if you (or your dependents):

- have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you (or your dependents) lose eligibility for that coverage. However, you must request enrollment within 60 days after the Medicaid or CHIP coverage ends.
- become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within 60 days after you (or your dependents) are determined to be eligible for such assistance.

• **Mid-Year Change in Status Event:**

The following events **may** allow certain changes in benefits mid-year, **if** permitted by the Internal Revenue Service (IRS) and City policy:

- Change in legal marital status (e.g. marriage, divorce/legal separation, dependent's death).
- Change in number or status of dependents (e.g. birth, adoption, dependent's death).
- Change in employee/spouse/dependent's employment status, work schedule, or residence that affects their eligibility for benefits.
- Coverage of a child due to a Qualified Medical Child Support Order (QMCSO).
- Entitlement or loss of entitlement to Medicare or Medicaid.
- Certain changes in the composition of coverage or curtailment of coverage of the spouse's plan.
- Changes consistent with Special Enrollment rights and FMLA leaves.

Unless otherwise specified above, the City Benefits team must receive requests for coverage and acceptable proof of the event within 31 days of a mid-year or special enrollment event. Visit www.tucsonaz.gov/insurance for details. The Plan will determine if your change request is permitted; if so, changes become effective prospectively, on the first day of the month, following the approved change in status event (except for newborn and adopted children, who are covered back to the date of birth, adoption, or placement for adoption).

HIPAA PRIVACY NOTICE REMINDER

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires health plans to comply with privacy rules. These rules are intended to protect your personal health information from being inappropriately used and disclosed. The rules also give you additional rights concerning control of your own healthcare information. This Plan's HIPAA Privacy Notice explains how the group health plan uses and discloses your personal health information. You are provided a copy of this Notice when you enroll in the Plan. You can get a copy of this Notice at www.tucsonaz.gov/insurance, or by contacting the City's Benefits team at the contact information at the top of this Notice. For copies of the insured medical, dental or vision privacy notices, contact CIGNA (medical/dental) at (800) 244-6224 or Avesis (vision) at (800) 828-9341.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA) ANNUAL NOTICE

You or your dependents 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, copayment and coinsurance applicable to other medical and surgical benefits provided under the various medical plans offered by the City.

AVAILABILITY OF SUMMARY OF BENEFIT AND COVERAGE (SBC) DOCUMENTS

The health 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 medical Summary of Benefits and Coverage (SBC) documents, and the Uniform Glossary that defines many terms in the SBC, visit www.tucsonaz.gov/insurance, or contact the City Benefits team to request a paper copy.

COBRA COVERAGE

In compliance with a federal law referred to as COBRA Continuation Coverage, this plan offers its eligible employees and their covered dependents (known as qualified beneficiaries) the opportunity to elect temporary continuation of their group health coverage when that coverage would otherwise end because of certain events (called qualifying events).

Qualified beneficiaries are entitled to elect COBRA when certain events occur, and, as a result of the event, coverage of that qualified beneficiary ends (together, the event and the loss of coverage are called a qualifying event). Qualified beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense.

Qualifying events may include termination of employment, reduction in hours of work making the employee ineligible for coverage, death of the employee, divorce/legal separation, or a child ceasing to be an eligible dependent child under the terms of the plan, if a loss of coverage results.

In addition to considering COBRA as a way to continue coverage, there may be other coverage options for you and your family. You may want to look for coverage through the Health Care Marketplace. See <https://www.healthcare.gov/>. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums for Marketplace coverage, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility Marketplace coverage or for the tax credit. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan) if you request enrollment within 30 days, even if the plan generally does not accept late enrollees.

The maximum period of COBRA coverage is generally either 18 months or 36 months, depending on which qualifying event occurred.

In order to have the chance to elect COBRA coverage after a divorce/legal separation or a child ceasing to be a dependent child under the plan, **you and/or a family member must inform the plan in writing of that event no later than 60 days after that event occurs.** That notice must be sent to the City's Benefits Office via first class mail and is to include the employee's name, the qualifying event, the date of the event, and the appropriate documentation in support of the qualifying event (such as divorce documents).

If you have questions about COBRA, contact the City's Benefits Office at 255 W. Alameda, 3rd Floor, P. O. Box 27210 Tucson, AZ 85726-7210, benefitquestions@tucsonaz.gov, or 1-520-791-4597. **If you would like to visit us in person, please make an appointment.**

PATIENT PROTECTION RIGHTS OF THE AFFORDABLE CARE ACT

HMO MEDICAL PLAN

Designation of a Primary Care Provider (PCP):

The HMO medical plan generally requires the designation of a primary care provider (PCP). You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. Until you make this designation, no claims will be paid. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact CIGNA at (800) 244-6224. For children, you may designate a pediatrician as the primary care provider.

Direct Access to OB/GYN Providers:

You do not need prior authorization (pre-approval) from CIGNA or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological (OB/GYN) care from an in-network health care professional 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 CIGNA at (800) 244-6224.

HRA / HSA MEDICAL PLAN

Designation of a Primary Care Provider (PCP):

The HRA / HSA medical plans offered by the City of Tucson do not require the selection or designation of a primary care provider (PCP). You have the ability to visit any network or non-network health care provider; however, payment by the Plan may be less for the use of a non-network provider.

Direct Access to OB/GYN Providers:

You also do not need prior authorization (pre-approval) from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional 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 CIGNA at (800) 244-6224.

MEDICARE NOTICE OF CREDITABLE COVERAGE

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 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 the City are or are not creditable you should review the Plan's Medicare Part D Notice of Creditable Coverage available on www.tucsonaz.gov/insurance, or contact the City's Benefits Department at benefitquestions@tucsonaz.gov or (520) 791-4597.

