City of Phoenix

May 2009

Dear SelectCare® Member:

The City of Phoenix is pleased to continue to offer you and your eligible dependents comprehensive retiree medical coverage through the SelectCare® program. Once each year, typically in June, you have the opportunity to make changes to your SelectCare® enrollment for any reason. This is known as **SelectCare® Open Enrollment** which runs from **June 1st to June 19th** this year. The new plan year begins on August 1, 2009 which is when any changes you make during Open Enrollment will take effect.

There are several changes taking place August 1st that you should be aware of:

- Premium rates for retiree medical coverage will increase overall by 8.9% with the new plan year. For the first time you will see different rates for the two HMO plans. These rates are based on the actual experience for each medical plan. Please see page 7 in this booklet for details.

- As we all know, medical and prescription drug costs rise steadily. When our medical and prescription drug co-pays stay the same as they have since 2005, the City's self-insured healthcare trust pays an ever increasing share of our medical expenses. To maintain the financial wellbeing of our programs, certain co-pays will increase effective August 1, 2009. Please see page 6 for more information.

I encourage you to review all the information in this booklet carefully and to contact the Personnel Department Benefits Office promptly with any questions or for assistance. The Benefits staff can be reached at (602) 262-4777 or benefits.questions@phoenix.gov.

Sincerely,

Mary Kyle
Deputy Personnel Director

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Important!

You are expected to read this booklet and be familiar with plan requirements and your responsibilities concerning coverage.

Your medical coverage runs on an August 1 – July 31 plan year. Premium rates, coverage and co-pays can change from one plan year to the next. For this reason, you have an Open Enrollment period prior to each new plan year. Open Enrollment gives you a one-time-per-year opportunity to make changes to your medical coverage election for any reason.

2009 SelectCare®
Open Enrollment
Monday, June 1 - Friday, June 19 at 5:00 p.m.

No exceptions!

Changes to your SelectCare® coverage can be made using e-CHRIS Self Service **or** by contacting the Benefits Office. eCHRIS Self-Service instructions are provided on page 19. Either way, you can call the **Benefits Office** for assistance at **(602) 262-4777**.

After reading about changes for the 2009-10 plan year on page 6 you may decide not to make changes to your current benefit elections. If you do nothing your current medical election will continue.

Benefits Contact Information

Important phone numbers and web sites for your benefit needs

Coverage	Provider / Contact	Phone	Web
MEDICAL	**BlueCross/BlueShield HMO or PPO**	(602) 864-4857 (800) 232-2345 x4857 or, contact the City's onsite representative at (602) 534-5165 M-F, 8:00 – 5:00	azblue.com/cityofphoenix
	CIGNA HMO	(800) 244-6224 or, contact the City's onsite representative at (602) 495-5724 M-F, 8:00 – 5:00	cigna.com mycigna.com Vision Benefits: www.vsp.com
24-HOUR NURSE LINE	**BlueCross/BlueShield Nurse On Call Line**	866-4-BCBSAZ (866) 422-2729	*When you or a family member are ill or injured, you want help quickly Registered Nurses are on duty 24/7 to answer your health-related questions. This service is available to you at no charge.*
	CIGNA 24 Hour Health Information Line	(800) 244-6224	
BEHAVIORAL HEALTH	**CIGNA HMO**	(800) 343-2183	cignabehavioral.com
	BlueCross/BlueShield	HMO: (800) 224-2125 PPO: You may directly contact any network behavioral health provider	
PHARMACY	**CVS/Caremark**	(877) 209-5167 or, contact the City's onsite representative at (602) 534-5370 M-F, 8:00 – 5:00	caremark.com
401(a) & 457	**Nationwide Retirement Services**	(602) 266-2733	phoenixdcp.com
PENSION	**COPERS (General City)**	(602) 534-4400	Cityofphoenix.org/phxcopers.html
	PSPRS (Public Safety)	(602) 255-5575	psprs.com

Definitions

Child
The term "child" includes a biological child, adopted child, child placed for adoption, stepchild, qualified domestic partner's child, or a child living with you for whom you have either legal custody due to court order or court approved legal guardianship.

Co-Pay
The amount an enrolled retiree or dependent pays toward the full cost of a medical service. For example, an retiree seeing a primary care physician in-network pays $15 as their co-pay and the City pays the remainder of the office visit cost.

Deductible
The amount you pay out-of-pocket for covered services before the plan begins paying. For example, the BlueCross/BlueShield PPO out-of-network deductible.

Eligible Dependent
Only eligible dependents can be covered by the City's medical or dental plans. See pages 8-10 for details on who are and are not eligible dependents.

Formulary
A list of preferred name brand drugs that usually have a lower co-pay based on clinical efficacy and cost.

