mesa·az

New Hire Employee Benefits Guide Plan Year 2024

This Open Enrollment Guide provides you with all you need to know to allow you to make informed choices for you and your family in 2024

Email:
benefits.info@mesaaz.gov

Phone:
(480) 644-21299

Website:
www.mesaaz.gov/benefits

Contents

YOUR BENEFITS GUIDE 2
WHO CAN YOU COVER UNDER YOUR BENEFIT PLANS? 2
REVIEW YOUR LIFE INSURANCE BENEFICIARIES REGULARLY 3
KEEP YOUR CONTACT INFORMATION CURRENT USING EMPLOYEE SELF SERVICE (ESS) 3
SPECIAL QUALIFYING EVENT ENROLLMENT (AKA "MID-YEAR" ENROLLMENT) 3
MEDICAL AND PRESCRIPTION DRUG BENEFIT HIGHLIGHTS AND RATES 3
DENTAL PLAN BENEFIT HIGHLIGHTS AND RATES 6
VISION CARE BENEFIT HIGHLIGHT AND RATES 7
FLEXIBLE SPENDING ACCOUNTS (FSA) – HEALTH AND DEPENDENT CARE 8
GROUP TERM LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE 9
BUSINESS TRAVEL ACCIDENT/COMMUTER TRAVEL ACCIDENT (BTA) INSURANCE 11
SHORT TERM DISABILITY (STD) INSURANCE 11
LINKS TO REQUIRED NOTICES 12
CONTACTS 13

YOUR BENEFITS GUIDE

The employee benefit programs described in this Guide are effective January 1, 2024. Take the time to familiarize yourself with benefit options, eligibility rules, and costs. This Guide provides you with important summary and highlights about City of Mesa's benefit programs so you can make the best plan choices for your and your family's needs in 2024. Every attempt has been made to ensure the accuracy of the information in this Guide. It provides general information on programs and summaries of benefits offered to city employees and their dependents. All information is subject to change and is not a guarantee of benefits.

For more detailed information about benefit programs, including eligibility and coverage, exclusions and limitations, please refer to the City of Mesa Plan Document /Summary Plan Description ["Plan Document"] available at www.mesaaz.gov/benefits. If there is a difference between this Guide, our benefits website information and any other benefits-related publications and the Plan Document (or under policies/certificates), the Plan Document (or underlying policies/certificates) will prevail.

WHO CAN YOU COVER UNDER YOUR BENEFIT PLANS?

Eligible dependents include:

- A legally married spouse
- A committed partner as defined under the City's Plan Document
- Child(ren) up to age 26:
  - Natural born children
  - Stepchildren (natural born or adopted children of your spouse/committed partner)
  - Adopted or legally placed for adoption children of you and/or your spouse/committed partner
  - Child (up to age 18) for whom the employee and/or the employee's spouse/committed partner has obtained a court-ordered and current foster or legal guardianship status
  - Disabled adult children over age 26 with current social security award eligibility, who are natural born, adopted, adult foster or adult legal guardianship status of employee and/or spouse/committed partner

When you first enroll/re-enroll a dependent, you must provide proof of dependent status, which may include the following:

- For legal spouse: marriage certificate
- For Children:
  - Birth certificate and,
    - Marriage Certificate for spouse for stepchildren or,
    - Legal or Court documents for adoption, foster, legal guardianship children or,
    - Current social security award determination (or documentation that proves eligibility for such) for adult *disabled children*

For Committed Partners, you must provide proof of status upon initial enrollment, and during every Open Enrollment period thereafter, which includes the following: Affidavit of Committed Partnership and two documents that verify joint address and financial inter-dependence.

REVIEW YOUR LIFE INSURANCE BENEFICIARIES REGULARLY

You will see information in later sections about Life Insurance, Accidental Death and Dismemberment Insurance and Business Travel Accident/Commuter Travel Accident Insurance. If you are eligible for any of these coverages, take a moment to review your beneficiaries regularly and make any needed updates. This protects both you and your beneficiaries' rights under these various insurance programs. You can use eBenMesa to make beneficiary changes at any time throughout the year.

KEEP YOUR CONTACT INFORMATION CURRENT USING EMPLOYEE SELF SERVICE (ESS)

Our insurance administrators and carriers rely on your contact information being up to date. We provide them with the address information you provided in ESS. If your information is not current, you may miss time-sensitive and important benefit information which may include Explanation of Benefits, denied claims, precertification approvals or denials, etc. Additionally, as we move towards the end of the year, various payroll and benefit tax forms may be mailed to you using your ESS contact information.

SPECIAL QUALIFYING EVENT ENROLLMENT (AKA "MID-YEAR" ENROLLMENT)

If you do not enroll in benefits during an initial eligibility period or during an Open Enrollment period, you are not able to enroll until the next Open Enrollment period unless you experience a Special Qualifying Event or "mid-year" status change. These changes must generally be made/notified within 31 days of the qualifying event. Common qualifying events include:

- Marriage
- Divorce
- Gain of child(ren)
- Qualified Medical Support Court Order
- Loss of eligibility (child turns 26 or age 18 if previously a foster or legal guardianship child)
- Death of a dependent
- Loss of other health insurance coverage

If you have questions on qualifying events see the Plan document, visit the Benefits website, or call the Benefits Department at 480-644-2299.

MEDICAL AND PRESCRIPTION DRUG BENEFIT HIGHLIGHTS AND RATES

You have the option to choose from three medical plan design options that are each Preferred Provider Organization (PPO) Plans with Cigna administration and Open Access Plus (OAP) provider (national) network: Basic Medical Plan, Choice Medical Plan and Copay Medical Plan.