IMPORTANT REMINDER TO PROVIDE THE PLAN WITH THE SOCIAL SECURITY NUMBER (SSN) OF EACH ENROLLEE IN A HEALTH PLAN

Employers are required by law to collect the taxpayer identification number (TIN) or social security number (SSN) of each medical plan participant and provide that SSN on future reports that will be provided to the IRS each year. Employers are required to make at least two consecutive attempts each year to gather missing TINs/SSNs. If a dependent does not yet have a social security number, you can go to this website to complete a form to request a SSN: <http://www.socialsecurity.gov/online/ss-5.pdf>. Applying for a social security card is free.

The SSN will also be used to help fulfill mandatory reporting requirements to the Centers for Medicare and Medicaid (CMS) for the purposes of permitting Medicare to coordinate benefits for individuals enrolled in both an employer-sponsored medical plan and Medicare.

If you have not yet provided the social security number (or other TIN) for each of your dependents that you have enrolled in the health plan, please contact the City's Insurance Benefits Office at (520) 791-4597.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

Hospital Length of Stay for Childbirth: Under federal law, group health plans generally may not restrict benefits for any hospital length of stay in connection with childbirth for the month or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the Plan may pay for a shorter stay if the attending Physician (e.g., Physician, or Health Care Practitioner), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, the Plan may not, under federal law, require that a Physician or other Health Care Practitioner obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification.

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

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

If you or your dependents are already enrolled in Medicaid or CHIP 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 www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

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 January 31, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711
ALASKA – Medicaid	FLORIDA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://flmedicaidprecovery.com/hipp/ Phone: 1-877-357-3268
ARKANSAS – Medicaid	GEORGIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131

CALIFORNIA – Medicaid	INDIANA – Medicaid
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-800-541-5555	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
IOWA – Medicaid and CHIP (Hawki)	MONTANA – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	NEBRASKA – Medicaid
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	NEVADA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcnp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	NEW HAMPSHIRE – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MASSACHUSETTS – Medicaid and CHIP	NEW YORK – Medicaid
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	NORTH CAROLINA – Medicaid
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp [Under ELIGIBILITY tab, see “what if I have other health insurance?”] Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	VERMONT – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427

PENNSYLVANIA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	WASHINGTON – Medicaid
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	WEST VIRGINIA – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	WISCONSIN – Medicaid and CHIP
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
TEXAS – Medicaid	WYOMING – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2020, or for more information on special enrollment rights, contact either:

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

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

OMB Control Number 1210-0137 (expires 1/31/2023)

CAUTION: IF YOU DECLINE MEDICAL PLAN COVERAGE OFFERED THROUGH THE CITY OF TUCSON

If you choose to not be covered by one of the City's medical plan options, remember that you must maintain medical plan coverage elsewhere or you can purchase health insurance through a Marketplace (www.healthcare.gov). Americans without medical plan coverage could have to pay a penalty when they file their personal income taxes. Visit the Healthcare Marketplace at <https://www.healthcare.gov/fees-exemptions/fee-for-not-being-covered/> for detailed information on individual shared responsibility payment penalty. In December 2017, Congress passed the Tax Cuts and Job Acts that reduces the Individual Mandate penalty to zero starting in 2019; for 2018, you still need to maintain minimum essential medical plan coverage for yourself and your family members in order to avoid paying a penalty when you file your 2018 income taxes. If you choose not to enroll now in a City of Tucson medical plan, you will have the opportunity to enroll during annual open enrollment or within specified deadlines for recognized mid-year life events. For a list of qualifying events, please visit the Insurance Handbook at www.tucsonaz.gov/insurance. Enrollment and disenrollment through the Marketplace are not qualifying events; as a result, you may *not* change your City of Tucson medical insurance mid-year as a result of changes you may make through the Marketplace.

NOTICE REGARDING WELLNESS PROGRAM (EEOC)

The City of Tucson Wellness Program is a voluntary wellness program available to all employees and is designed to promote health or prevent disease. 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 may be asked to complete a voluntary health risk assessment or "assessment" 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 complete a biometric screening. You are not required to complete the assessment or to participate in biometric screening.

This is an entirely voluntary program; however, employees who choose to participate in the wellness program may receive an incentive of a monetary amount or a wellness prize item that will be identified and communicated during any and all health campaigns. Incentives may include a Premier Rewards Card that may be available for employees who participate in certain health-related activities such as: Cigna Telephonic Health Coaching, Preventive Care, on-site wellness activities, and more. 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 City Benefits team at (520) 791-4597.

The information from your health risk assessment 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 health coaching. 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 Tucson may use aggregate information collected to design programs based on identified health risks in the workplace, the City of Tucson Wellness program will never disclose any of your personal information either publicly or to your 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. The only individual(s) who will receive your personally identifiable health information is (are) the Cigna wellness team and possibly Cigna health coaches and nurses in order to provide you with services under the wellness program.

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

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

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Anita Hart, Human Resources Manager, at 520-791-4597.

IMPORTANT INFORMATION ABOUT THE WELLNESS PROGRAM (HIPAA NONDISCRIMINATION NOTICE)

The City of Tucson Wellness Program is voluntary and is designed to promote health or prevent disease. The term "Wellness Program" includes both:

- a. ways that we help individuals identify and reduce health risk factors, like elevated blood pressure or excess weight, along with
- b. ways to help individuals with chronic conditions, like diabetes, take better care of their condition, for example by working with a coach through your medical insurance to encourage you to take the medication the doctor prescribes for your chronic condition.

The City's Wellness Program also offers **incentives** for participation (such as for completing a Health Risk Assessment questionnaire), and you may receive incentives if you positively change behavior (including but not limited to maintaining or losing excess weight, increasing activity, and maintaining or working toward healthy BMI and cholesterol). Only employees enrolled as a primary subscriber in one of the City's medical plan options under *active employee* insurance (not retiree insurance) at the City have the opportunity to qualify for wellness program incentives. Incentives are able to achieved **at least once a year**; receiving incentives may be raffle-based and not guaranteed. The **time commitment required to achieve incentives in our City Wellness Program is reasonable**. More information about our City Wellness Program incentives is described at www.tucsonaz.gov/wellness.