Member
Any person covered under a plan, including retiree, spouse, domestic partner, or child. Sometimes also referred to as an enrollee or participant.

Network
A group of physicians, hospitals and other health care service providers who have agreed to provide medical services under a preferential contracted arrangement.

PCP (Primary Care Physician)
The physician you see for general health care services: Family Practice, Internal Medicine, General Practice or Pediatrician.

Plan Year
The period of time during which premium rates, co-pays and other plan provisions are set. The SelectCare® plan year runs August 1 – July 31.

Premium Rate
Actuarially determined expected value of medical or dental benefits based on experience, trends and associated expenses.

SelectCare®
This is the name of the program that offers medical coverage to eligible City retirees.

Waive
You'll see the word "waive" as an option when you make benefit enrollment choices. To waive something is to intentionally give it up. If you choose "waive" you are choosing to ***not enroll***.

Changes

Plan Year 2009 - 2010

These changes occur on August 1, 2009:

MEDICAL CO-PAY CHANGES

All three medical plans will have increased co-pays for these services. Co-pays for other services are unchanged.

Description of Service	Current Co-Pay	Co-Pay as of 8/1/09
Specialist Office Visit	$25.00	**$35.00**
Outpatient Surgery	$50.00	**$75.00**
Emergency Room	$100.00	**$125.00**

PRESCRIPTION DRUG CO-PAY CHANGES

Prescription drug coverage for all medical plans is provided by Caremark. Co-pays for name brand drugs will increase. The generic medication co-pay will not change.

Prescription Drug Type	Current Co-Pay	Co-Pay as of 8/1/09
Generic	$10.00	$10.00
Formulary Name Brand	$20.00	**$25.00**
Non-Formulary Name Brand	$35.00	**$40.00**

HMO PREMIUM RATES UNBLENDED

The City offers two HMO plans – CIGNA HMO and BlueCross/BlueShield of AZ HMO. For the first time you'll see different premium rates for each HMO. This change reflects the City's actual claims experience and claims cost for each plan. Please see the monthly premium rates on page 7 of this book.

Medicare and Dependent Status	Code	Qualified City Contribution	2009-2010 Retiree Monthly Medical Premiums		
			CIGNA HMO	BCBS HMO	BCBS PPO
Single – Retiree or survivor not on Medicare	A	$105	$513.50	$467.27	$472.91
Family – Retiree and 1 or more dependents not on Medicare	B	$375	$1,407.53	$1,274.30	$1,290.51
Family – Retiree not on Medicare, all dependents on Medicare	C	$260	$939.96	$850.27	$861.16
Single – Retiree or survivor on Medicare	D	$90	$438.85	$399.32	$404.16
Family – Retiree with Medicare, any dependent not on Medicare	E	$245	$846.61	$765.02	$774.80
Family – Retiree and all dependents on Medicare	F	$235	$822.72	$743.66	$753.27
The Qualified City Contribution amount is reflected in the Monthly Premium amounts above					

MERP – Medical Expense Reimbursement Plan

The City of Phoenix Medical Expense Reimbursement Plan (MERP) provides eligible retirees with a monthly amount to offset out-of-pocket medical expenses such as medical premiums, deductibles, co-pays, dental care and vision care. MERP is tax-free as long as all of it is used for eligible health expenses in the same calendar year in which it is received. If you are unable to use all of the tax free Basic MERP for health related expenses, you must return the remaining MERP money to the city by January 15th of the following year. For a list of eligible MERP expenses, please call the Benefits Office at 602-262-4777.

If you have medical coverage through the City and your final cost for that coverage is more than your MERP amount, your MERP payments are considered to be used in full for eligible health expenses.

If your cost for medical coverage is less than your MERP amount and if you do not have other sufficient health expenses, you may choose to receive MERP as ordinary income. Contact the Benefits Office for a tax form.

A table showing monthly Basic MERP amounts is found on the next page.

MERP Table 1	Basic MERP
Criteria	**Monthly MERP Amount**
Under age 60, or over age 60 less than 5 years of credited city service*	$117
With 5 – 14 years of active credited city service	$135
With 15 – 24 years of active credited city service	$168
With 25 years or more of active credited city service	$202
All sworn Fire Fighter retirees without regard to years of service	$202
Middle Managers and Executives retiring on or after 7/1/06	$202
General City Supervisory and Professional retiring on or after 7/1/07	$202
Police Supervisory and Professional retiring on or after 7/1/07	$202

**Benefit eligible Police Supervisory and Professional who retired before 8/1/89 and Police Officers who retired before 8/1/92 become eligible at age 60 for MERP based solely on years of service.*

Supplemental MERP

You may qualify for an additional MERP amount based on your gross annualized pension amount. See the table below.