The wellness program incentives have been reviewed and in accordance with law, do not exceed 30% of the total cost of employee-only coverage under the plan (including employee & employer contributions).

If you think you might be unable to meet a standard for a certain reward under our Wellness Program, you might qualify for an opportunity to earn the same reward by a different means. If an individual has physical disabilities or a medical condition such that it is unreasonably difficult or medically inadvisable due to their medical condition to satisfy the standards of the City's Wellness Program, then reasonable alternative standards will be made available upon request. If the individual's personal doctor states that the alternative is not medically appropriate, a more accommodating alternative will be provided.

Contact the Benefits Office (520-791-4597) for information about the City's Wellness Program and for information on reasonable alternative standards and accommodations. We will work with you and, if you wish, we will work with your doctor, to find a Wellness Program standard with the same reward that is right for you in light of your health status.

CITY OF TUCSON SELF-FUNDED BENEFITS

The City of Tucson self-funds certain group health plan benefits, including the Cigna HSA plan with prescription drug coverage, Health Savings Account (HSA), Health Flexible Spending Account (FSA) administration, and COBRA administration benefits under the Plan. Claims for these benefits are administered by independent claims administrators. The funding for the benefits is derived from the funds of the City of Tucson and contributions made by covered Employees. When it comes to using the coverage provided by your health plan, the decisions you make today have financial implications for tomorrow. Because these benefits are self-funded, they are paid for from the City's financial assets—not from an insurance company. Therefore, every dollar that's saved when you use the Plan in the smartest ways possible supports the good financial health of our plan and shores up the City's ability to continue providing benefits to you.

Please share this Notice with family members who are currently eligible for Medicare or who may become eligible for Medicare within the next 12 months.

Important Notice from the City of Tucson About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the City of Tucson 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 prescription 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.

- **If you and/or your family members are not now eligible for Medicare, and will not be eligible during the next 12 months, you may disregard this Notice.**
- **If, however, you and/or your family members are now eligible for Medicare or may become eligible for Medicare in the next 12 months, you should read this Notice very carefully and keep a copy of this Notice.**

This announcement is required by law whether the group health plan's coverage is primary or secondary to Medicare. **Because it is not possible for our Plan to always know when a Plan participant or their eligible spouse or children have Medicare coverage or will soon become eligible for Medicare, we have decided to provide this Notice to all plan participants.**

Prescription drug coverage for Medicare-eligible people is available through Medicare prescription drug plans (PDPs) and Medicare Advantage Plans (like an HMO or PPO) that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more drug coverage for a higher monthly premium.

The City of Tucson has determined that the prescription drug coverage is "creditable" under the City of Tucson's Network (HMO) and HRA medical plans. "Creditable" means that the value of this Plan's prescription drug benefit is, on average for all plan participants, expected to pay out as much as or more than the standard Medicare prescription drug coverage will pay.

Active Employees: Because the City's Network (HMO) and HRA plan provide drug coverage that is considered "creditable", you can elect or keep prescription drug coverage under these City of Tucson plans, and you should not pay a higher premium (a late enrollment fee penalty) if you later decide to enroll in Medicare prescription drug coverage. However, we encourage you to discuss your personal situation with the Social Security Administration (800-772-1213) to confirm that this applies to you.

Retirees: In general, retirees age 65+ may not remain on a City of Tucson medical/prescription plan. Also, Medicare-eligible dependents of retirees, regardless of age, are **not** eligible to continue on the City's group medical and prescription drug plan.

Medicare-eligible retirees who are under age 65 must enroll in Medicare (Parts A & B) when they become eligible and notify the City Benefits team within 31 days of Medicare eligibility in order to remain on the City's group medical and prescription drug plan; the City's group plan will pay secondary to Medicare. These retirees may be eligible for a reduced City plan premium. Be aware that if you decide to join a Medicare drug plan and drop your City of Tucson coverage, re-enrollment in the City's plan is limited to the annual open enrollment period, or within 31 days of a special enrollment event (60 days for a birth/adoption special enrollment), provided that you still qualify. See the Insurance Handbook and Retiree Health Benefits Continuation Administrative Directive at www.tucsonaz.gov/insurance for details. Contact the Benefits Office at (520) 791-4597 with questions.

Retirees age 65+ with fewer than 40 Medicare/Social Security quarters: A handful of public safety employees were not permitted to pay into Medicare while working for City of Tucson and thus may not be eligible for premium-free Medicare Part A coverage. These individuals may have an option to remain enrolled in a City medical and prescription drug plan upon reaching age 65. Contact the Benefits Office at (520) 791-4597 to verify your status. **If an individual in this category chooses to remain enrolled in a City plan and later qualifies for Medicare through a spouse or former spouse who has the requisite quarters, City coverage will end, and Medicare penalties may apply.** It is important that you discuss your personal situation with the Social Security Administration (800-772-1213) and the City Benefits team (520-791-4597) so you understand your options and potential for Medicare penalties.

When Can You Join A Medicare Drug Plan?

Medicare-eligible people can enroll in a Medicare prescription drug plan at one of the following 3 times:

- when they first become eligible for Medicare; or
- during Medicare's annual election period (from October 15th through December 7th); or
- for beneficiaries leaving employer/union coverage, you may be eligible for a two-month Special Enrollment Period (SEP) in which to sign up for a Medicare prescription drug plan.

When you make your decision whether to enroll in a Medicare prescription drug plan, you should also compare your current prescription drug coverage, (including which drugs are covered and at what cost) with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

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

Your Choices:	What you can do:	What this option means to you:
Option 1	If you are eligible to do so (see above in this Notice), you can select or keep your current medical and prescription drug coverage with a City of Tucson creditable plan and not enroll in a Medicare prescription drug plan.	You will continue to be able to use your prescription drug benefits through City of Tucson creditable plans. <ul style="list-style-type: none"> You may, in the future, enroll in a Medicare prescription drug plan during Medicare's annual enrollment period (during October 15th through December 7th of each year). As long as you are an active employee or a retiree under age 65 and enrolled in creditable drug coverage, you should not have to pay a higher premium (a late enrollment fee) to Medicare when you do choose, at a later date, to sign up for a Medicare prescription drug plan. <u>Discuss your personal situation with the Social Security Administration (800-772-1213) to confirm that this is true for your situation.</u>
Option 2	If you are eligible to do so (see above in this Notice), you can select or keep your current medical and prescription drug coverage with the City of Tucson creditable plan and also enroll in a Medicare prescription drug plan. If you enroll in a Medicare prescription drug plan, you will need to pay the Medicare Part D premium out of your own pocket.	Your creditable City plan pays for certain other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. Having dual prescription drug coverage under this Plan and Medicare means that this Plan will coordinate its drug payments with Medicare, as follows: <ul style="list-style-type: none"> for Medicare eligible Retirees and their Medicare eligible Dependents, Medicare Part D coverage pays primary and the group health plan pays secondary. for Medicare eligible Active Employees and their Medicare eligible Dependents, the group health plan pays primary and Medicare Part D coverage pays secondary. Note that you may not drop just the prescription drug coverage under the City of Tucson creditable plan because prescription drug coverage is part of the entire medical plan. Generally, you may drop medical plan coverage only during this Plan's next Open Enrollment period. However, retirees may drop City medical the first of any given month, with proper notification to City Benefits. Note that each Medicare prescription drug plan (PDP) may differ. Compare coverage, such as: <ul style="list-style-type: none"> PDPs may have different premium amounts; PDPs cover different brand name drugs at different costs to you; PDPs may have different prescription drug deductibles and different drug copayments; PDPs may have different networks for retail pharmacies and mail order services.

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 City of Tucson 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 or Tucson Insurance Benefits Office if you would like more information. Contact information is included at the end of this Notice. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through City of Tucson 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-approved prescription drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (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 www.socialsecurity.gov, or call them at (800) 772-1213 (TTY 800-325-0778).

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 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: May 1, 2020
Name of Entity/Sender: City of Tucson
Contact: Employee/Retiree Benefits, 255 W Alameda, 3rd Fl, Tucson, AZ 85726, benefitquestions@tucsonaz.gov, (520) 791-4597
If you would like to visit us in person, please make an appointment.

Please share this Notice with family members who are currently eligible for Medicare or who may become eligible for Medicare within the next 12 months.

Important Notice from the City of Tucson About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the City of Tucson 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 prescription 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.

- **If you and/or your family members are not now eligible for Medicare, and will not be eligible during the next 12 months, you may disregard this Notice.**
- **If, however, you and/or your family members are now eligible for Medicare or may become eligible for Medicare in the next 12 months, you should read this Notice very carefully and keep a copy of this Notice.**

This announcement is required by law whether the group health plan's coverage is primary or secondary to Medicare. **Because it is not possible for our Plan to always know when a Plan participant or their eligible spouse or children have Medicare coverage or will soon become eligible for Medicare we have decided to provide this Notice to all plan participants.**

Prescription drug coverage for Medicare-eligible people is available through Medicare prescription drug plans (PDPs) and Medicare Advantage Plans (like an HMO or PPO) that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more drug coverage for a higher monthly premium.

The City of Tucson has determined that the prescription drug coverage is "NOT CREDITABLE" under the Cigna HSA plan.

"Not Creditable" means that the value of this prescription drug benefit is, on average for all plan participants, NOT expected to pay out as much as the standard Medicare prescription drug coverage will pay.

This means that the Cigna HSA plan is NOT as valuable as the standard Medicare prescription drug coverage. This is important because, for most Medicare-eligible people, enrolling in Medicare prescription drug coverage instead of or in addition to this non-creditable plan means you will get MORE assistance with drug costs than if you had prescription drug coverage exclusively through the Cigna HSA plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible and in future years.

IMPORTANT NOTE: *In accordance with IRS regulations, individuals enrolled in any part of Medicare (A, B, or other parts) may not make personal contributions or receive employer contributions into an HSA bank account. Please see the Insurance Handbook and HSA terms and conditions at www.tucsonaz.gov/insurance.*

When Can You Join A Medicare Drug Plan?

Medicare-eligible people can enroll in a Medicare prescription drug plan at one of the following 3 times:

- when they first become eligible for Medicare; or
- during Medicare's annual election period (from October 15th through December 7th); or
- for beneficiaries leaving employer/union coverage, you may be eligible for a two-month Special Enrollment Period (SEP) in which to sign up for a Medicare prescription drug plan.

When you make your decision whether to enroll in a Medicare prescription drug plan, you should also compare your current prescription drug coverage, (including which drugs are covered and at what cost) with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

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

Since the coverage under Cigna's HSA plan is not creditable, depending on how long you go without creditable prescription drug coverage, you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, 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 (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

Special Note to Retirees: In general, retirees age 65+ may not remain on a City of Tucson medical/prescription plan. Also, Medicare-eligible dependents of retirees, regardless of age, are **not** eligible to continue on the City's group medical and prescription drug plan.

Medicare-eligible retirees who are under age 65 must enroll in Medicare (Parts A & B) when they become eligible and notify the City Benefits team within 31 days of Medicare eligibility in order to remain on the City's group medical and prescription drug plan; the City's group plan will pay secondary to Medicare. These retirees may be eligible for a reduced City plan premium. Be aware that if you decide to join a Medicare drug plan and drop your City of Tucson coverage, re-enrollment in the City's plan is limited to the annual open enrollment period, or within 31 days of a special enrollment event (60 days for a birth/adoption special enrollment), provided that you still qualify. See the Insurance Handbook and Retiree Health Benefits Continuation Administrative Directive at www.tucsonaz.gov/insurance for details. Contact the Benefits Office at (520) 791-4597 with questions.