MERP Table 2	Supplemental MERP
Annualized Pension Amount	Supplemental MERP Amount
Up to $10,000	$50/month
$10,001 - $15, 000	$40/month
$15,001 - $20,000	$25/month
$20,001 - $25,000	$10/month

If you qualify for Supplemental MERP, this additional amount is added to your Basic MERP amount each month. Qualification for Supplemental MERP is based on your pension amount as of July 15th each year with an effective date of August 1st. If you receive more than one pension from the City, all pensions are added together to determine Supplemental MERP eligibility.

Special MERP

Retirees from certain categories enrolled in City retiree medical coverage receive an additional $100 per month in MERP. Please see the table on the next page.

MERP Table 3	Special MERP			
Employee Group	**Supervisory & Professional, Middle Manager, Executive, City Manager**	**Unit 1**	**Unit 3 and Unit 8**	**Unit 2**
Effective Date	Retired 7/1/98 – 6/30/09	Retiring on or after 7/1/06	Retired 7/1/07 – 6/30/09	Retiring on or after 7/1/09
Criteria	Not Medicare eligible and enrolled in <u>family</u> City medical coverage	Enrolled in City medical coverage	Not Medicare eligible and enrolled in <u>family</u> City medical coverage	Enrolled in City medical coverage
Effective Date	Retired on or after 7/1/2009		Retired on or after 7/1/2009	
Criteria	Not Medicare eligible and enrolled in <u>family or single</u> City medical coverage		Not Medicare eligible and enrolled in <u>family or single</u> City medical coverage	
When Special MERP Ends	Ends when medical coverage is waived or when anyone covered turns 65	Ends when medical coverage is waived	Ends if medical coverage is waived or when retiree turns 65	Ends if medical coverage is waived or when retiree turns 65

Questions About MERP

Questions about MERP should be directed to the Benefits Office at 602-262-4777.

Eligible Dependents

Legally Married Spouse
The retiree's legally married spouse is eligible for coverage.

Qualified Domestic Partner
The City offers medical coverage to qualified domestic partners and their benefits eligible dependent children. Domestic partners may be same or opposite gender. A domestic partner application and satisfactory evidence of financial interdependence must be received and approved by the Benefits Office. A domestic partner is someone who:

1. Shares the retiree's permanent residence and has resided with the retiree continuously for at least the past 12 consecutive months and is expected to reside with the retiree indefinitely.

2. Is financially interdependent with the retiree in at least two of these ways
    a. The retiree and domestic partner have both names on a joint bank account such as a checking or savings account, or credit account such as an auto loan,
    b. The retiree and domestic partner are both named as joint owners or tenants of their permanent residence,
    c. Both the retiree and the domestic partner name each other as beneficiary for life insurance or in a will,
    d. The retiree and domestic partner can each provide a durable power of attorney for the other,
    e. Other proof of financial interdependence as approved by the Personnel Director.

3. Has not signed a declaration or affidavit of domestic partnership with anyone else within the prior 12 months.

4. Does not have any other domestic partner, spouse, or spousal equivalent of the same or opposite gender within the 12 months prior to Domestic Partner application.

5. Is not a blood relative closer than would prohibit legal marriage.

6. Is mentally competent; is not acting under fraud or duress.

7. Is at least 18 years old.

Child(ren)

The retiree's unmarried child whose primary support comes from the retiree is eligible for coverage through the end of the month in which they turn **23 years old.** Determination of "primary support" is typically based on whether or not the child is considered a dependent for Federal tax purposes, but may also be based on the percentage of time the child resides in the retiree's primary residence. The term "child" includes a biological child, adopted child, child placed for adoption, stepchild, qualified domestic partner's child, or a child living with you for whom you have either legal custody due to court order or court approved legal guardianship.

An unmarried child age 23 and older may continue their already existing coverage as an eligible dependent if they are incapable of self-sustaining employment due to serious, long-term mental or physical disability. The insurance carrier will require evidence of the child's condition and may approve or deny continued coverage. Contact the Benefits Office at (602) 262-4777 no later than 31 days following the child's 23rd birthday for more information.

Individuals Not Eligible for Coverage

Those who are ***not eligible for coverage*** include but are not limited to:

- ✘ Ex-spouse, legally separated spouse
- ✘ Child in active military service
- ✘ Child who is self-supporting
- ✘ Grandchild
- ✘ Married child
- ✘ Incarcerated child
- ✘ Foster child
- ✘ Child not a dependent for tax purposes

Newborn Eligibility

When a covered retiree, spouse or domestic partner gives birth the newborn is, in most cases, covered for their first 31 days. Coverage can be continued IF the retiree adds the newborn to their coverage within their first 31 days. *Please note:* If a covered dependent child gives birth, the mother is covered but the baby is not covered. A grandchild is not an eligible dependent.

Dependent Documentation Requirements

If a retiree enrolls a spouse or dependent whose last name is different than their own, supporting documentation such as a marriage license for a spouse or birth certificate or court order for a dependent may be required. Other documentation may be required as deemed necessary to establish dependent eligibility for coverage.

Qualified Medical Child Support Order (QMCSO)

Retirees may not terminate coverage for a dependent whose enrollment is mandated by a QMCSO. This is State ordered medical coverage for a child or children and the city's compliance is required.

Eligibility Determinations

The City of Phoenix Personnel Department Benefits Office determines eligibility and effective dates of coverage.

WARNING

When a covered dependent (spouse, domestic partner or child) is no longer eligible for benefits coverage, it is the retiree's responsibility to drop the ineligible dependent from coverage within 31 days.

Failure to do so makes the retiree financially responsible for all medical, prescription drug and/or dental claim expenses incurred by the ineligible dependent.

24-Hour Medical Information

Whether you have a question about medications or need assistance determining if a visit to the doctor is recommended, CIGNA's 24-Hour *Health Information Line* and BCBS's *Nurse On Call* can provide the health information you need. You can speak with experienced registered nurses 24 hours a day to help you make informed medical decisions by identifying and evaluating symptoms, assessing medical needs and recommending next steps.

CIGNA
24-Hour Health Information Line
1-800-244-6224

Blue Cross Blue Shield Nurse On Call
1-866-422-2729
azblue.com/nurseoncall

SELECTCARE® Mid-Year Enrollment Changes

Elections made during Open Enrollment must stay in effect for the entire year unless the retiree experiences a qualified change of status such as

- Marriage
- Divorce or legal separation
- Birth
- Adoption or placement for adoption
- Loss of other employer-provided coverage
- Enrolling in other coverage

Changes to coverage must be made within 31 days of the change in status and must be consistent with the change in status. After that time retirees must wait until the next Open Enrollment.

Effective April 1, 2009, you may make a mid-year enrollment change if you or your eligible dependents either lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or become eligible for a state's premium assistance program under Medicaid or CHIP. For these two new enrollment opportunities, you will have 60 days – instead of 31 – from the date of the Medicaid/CHIP eligibility change to request a mid-year enrollment change to your City benefits.

SELECTCARE® Re-enrollment

If you have waived your city medical coverage and wish to re-enroll, you may do so at Open Enrollment each year or you may re-enroll within 31 days after loss of other group medical coverage. Please read the following important information:

Re-enrollment at Open Enrollment

- Contact a Benefits Analyst in the City of Phoenix Personnel Department Benefits Office by calling 602-262-4777 during Open Enrollment, June 1 – June 19, 2009.

- Be prepared to provide evidence of continuous and comparable medical coverage which may include evidence of current premium payment.

Re-enrollment Upon Loss of Other Group Medical Coverage

- Within 31 days of your loss of coverage, contact the City of Phoenix Benefits Office and provide an official letter from the plan administrator that names who was covered, the coverage effective date(s), and the date on which coverage was lost.

- Be prepared to provide evidence of continuous and comparable medical coverage.

"Continuous and comparable medical coverage" means an insurance plan that began on or before your PSPRS or General City retirement date and includes coverage for all the following:

- Major medical with at least 60% coverage *(Health Savings Accounts do not qualify)*
- Doctor's office visits
- Prescription drug coverage *(drug discount drug programs do not qualify)*

You will be expected to provide a summary plan description, medical certificate, benefits guide, or other acceptable documentation of prior coverage.

Premium Payments

You are responsible to pay medical premiums in full each month. If your monthly pension check is insufficient to allow an automatic deduction, you are responsible to make timely payments each month to the City of Phoenix Personnel Department Benefits Office at 135 N. Second Ave., Phoenix, AZ 85003 whether or not you receive a bill from the city. Failure to make timely payments may result in termination of your medical coverage.

Medicare Information

Medicare is available to you if you are

- Age 65 or over
- Under age 65 and receiving Social Security Disability Income (SSDI)
- Undergoing dialysis due to End Stage Renal Disease (ESRD)

All retirees and their dependents who are eligible for Medicare are **required** to enroll in **Medicare Part A & B** at the earliest enrollment date available to them. Once enrolled, forward a copy of your Medicare A & B card to the Benefits Office via fax at 602-534-2848 or via mail at 135 N. Second Ave., Phoenix, AZ 85003. Evidence of enrollment in Medicare A & B will reduce your monthly premium cost for city medical coverage.

If you or a dependent do not enroll in Medicare Part A **and** B when first eligible, you may be financially liable for claims costs incurred during the time you were eligible but did not enroll. If you have any questions about Medicare coverage, please contact a Benefits Analyst in the Personnel Department Benefits Office at 602-262-4777.