Retirees age 65+ with fewer than 40 Medicare/Social Security quarters: A handful of public safety employees were not permitted to pay into Medicare while working for City of Tucson. These individuals may have an option to remain enrolled in a City medical and prescription drug plan upon reaching age 65. Contact the Benefits Office at (520) 791-4597 to verify your status. **If an individual in this category chooses to remain enrolled in a City plan and later qualifies for Medicare through a spouse or former spouse who has the requisite quarters, City coverage will end, and Medicare penalties may apply. It is important that you discuss your personal situation with the Social Security Administration (800-772-1213) and the City Benefits team (520-791-4597) so you understand your options and potential for Medicare penalties.**

If you do decide to join a Medicare drug plan and drop your City of Tucson coverage, be aware that you and your eligible dependents will be able to get this coverage back only during the City's annual open enrollment or within 31 days of a special enrollment event (60 days for a birth/adoption special enrollment), if you still qualify. See the Insurance Handbook posted at www.tucsonaz.gov/insurance for full rules.

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

Because any Medicare enrollment (A, B, or other parts) conflicts with eligibility for HSA bank account contributions, if you remain enrolled in the City's HSA plan, you will need to consult with your tax specialist regarding any HSA bank account contributions that you make or receive. You have the option to drop your City medical coverage within 31 days of your enrollment in Medicare. Visit www.tucsonaz.gov/insurance or contact your City of Tucson Benefits team for details about how to do so and for additional resources to determine your eligibility under an HSA.

For More Information about This Notice or Your Current Prescription Drug Coverage

Contact the City of Tucson Benefits Office if you would like more information. Contact information is included at the end of this Notice. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through City of Tucson 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-approved prescription drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (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 www.socialsecurity.gov, or call them at 1- 800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this 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: May 1, 2020
Name of Entity/Sender: City of Tucson
Contact: Employee/Retiree Benefits, 255 W Alameda, 3rd Fl, Tucson, AZ 85726, benefitquestions@tucsonaz.gov, (520) 791-4597

If you would like to visit us in person, please make an appointment.



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Benefits Office (eligibility): 520-791-4597 or Cigna (coverage): 800-244-6224.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name CITY OF TUCSON		4. Employer Identification Number (EIN) 86-6000266	
5. Employer address PO BOX 27210 (BENEFITS OFFICE)		6. Employer phone number 520-791-4597	
7. City TUCSON		8. State AZ	9. ZIP code 85726
10. Who can we contact about employee health coverage at this job? INSURANCE BENEFITS OFFICE			
11. Phone number (if different from above) 520-791-4597		12. Email address BENEFITQUESTIONS@TUCSONAZ.GOV	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

All employees. Eligible employees are:

Some employees. Eligible employees are:

Permanent or appointed employees averaging 30+ hours of service per week; elected officials; variable hour employees averaging 30+ hours of service per week as measured by the City's 12-month measurement period. See Insurance Handbook at tucsonaz.gov/insurance for details.

- With respect to dependents:

We do offer coverage. Eligible dependents are:

Spouses, and children under age 26. See Insurance Handbook at tucsonaz.gov/insurance for details.

We do not offer coverage.

If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

City of Tucson Group Health Plan HIPAA Notice of Privacy Practices

Esta noticia es disponible en español si usted lo solicita. Por favor contacte el oficial de privacidad indicado a continuación.

Purpose of This Notice

This Notice describes how medical information about you may be used and disclosed and how you may get access to this information.

This Notice is required by law.

The City of Tucson's self-funded group health plan including the medical plan options along with outpatient prescription drugs, Health Savings Account (HSA) Health Flexible Spending Account (FSA) administration and COBRA administration, (hereafter referred to as the "Plan"), is required by law to take reasonable steps to maintain the privacy of your personally identifiable health information (called **Protected Health Information or PHI**) and to inform you about the Plan's legal duties and privacy practices with respect to protected health information including:

1. The Plan's uses and disclosures of PHI,
2. Your rights to privacy with respect to your PHI,
3. The Plan's duties with respect to your PHI,
4. Your right to file a complaint with the Plan and with the Secretary of the U.S. Department of Health and Human Services (HHS),
5. The person or office you should contact for further information about the Plan's privacy practices,
6. To notify affected individuals following a breach of unsecured protected health information.

The Plan Sponsor has amended its Plan documents to protect your PHI as required by Federal law.

PHI use and disclosure by the Plan is regulated by the Health Insurance Portability and Accountability Act (HIPAA). You may find these rules in Section 45 of the Code of Federal Regulations, Parts 160 and 164. The regulations will supersede this Notice if there is any discrepancy between the information in this Notice and the regulations. The Plan will abide by the terms of the Notice currently in effect. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all PHI it maintains.

You may receive a Privacy Notice from a variety of the insured group health benefit plans offered by the City of Tucson. Each of these notices will describe your rights as it pertains to that plan and in compliance with the Federal regulation, HIPAA. This Privacy Notice however, pertains to your protected health information held by the City of Tucson's self-funded group health plan (the "Plan") and outside/subcontracted companies contracted to help administer Plan benefits, also called "business associates."

Effective Date

The effective date of this Notice is July 1, 2020.

Privacy Officer

The Plan has designated a Privacy Officer to oversee the administration of privacy by the Plan and to receive complaints. The Privacy Officer may be contacted at:

Privacy Officer for the City of Tucson
255 W. Alameda, 3rd Floor Tucson, AZ 85701
Telephone: (520) 791-4597 (direct) Confidential fax #: (520) 791-5942

Your Protected Health Information

The term "**Protected Health Information**" (PHI) includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form.

PHI does not include health information contained in employment records held by your employer in its role as an employer, including but not limited to health information on disability, work-related illness/injury, sick leave, Family or Medical Leave (FMLA), life insurance, dependent care flexible spending account, drug testing, etc.

PHI also does not include health information that has been de-identified. **De-identified information** is information that does not identify

you and there is no reasonable basis to believe that the information can be used to identify you.