Medicare and Pharmacy Coverage

The City of Phoenix SelectCare® medical plans have filed with Medicare to offer "creditable coverage" for pharmacy coverage. This means that the City's medical plans provide equal or better pharmacy coverage than Medicare pharmacy coverage, Medicare Part D. *If you are enrolled in the city's retiree medical coverage DO NOT ENROLL IN Medicare Part D.*

Enrolling in a Separate Pharmacy Plan

If you enroll in a separate pharmacy plan such as Medicare Part D, you cannot remain enrolled in the City of Phoenix retiree medical plan. Medicare does not allow Medicare-eligible persons to be enrolled in two approved Medicare prescription plans at the same time. For more information about Medicare and Medicare prescription drug plans, log on to medicare.gov or call 1-800-633-4227.

SELECTCARE® Medical Plans

The City of Phoenix SelectCare® program offers three medical plans to choose from:

- HMO administered by CIGNA
- HMO administered by BlueCross/BlueShield of Arizona (BCBSAZ)
- PPO administered by BlueCross/BlueShield of Arizona (BCBSAZ)

HMO (Health Maintenance Organization)	PPO (Preferred Provider Organization)
Members must use HMO Network physicians, hospitals, labs, and other facilities for routine care. There is no coverage for out-of-network services unless ▪ services are for out-of-area bona fide emergency care ▪ necessary medical expertise is not found in the network – out of network coverage MUST be pre-authorized by the insurance company HMOs have no deductible.	Coverage can be accessed by in-network providers and out-of-network providers. It is important to note that when you use in-network providers your out-of-pockets costs are lower. When you use any out-of-network physician, hospital, lab or other facility, you pay a calendar year deductible and 30% of the allowable amount for covered services. Preventive care is not covered out-of-network. When you receive care out-of-network you may be asked to pay the full cost for the service up front and then file a claim for normal reimbursement.
See the Medical Plan Comparison Summary on the next page for more information	

Plan Year 2009 – 10
Medical Plan Comparison Summary

Plan Designs	HMO	PPO	
Carrier Names	BCBSAZ HMO or CIGNA HMO	BCBSAZ PPO	
	BCBSAZ stands for BlueCross/BlueShield of Arizona		
Coverage and Co-Pays	In-Network	In-Network	Out-of-Network
Lifetime Maximum Benefit	Unlimited	Unlimited	$1,000,000
Out of Pocket Maximums	None	None	$2,400 for 1 $4,800 for 2 $5,200 for 3+
Referral Required to see a Specialist?	No	No	No
Calendar Year Deductible	$0	$0	$400 per person $1,200 maximum per family
Office Visit – Primary Care Physician*	$15	$15	Plan pays 70% of the BCBSAZ allowed amount for covered services after the calendar year deductible is fulfilled
Office Visit – Specialist*	**$35**	**$35**	
Outpatient Surgery	**$75**	**$75**	
Inpatient Hospitalization	$100 per day, maximum $300 per admission	$100 per day, maximum $300 per admission	
Lab and X-rays	$0	$0	
Behavioral Health Individual or Group Therapy Office Visit	$10	$10	
Infertility Procedures	Office visit co-pay plus $500 per procedure	Office visit co-pay plus $500 per procedure	
Skilled Nursing Facility	$0	$0	
Home Health Care	$0	$0	
Hospice Care	$0	$0	
Chiropractic	**$35**	**$35**	
Hearing Exam	$15 for Primary Care Physician or $35 for Specialist		
Hearing Devices	Plan pays 100% for covered devices up to $2,000 per calendar year.	Plan pays 100% for covered devices up to $2,000 per calendar year, then Plan pays 70% of the allowed amount.	
Urgent Care	$40	$40	$40
Emergency Room (ER)	**$125**	**$125**	**$125**
	---------- *Waived if admitted to the hospital* ----------		
Ambulance	$0	$0	$0
Preventive Care/Routine Physicals	$0	$0	Not covered
Vision Exam (every 12 months)	$5	$5	
Vision Benefits	$75 credit for contacts, $20 credit for single vision lenses, $30 credit for bifocals, $40 for trifocals, $30 credit for frames.		
Vision Networks	CIGNA members use the VSP Network, Blue Cross HMO members use the BCBSAZ Network	BCBS National Network	

*Note: Plan Year 2009 – 2010 Co-Pay Changes are in **bold***

** some doctors do not charge co-pays when you have Medicare coverage*

This is a summary – please see Plan Certificates for detailed coverage provisions. Plan Certificates are online at echris.phoenix.gov under Benefits or you may request to have a hard copy mailed to you by calling 602-262-4777.

SELECTCARE® Prescription Drug Benefits

If you enroll in any of the City's medical plans, your prescription drug benefits will be provided by CVS/Caremark. Enrollment is automatic with your medical plan enrollment and there is no separate cost. CVS/Caremark is the largest provider of prescriptions and related health care services in the nation filling more than 1 billion prescriptions annually.

Prescriptions can be filled at any retail pharmacy such CVS, Walgreens, Target, Wal-Mart, Fry's, Safeway, Bashas', Costco, and others. You will save money when you fill maintenance prescriptions using the CVS/Caremark mail order pharmacy. To use the mail order pharmacy, see instructions on the next page.

Prescription Co-Pays for Plan Year 2009 – 10		
Tier	Retail Pharmacy Co-Pay	Mail Order Pharmacy Co-Pay
Formulary Generic	**$10** / 30 day supply	**$20** / 90 day supply
Formulary Name Brand	**$25** / 30 day supply	**$50** / 90 day supply
Non-formulary Name Brand	**$40** / 30 day supply	**$80** / 90 day supply

About Generics

Generic drugs are copies of name brand drugs that have exactly the same dosage, intended use, effects, side effects, route of administration, risks, safety, and strength as the original drug. In other words, their pharmacological effects are exactly the same as those of their brand-name counterparts.

Sometimes people become concerned because generic drugs are often much less expensive than the brand-name versions. The Food and Drug Administration (FDA) requires that generic drugs be as safe and effective as brand-name drugs. The FDA has rules in force to ensure that every generic drug contains the same components as its brand-name equivalent. All generic drugs must have the same quality, strength, purity and stability as their counterparts. Generics use the same active ingredients, are shown to act in the same way in the body, and have the same risk-benefit profile as a brand name drug.

Generic drugs are less expensive because the manufacturers have not had the expenses of developing and marketing a new drug. When a company brings a new drug onto the market, the firm has already spent substantial money on research, development, marketing and promotion of the drug. A patent is granted that gives the company that developed the drug an exclusive right to sell the drug as long as the patent is in effect. As the patent nears expiration, manufacturers can apply to the FDA for permission to make and sell generic versions of the drug. Without the startup costs for development of the drug, other companies can afford to make and sell it more cheaply. When multiple companies begin producing and selling a drug, the competition among them can also drive the price down even further.

"Dispense as Written"

Your pharmacist will dispense generic medications whenever available, unless your physician specifically writes "Dispense as Written (DAW)" on the prescription. You will pay the applicable brand name co-pay for the medication. If the member requests that a prescription is filled with brand name instead of generic but the physician did not write DAW on the prescription, the member will be responsible to pay the cost difference between the brand and generic product plus their applicable co-pay.

What is a Formulary?

Pharmacy benefit programs typically use a formulary to maximize the value of prescription benefits. A formulary is a list of generic and brand name medications that are chosen by a committee of doctors and pharmacists to provide the best therapeutic value. Once each year the formulary is reviewed and medications that no longer provide the best therapeutic value for the plan are deleted and new medications may be added. CVS/Caremark notifies members by mail when they are affected by formulary changes. The formulary used by the City can be viewed by registering at caremark.com and clicking on *My Drug List*.

Save Money with Mail Order

If you or a covered family member takes medication month in and month out for an ongoing condition you can save time and money by having your prescriptions filled using mail order. Every mail order prescription provides you with a 90 day supply of medication for two co-pays instead of three. Below are three ways to get started using mail order.

Your Prescription Mailed Directly to You
Fast Start Program Have CVS Caremark contact your doctor directly for a new prescription. **By Internet:** 1. Log in to Caremark.com and sign in or register if necessary. (To register, click on Not Registered? At the top of the screen. You'll need your CVS/Caremark ID number which is found on front of your CVS/Caremark ID card.) 2. Click on 'Start a New Prescription' and then click on 'FastStart®' **By Phone:** 1. Call **FastStart** toll-free at 1-800-875-0867; M-F, 7 a.m. to 7 p.m. (Central Time Zone)
New Prescription Phone/Fax Line Ask your doctor to call or fax in your new 90 day prescription with up to 3 refills to the CVS/Caremark mail order pharmacy. **Doctor Phone Line:** 1-800-378-5697 **Doctor Fax Line:** 1-800-378-0323
Mail Order Form 1. Call CVS/Caremark Customer Service at 1-877-209-5167 to request a mail order form. 2. Obtain a 90 day prescription with up to 3 refills from your doctor. 3. Mail the completed form with your 90 day prescription and co-pay to the address on the form.

Your new mail order prescription will be delivered to your home in approximately 10 – 14 days. You may charge your mail order co-pay to Visa, MasterCard, American Express or Discover. Mail order features you can elect include email updates and reminders about your mail order prescriptions and automatic refills.