When the Plan May Disclose Your PHI

Under the law, the Plan may disclose your PHI without your written authorization in the following cases:

- **At your request.** If you request it, the Plan is required to give you access to your PHI in order to inspect it and copy it.
- **As required by an agency of the government.** The Secretary of the Department of Health and Human Services may require the disclosure of your PHI to investigate or determine the Plan’s compliance with the privacy regulations.
- **For treatment, payment or health care operations.** The Plan and its business associates will use your PHI (except psychotherapy notes in certain instances as described below) without your consent, authorization or opportunity to agree or object in order to carry out treatment, payment, or health care operations.

The Plan may disclose PHI to the Plan Sponsor for purposes of treatment, payment and health care operations in accordance with the Plan amendment. The Plan may disclose PHI to the Plan Sponsor for review of your appeal of a benefit or for other reasons related to the administration of the Plan.

Definitions and Examples of Treatment, Payment and Health Care Operations	
Treatment is health care.	Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to coordination of benefits with a third party and consultations and referrals between one or more of your health care providers. <ul style="list-style-type: none"> • For example: The Plan discloses to a treating specialist the name of your treating primary care physician so the two can confer regarding your treatment plan.
Payment is paying claims for health care and related activities.	Payment includes but is not limited to making payment for the provision of health care, determination of eligibility, claims management, and utilization review activities such as the assessment of medical necessity and appropriateness of care. <ul style="list-style-type: none"> • For example: The Plan tells your doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan. If we contract with third parties to help us with payment, such as a claims payer, we will disclose pertinent information to them. These third parties are known as “business associates.”
Health Care Operations keep the Plan operating soundly.	Health care operations includes but is not limited to quality assessment and improvement, patient safety activities, business planning and development, reviewing competence or qualifications of health care professionals, underwriting, enrollment, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs and general administrative activities. <ul style="list-style-type: none"> • For example: The Plan uses information about your medical claims to refer you to a disease management program, to project future benefit costs or to audit the accuracy of its claims processing functions.

Although the Plan does not routinely obtain psychotherapy notes, generally, an authorization will be required by the Plan before the Plan will use or disclose psychotherapy notes about you. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. However, the Plan may use and disclose such notes when needed by the Plan to defend itself against litigation filed by you.

The Plan generally will require an authorization form for uses and disclosure of your PHI for sales or marketing purposes if the Plan receives direct or indirect payment from the entity whose product or service is being marketed or sold. You have the right to revoke an authorization at any time.

Use or Disclosure of Your PHI Where You Will Be Given an Opportunity to Agree or Disagree Before the Use or Release

Disclosure of your PHI to family members, other relatives and your close personal friends without your written consent or authorization is allowed if:

- The information is directly relevant to the family or friend’s involvement with your care or payment for that care, and
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Under this Plan your PHI may automatically be disclosed to internal employer departments as outlined below. If you disagree with this automatic disclosure by the Plan you may contact the Privacy Officer to request that such disclosure not occur without your written authorization:

- In the event of your death while you are covered by this Plan, when the Plan is notified it may automatically communicate this

information to the following: Other areas within the City Human Resources department including but not limited to payroll, records, leaves of absence, worker's compensation, retirement, and insurance carriers for any plans in which you are enrolled.

- In the event the Plan is notified of a work-related illness or injury, the Plan may automatically communicate this information to the other branches of the City's HR and Business Services departments such as Worker's Compensation and Safety Department staff to allow the processing of appropriate paperwork.
- In the event the Plan is notified of a condition that may initiate a short term disability benefit, the Plan may direct the person to the applicable voluntary short term disability carrier to allow the processing of appropriate paperwork.
- In the event the Plan is notified of a situation where it may be possible to initiate a medical leave under the Family and Medical Leave Act (FMLA) benefit or any other City-sponsored leave benefits, the Plan may automatically communicate this information to the City's leave department to allow the processing of appropriate leave paperwork.

Note that PHI obtained by the Plan Sponsor's employees through Plan administration activities will NOT be used for employment related decisions.

Use or Disclosure of Your PHI Where Consent, Authorization or Opportunity to Object Is Not Required

In general, the Plan does not need your written authorization to release your PHI if required by law or for public health and safety purposes. The Plan and its Business Associates are allowed to use and disclose your PHI **without** your written authorization under the following circumstances:

1. When **required by law**.
2. When permitted for **purposes of public health activities**. This includes reporting product defects, permitting product recalls and conducting post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
3. To a school about an individual who is a student or prospective student of the school if the protected health information this is disclosed is limited to **proof of immunization**, the school is required by State or other law to have such proof of immunization prior to admitting the individual and the covered entity obtains and documents the agreements to this disclosure from either a parent, guardian or other person acting in loco parentis of the individual, if the individual is an unemancipated minor; or the individual, if the individual is an adult or emancipated.
4. When authorized by law to report information about **abuse, neglect or domestic violence** to public authorities if a reasonable belief exists that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives, although there may be circumstances under Federal or state law when the parents or other representatives may not be given access to the minor's PHI.
5. To a public health oversight agency for **oversight activities authorized by law**. These activities include civil, administrative or criminal investigations, inspections, licensure or disciplinary actions (for example, to investigate complaints against providers) and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
6. When required **for judicial or administrative proceedings**. For example, your PHI may be disclosed in response to a subpoena or discovery request, provided certain conditions are met, including that:
 - the requesting party must give the Plan satisfactory assurances a good faith attempt has been made to provide you with written Notice, and
 - the Notice provided sufficient information about the proceeding to permit you to raise an objection, and
 - no objections were raised or were resolved in favor of disclosure by the court or tribunal.
7. When required for **law enforcement health purposes** (for example, to report certain types of wounds).
8. For **law enforcement purposes** if the law enforcement official represents that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and the Plan in its best judgment determines that disclosure is in the best interest of the individual. Law enforcement purposes include:
 - identifying or locating a suspect, fugitive, material witness or missing person, and
 - disclosing information about an individual who is or is suspected to be a victim of a crime.
9. When required to be given **to a coroner or medical examiner** to identify a deceased person, determine a cause of death or other authorized duties. When required to be given **to funeral directors** to carry out their duties with respect to the decedent; for use and

disclosures for cadaveric *organ, eye or tissue donation* purposes.