Specialty Medications

Complex or genetic conditions require special pharmacy products. CVS/Caremark provides these medications directly to members along with support for administration, storage, handling and delivery. Specialty medications are limited to a 30 day supply and can be obtained through mail order or at the Apothecary Shop of Phoenix, 1144 E. McDowell Road, 602-257-1133. For more information on Specialty Medications please call 1-800-237-2767.

SELECTCARE® Vision Benefits

Vision coverage is automatically included with your medical coverage. Vision benefits are available only when using an in-network provider. Details are below.

	CIGNA HMO	BCBS HMO	BCBS PPO	
			In- Network	Out-of-Network
Network	VSP network	Arizona Blue Cross network	National Blue Cross network	*Not covered*
	Information below is the same for all 3 plans:			
Benefit Frequency	Every 12 months			
Basic Exam	$5 co-pay			
Contacts	$75 credit			
Eyeglass Frames	$30 credit			
Lenses	Single Vision: $20 credit Bifocal: $30 credit Trifocal: $40 credit			

Finding Vision Providers

CIGNA members should register at vsp.com using their CIGNA ID number or last four digits of their social security number to find vision providers in the network.

BlueCross/BlueShield members can find vision providers at azblue.com/cityofphoenix.

If you'd like assistance to find a vision provider or if you have questions about vision coverage, please contact the City's CIGNA or BlueCross/BlueShield on-site representative – see page 20 for contact information.

Personalized Customer Service

Full-time customer service representatives from CIGNA, BlueCross/BlueShield of Arizona and CVS/Caremark have offices in the City of Phoenix Personnel Building located at 135 N. Second Avenue in downtown Phoenix.

These representatives dedicate their time to City of Phoenix employees, retirees and their covered dependents. They are knowledgeable about the City's coverage and committed to providing excellence in service. You can contact them by calling the main Benefits Office phone number, (602) 262-4777 or by calling their direct lines:

CIGNA
602 – 495-5724

BlueCross BlueShield of Arizona
An Independent Licensee of the Blue Cross and Blue Shield Association
602 – 534-5165

CVS CAREMARK
602 – 534-5370

ID Cards

New ID cards will be issued in July 2009 for retirees or survivors and their covered dependents with City medical coverage on August 1, 2009. This includes new medical ID cards from CIGNA or BlueCross/BlueShield of Arizona and new prescription drug ID cards from CVS/Caremark. When you receive new ID cards you should immediately destroy your old ID cards – it's important to use the most current ID card to assure coverage and access to services.

Please note that ID cards are for identification purposes only and do not guarantee eligibility for coverage.

Elder Care Consulting Services

Caring for an aging parent, spouse, or domestic partner presents difficult challenges – especially when a crisis hits and you are suddenly faced with the responsibilities of elder care. The City provides free elder care consulting services to employees and retirees. You can access Elder Care information online at phoenix.gov/phxwell.html or you can call 602-534-5433 to connect with a specialist who can offer free advice and assistance.

To Make Open Enrollment Changes

You can make Open Enrollment changes either by phone or online **between June 1 and June 19, 2009**. Remember please, Open Enrollment changes can be made during these dates, only.

To make changes by phone, please call the Benefits Office at 602-262-4777 between 8:00 a.m. and 5:00 p.m. Monday through Friday between June 1 and June 19. Open Enrollment ends at 5:00 p.m. on June 19, 2009 – changes will not be accepted after that date.

To make changes online, please see the e-CHRIS instructions on the following page. Call the Benefits Office for assistance at 602-262-4777.

Making Open Enrollment Changes using e-CHRIS

Open Enrollment Changes can be made using eCHRIS Self-Service. Information is found below. Personal assistance is available at the Personnel Department Benefits Office located in the Personnel Building at 135 N. Second Avenue in downtown Phoenix, or by calling the Benefits Office at 602-262-4777.

Finding eCHRIS

Go to echris.phoenix.gov

Logging in to eCHRIS

If you are a first-time user

USER ID:	Is always your six digit retiree ID number
First Time PASSWORD:	An 8-digit number consisting of your birth month (two digits) followed by the last four numbers of your Social Security Number followed by your birth year (two digits).

If you are not a first-time user

If you have forgotten your password click on **Forgot your password?** To use this feature you will have already set up a question/response in the system. If you have not done this, you'll need to call the Help Desk for a new temporary password. The Help Desk is open Monday through Friday, 7:00 a.m. – 5:30 p.m.

HELP DESK
Phone: (602) 534-4357
Email Address: ent.technology.hd@phoenix.gov

The Help Desk is typically closed on weekends. However, on weekends during 2009 Open Enrollment (June 6-7 and June 13-14) the Help Desk will take messages from 10:00 a.m. – 3:00 p.m. Leave a message with your name and phone number, and your call will be returned promptly.

Making Open Enrollment Changes on eCHRIS

When you have successfully logged into eCHRIS

1) Click Self Service
2) Click Benefits
3) Click Benefits Enrollment
4) Follow the instructions carefully and be sure to **Submit** your changes

Retirees can also make Open Enrollment changes by phone. Contact the Benefits Office at (602) 262-4777.

City of Phoenix

HIPAA Privacy Notice

Please carefully review this notice. It describes how medical information about you may be used and disclosed and how you can get access to this information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by employer health plans. This information, known as protected health information, includes almost all individually identifiable health information held by a plan – whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of these plans: The City of Phoenix Medical, Dental, Pharmacy and Flexrap (Flexible Spending Account program). The plans covered by this notice may share health information with each other to carry out treatment, payment, or health care operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

The Plan's duties with respect to health information about you

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important to note that these rules apply to the Plan, not City of Phoenix as an employer – that's the way the HIPAA rules work. Different policies may apply to other City of Phoenix programs or to data unrelated to the Plan.

How the Plan may use or disclose your health information

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

- ***Treatment*** includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. *For example, the Plan may share your health information with physicians who are treating you.*

- ***Payment*** includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include eligibility determinations, reviewing services for medical necessity or appropriateness, utilization management activities, claims management, and billing; as

well as "behind the scenes" plan functions such as risk adjustment, collection, or reinsurance. *For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan in order to coordinate payment of benefits.*

- ***Health care operations*** include activities by this Plan (and in limited circumstances other plans or providers) such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include vendor evaluations, credentialing, training, accreditation activities, underwriting, premium rating, arranging for medical review and audit activities, and business planning and development. *For example, the Plan may use information about your claims to review the effectiveness of wellness programs.*

The amount of health information used or disclosed will be limited to the minimum necessary for these purposes, as defined under the HIPAA rules. The Plan may also contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

How the Plan may share your health information with the City of Phoenix

The Plan may disclose your health information without your written authorization to City of Phoenix for plan administration purposes. City of Phoenix may need your health information to administer benefits under the Plan. City of Phoenix agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. Certain Personnel Department staff are the only City of Phoenix retirees who will have access to your health information for plan administration functions.

Here's how additional information may be shared between the Plan and City of Phoenix, as allowed under the HIPAA rules:

- The Plan may disclose "summary health information" to City of Phoenix if requested for purposes of obtaining premium bids to provide coverage under the Plan, or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.

- The Plan may disclose to City of Phoenix information on whether an individual is participating in the Plan or has enrolled or disenrolled in medical, dental or Flexrap.

In addition, you should know that City of Phoenix cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by City of Phoenix from other sources, for example under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation is *not* protected under HIPAA (although this type of information may be protected under other federal or state laws).

Other allowable uses or disclosures of your health information

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made – for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

Workers' compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws.
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody.
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects.
Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk).
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information).
Law enforcement purposes	Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosure about a death that may have resulted from criminal conduct; and disclosure to provide evidence of criminal conduct on the Plan's premises.

Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties.
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death
Research purposes	Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project.
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws.
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates.
HHS investigations	Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule.

Except as described in this notice, other uses and disclosures will be made only with your written authorization. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made.

Your individual rights

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the table at the end of this notice for information on how to submit requests.

Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death – or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan

(including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

Right to receive confidential communications of your health information

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your health information

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible onsite), the Plan will provide you with:

- the access or copies you requested;
- a written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint; or
- a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage.

If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed of where to direct your request.

Right to amend your health information that is inaccurate or incomplete

With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and

complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).
If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will:

- make the amendment as requested;

- provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint; or

- provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

Right to receive an accounting of disclosures of your health information

You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an "accounting of disclosures." You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information for up to six years before the date of your request, but not earlier than April 14, 2003 (the general effective date of the HIPAA privacy rules). You do not have a right to receive an accounting of any disclosures made:

for treatment, payment, or health care operations;

to you about your own health information;

incidental to other permitted or required disclosures;

where authorization was provided;

to family members or friends involved in your care (where disclosure is permitted without authorization);

- for national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances; or

- as part of a "limited data set" (health information that excludes certain identifying information).

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to obtain a paper copy of this notice from the Plan upon request

You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

Changes to the information in this notice

The Plan must abide by the terms of the privacy notice currently in effect. This notice takes effect on April 14, 2009. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised privacy notice by mail to your mailing address of record.

Complaints

If you believe your privacy rights have been violated, you may complain to the Plan and to the Secretary of Health and Human Services. You won't be retaliated against for filing a complaint. To file a complaint, contact:

Privacy Officer
City of Phoenix Personnel Department
135 N. 2nd Avenue, Fourth Floor
Phoenix AZ 85003
(602) 262-4777

Contact

For more information on the Plan's privacy policies or your rights under HIPAA, contact the HIPAA Privacy Officer at 602-262-4777.