10. For *research*, subject to certain conditions.
11. When, consistent with applicable law and standards of ethical conduct, the Plan in good faith believes the use or disclosure is necessary to prevent or lessen a serious and *imminent threat to the health or safety* of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
12. When authorized by and to the extent necessary to comply with *workers' compensation* or other similar programs established by law.
13. When required, for *specialized government functions*, to military authorities under certain circumstances, or to authorized Federal officials for lawful intelligence, counter intelligence and other national security activities.

Any other Plan uses and disclosures not described in this Notice will be made only if you provide the Plan with written authorization, subject to your right to revoke your authorization, and information used and disclosed will be made in compliance with the minimum necessary standards of the regulation.

Your Individual Privacy Rights

A. *You May Request Restrictions on PHI Uses and Disclosures*

You may request the Plan to restrict the uses and disclosures of your PHI:

- To carry out treatment, payment or health care operations, or
- To family members, relatives, friends or other persons identified by you who are involved in your care.

The Plan, however, is not required to agree to your request if the Plan Administrator or Privacy Officer determines it to be unreasonable, for example, if it would interfere with the Plan's ability to pay a claim.

The Plan will accommodate an individual's reasonable request to receive communications of PHI by alternative means or at alternative locations where the request includes a statement that disclosure could endanger the individual. You or your personal representative will be required to complete a form to request restrictions on the uses and disclosures of your PHI. To make such a request contact the Privacy Officer at their address listed on the first page of this Notice.

B. *You May Inspect and Copy Your PHI*

You have the right to inspect and obtain a copy (in hard copy or electronic form) of your PHI (except psychotherapy notes and information compiled in reasonable contemplation of an administrative action or proceeding) contained in a "designated record set," for as long as the Plan maintains the PHI. You may request your hard copy or electronic information in a format that is convenient for you, and the Plan will honor that request to the extent possible. You may also request a summary of your PHI.

A **Designated Record Set** includes your medical records and billing records that are maintained by or for a covered health care provider. Records include enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan or other information used in whole or in part by or for the covered entity to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about you is not included in the designated record set.

The Plan must provide the requested information within 30 days of its receipt of the request, if the information is maintained onsite or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline and notifies you in writing in advance of the reasons for the delay and the date by which the Plan will provide the requested information.

You or your personal representative will be required to complete a form to request access to the PHI in your Designated Record Set. Requests for access to your PHI should be made to the Plan's Privacy Officer at their address listed on the first page of this Notice. You may be charged a reasonable cost-based fee for creating or copying the PHI or preparing a summary of your PHI.

If access is denied, you or your personal representative will be provided with a written denial describing the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Plan's Privacy Officer or the Secretary of the U.S. Department of Health and Human Services.

C. *You Have the Right to Amend Your PHI*

You or your Personal Representative have the right to request that the Plan amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set. The Plan has 60 days after receiving your request to act on it. The Plan is allowed a single 30-day extension if the Plan is unable to comply with the 60-day deadline (provided that the Plan notifies you in writing in advance of the reasons for the delay and the date by which the Plan will provide the requested information).

If the Plan denied your request in whole or part, the Plan must provide you with a written denial that explains the basis for the decision. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI. You should make your request to amend PHI to the Privacy Officer at their address listed on the first page of this Notice.

You or your personal representative may be required to complete a form to request amendment of your PHI. Forms are available from the Privacy Officer at their address listed on the first page of this Notice.

D. You Have the Right to Receive an Accounting of the Plan's PHI Disclosures

At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years (or shorter period if requested) before the date of your request. The Plan will not provide you with an accounting of disclosures related to treatment, payment, or health care operations, or disclosures made to you or authorized by you in writing. The Plan has 60 days after its receipt of your request to provide the accounting. The Plan is allowed an additional 30 days if the Plan gives you a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

E. You have the Right to Request that PHI be Transmitted to You Confidentially

The Plan will permit and accommodate your reasonable request to have PHI sent to you by alternative means or to an alternative location (such as mailing PHI to a different address or allowing you to personally pick up the PHI that would otherwise be mailed), if you provide a written request to the Plan that the disclosure of PHI to your usual location could endanger you. If you believe you have this situation, you should contact the Plan's Privacy Officer to discuss your request for confidential PHI transmission.

F. You Have the Right to Receive a Paper or Electronic Copy of This Notice Upon Request

To obtain a paper or electronic copy of this Notice, contact the Plan's Privacy Officer at the address listed on the first page of this Notice. This right applies even if you have agreed to receive the Notice electronically.

G. Breach Notification

If a breach of your unsecured protected health information occurs, the Plan will notify you.

Your Personal Representative

You may exercise your rights to your protected health information (PHI) by designating a person to act as your Personal Representative. Your Personal Representative will generally be required to produce evidence (proof) of the authority to act on your behalf **before** the Personal Representative will be given access to your PHI or be allowed to take any action for you. Under this Plan, proof of such authority will include (1) a completed, signed and approved Appoint a Personal Representative form; (2) a notarized power of attorney for health care purposes; (3) a court-appointed conservator or guardian; or, (4) for a Spouse under this Plan, the absence of a Revoke a Personal Representative form on file with the Privacy Officer.

This Plan will automatically recognize your legal Spouse as your Personal Representative and vice versa, without you having to complete a form to Appoint a Personal Representative. However, you may request that the Plan **not** automatically honor your legal Spouse as your Personal Representative by completing a form to Revoke a Personal Representative (copy attached to this notice or also available from the Privacy Officer). **If you wish to revoke your Spouse as your Personal Representative, please complete the Revoke a Personal Representative form and return it to the Privacy Officer and this will mean that this Plan will NOT automatically recognize your Spouse as your Personal Representative and vice versa.**

The recognition of your Spouse as your Personal Representative (and vice versa) is for the use and disclosure of PHI under this Plan and is not intended to expand such designation beyond what is necessary for this Plan to comply with HIPAA privacy regulations.

You may obtain a form to Appoint a Personal Representative or Revoke a Personal Representative by contacting the Privacy Officer at their address listed on this Notice. The Plan retains discretion to deny access to your PHI to a Personal Representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

Because HIPAA regulations give adults certain rights and generally children age 18 and older are adults, if you have **dependent children age 18 and older** covered under the Plan, and the child wants you, as the parent(s), to be able to access their protected health information (PHI), that child will need to complete a form to Appoint a Personal Representative to designate you (the employee/retiree) and/or your Spouse as their Personal Representatives.

The Plan will consider a parent, guardian, or other person acting *in loco parentis* as the Personal Representative of an unemancipated minor (a child generally under age 18) unless the applicable law requires otherwise. **In loco parentis** may be further defined by state law, but in general it refers to a person who has been treated as a parent by the child and who has formed a meaningful parental relationship with the child for a substantial period of time. Spouses and unemancipated minors may, however, request that the Plan restrict PHI that goes to family members as described above under the section titled "Your Individual Privacy Rights."

The Plan's Duties

The Plan is required by law to maintain the privacy of your PHI and to provide you and your eligible dependents with Notice of its legal duties and privacy practices. The Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices and the terms of this Notice and to apply the changes to any PHI maintained by the Plan.

Notice Distribution: The Notice will be provided to each person when they initially enroll for benefits in the Plan (the Notice is provided in the Plan's Initial Enrollment packets and enrollment website). The Notice is also available on the Plan's main website: www.tucsonaz.gov/insurance. The Notice will also be provided upon request. Once every three years the Plan will notify the individuals then covered by the Plan where to obtain a copy of the Notice. This Plan will satisfy the requirements of the HIPAA regulation by providing the Notice to the named insured (covered employee) of the Plan; however, you are encouraged to share this Notice with other family members covered under the Plan.

Notice Revisions: If a privacy practice of this Plan is changed affecting this Notice, a revised version of this Notice will be provided to you and all participants covered by the Plan at the time of the change. Any revised version of the Notice will be distributed within 60 days of the effective date of a material change to the uses and disclosures of PHI, your individual rights, the duties of the Plan or other privacy practices stated in this Notice. Material changes are changes to the uses and disclosures of PHI, an individual's rights, the duties of the Plan or other privacy practices stated in the Privacy Notice.

Because our health plan posts its Notice on its web site, we will prominently post the revised Notice on that web site by the effective date of the material change to the Notice. We will also provide the revised notice, or information about the material change and how to obtain the revised Notice, in our next annual mailing to individuals covered by the Plan.

Disclosing Only the Minimum Necessary Protected Health Information

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

As described in the amended Plan document, the Plan may share PHI with the Plan Sponsor for limited administrative purposes, such as determining claims and appeals, performing quality assurance functions and auditing and monitoring the Plan. The Plan shares the minimum information necessary to accomplish these purposes.

Your Right to File a Complaint

If you believe that your privacy rights have been violated, you may file a complaint with the Plan in care of the Plan's Privacy Officer, at the address listed on the first page of this Notice. Neither your employer nor the Plan will retaliate against you for filing a complaint.

You may also file a complaint (within 180 days of the date you know or should have known about an act or omission) with the Secretary of the U.S. Department of Health and Human Services by contacting their nearest office as listed in your telephone directory or at this website <https://www.hhs.gov/ocr/about-us/contact-us/index.html> or this website: <http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html> or contact the Privacy Officer for more information about how to file a complaint.

If You Need More Information

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Plan's Privacy Officer at the address listed on the first page of this Notice.

City of Tucson Group Health Plan Form to Revoke a Personal Representative

Complete the following chart to indicate the name of the Personal Representative to be revoked:

	Plan Participant	Person to be Revoked as my Personal Representative
Name (print):		
Address (City, State, Zip):		
Phone:	()	()

I, _____ (Name of Participant or Beneficiary) hereby
revoke _____ (Name of Personal Representative)

to act on my behalf,

to act on behalf of my dependent child(ren), named:

_____,
in receiving any protected health information (PHI) that is (or would be) provided to a personal representative, including
any individual rights regarding PHI under HIPAA, effective _____, 20____.

I understand that PHI has or may already have been disclosed to the above named Personal Representative prior to the
effective date of this form.

Participant or Beneficiary's Signature

Date

Once completed, please return this form to the Plan's Privacy Officer.

Privacy Officer for the City of Tucson
Physical Address: 255 W. Alameda, 3rd Floor **(Benefits Office)** Tucson, AZ 85701
Mailing Address: P.O. Box 27210 **(Benefits Office)** Tucson, AZ 85726
Telephone: (520) 791-4597 (direct) Confidential fax #: (520) 791-5942



General (Initial) Notice of COBRA Continuation Coverage Rights

Introduction

You're getting this notice because you recently gained 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.

A federal law, called the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), created this right to COBRA continuation coverage. 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 called a "qualifying event." This notice lists some Qualifying Events below. 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 your 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."

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

When is COBRA 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;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse, or a dependent child's losing eligibility for coverage

as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You also must follow the procedures outlined in the Insurance Handbook for removing the affected dependent and provide appropriate supporting documentation to City of Tucson Benefits within 31 days after the date of the qualifying event. Visit www.tucsonaz.gov/insurance for details, or contact benefitquestions@tucsonaz.gov or 520-791-4597 with questions.

How is COBRA 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 qualifying children.

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

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. The City of Tucson Benefits Office must receive your written proof from the Social Security Administration of your disability within 30 days of the date the Social Security Office notifies you. Our mailing address is at the end of this Notice.

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. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

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, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

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

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

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

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

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's

Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

If you have additional questions, please contact the following individual(s) at the City of Tucson Benefits Office:

Ashley Hendrix or Valerie Sparks

City of Tucson Benefits Office

P.O. Box 27210

255 W. Alameda, 3rd Floor

Tucson, AZ 85726-7210

520-791-4597

benefitquestions@tucsonaz.gov

Website: www.tucsonaz.gov/insurance