Prescription drug benefits are administered within these medical plans by MedImpact Healthcare Systems, who provides access to all the major pharmacy chains and many independent pharmacies in the prescription provider network. Mail Order and Specialty Pharmacy are also available.

Specialty Drug Advocacy Services are available through PaydHealth who coordinates with MedImpact to determine patient eligibility for alternative funding and dispensing for many very high-cost Specialty medications. Participation is mandatory and outcomes can result in significant savings to both the patient and the Plan.

MEDICAL PLAN HIGHLIGHTS

	BASIC PLAN		CHOICE PLAN		COPAY PLAN	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Deductible	$500/Single $1500/Family	$1500/Single $4500/Family	$250/Single $750/ Family	$1500/Single $4500/Family	$0	$1500/Single $4500/Family
Coinsurance (Plan Pays)	50% after deductible	25% + balance billing after deductible	80% after deductible	50% + balance billing after deductible	N/A, you pay Copays depending on the service	50% + balance billing after deductible
Out-of-Pocket Maximum	$4000/Single $8000/Family	No Maximum	$2000/Single $4000/Family	No Maximum	$3575/Single $7150/Family	No Maximum
Preventive Care (Plan Pays)	100% no deductible applies	Not covered	100% no deductible applies	Not covered	100% no deductible applies	Not covered
Physician/Specialist Office Visit (You Pay)	$20 / $20 Copay	75% + balance billing after deductible	20% / 20% after deductible	50% + balance billing after deductible	$20 / $40 Copay	50% + balance billing after deductible
Chiropractic or Rehabilitation Therapy (You Pay)	50% after deductible	75% + balance billing after deductible	20% after deductible	50% + balance billing after deductible	$20 Copay	50% + balance billing after deductible
Inpatient Hospital Services (You Pay)	50% after deductible	75% + balance billing after deductible	20% after deductible	50% + balance billing after deductible	$300 Copay	50% + balance billing after deductible
ER Visit (You Pay)	50% after deductible	Same as In-Network	20% after deductible	Same as In-Network	$150 Copay	Same as In-Network
Behavioral Health Outpatient Visits (Plan Pays)	100% no deductible applies	25% + balance billing after deductible	100% no deductible applies	50% + balance billing after deductible	100% no deductible applies	50% + balance billing after deductible

PRESCRIPTION DRUG HIGHLIGHTS

	BASIC and CHOICE PLANS	COPAY PLAN

NOTE: Rx *Out-of-Pocket Maximums are separate from medical plan out-of-pocket maximums.*

	BASIC and CHOICE PLANS	COPAY PLAN
Annual RX Deductible	None	None
Out-of-Pocket Maximum	$2500/Single $5000/Family	$3575/Single $7150/Family
30-Day Supply - Retail and Specialty (You Pay)		
Generic (Tier 1 & 4)	20% (min $5, max $50) *Insulin same*	$15 *Insulin same*
Preferred Brand (Tier 2 & 5)	25% (min $30, max $100) *Insulin same as Tier 1*	$50 *Insulin same as Tier 1*
Non-Preferred Brand (Tier 3 & 6)	40% (min $50, max $150) *Insulin same except max $105*	$85 *Insulin $35*
Diabetic supplies, products, sensors, monitors, delivery devices	Covered 100% if Generic or Preferred Brand 40% (min $50, max $150) if Non-Preferred Brand	Covered 100% if Generic or Preferred Brand $85 if Non-Preferred Brand
90-Day Supply – Retail and Mail Order (You Pay)		
Generic Tier 1 & 4	20% (min $10, max $100) *Insulin same*	$25 *Insulin same*
Preferred Brand Tier 2 & 5	25% (min $50, max $200) *Insulin same as Tier 1*	$90 *Insulin same as Tier 1*
Non-Preferred Brand Tier 3 & 6	40% (min $80, max $300) *Insulin same except max $105*	$160 *Insulin $105*
Diabetic supplies, products, sensors, monitors, delivery devices	Covered 100% if Generic or Preferred Brand 40% (min $80, max $300) if Non-Preferred Brand	Covered 100% if Generic or Preferred Brand $160 if Non-Preferred Brand

MEDICAL/PRESCIPTION PLAN RATES PER PAY PERIOD (FT AND PT)

	BASIC PLAN	CHOICE PLAN	COPAY PLAN
SINGLE	$0.00	$76.50	$115.00
FAMILY	$0.00	$170.00	$346.00

DENTAL PLAN BENEFIT HIGHLIGHTS AND RATES

The City of Mesa offers three Dental Plan options: Preventive Dental Plan, Dental Choice Plan and the Dental Choice Plus Plan. Dental Plans are administered by Delta Dental of Arizona (DDAZ) and use the DDAZ PPO provider network and the extended Delta Dental Premier Network. Dental benefit levels are the same in and out-of-network; however, if you use in-network dental providers, your benefits are calculated off discounted dental provider charges rather than full billed charges for covered dental services and this will save both you and the plan money.

DENTAL PLAN HIGHLIGHTS

	Preventive Choice Plan	Dental Choice Plan	Dental Choice Plus Plan
Annual Deductible	• No deductible for preventive and diagnostic services • $50 deductible per individual for basic services • Family deductible will not exceed $150	• No deductible for preventive and diagnostic services • $50 deductible per individual for basic services • Family deductible will not exceed $150	• No deductible for preventive and diagnostic services • $50 deductible per individual for basic services • Family deductible will not exceed $150
Annual Maximum (Plan Pays)	$1,000/person	$2,000/person	$2,300/person
Preventive Services (Plan Pays)	100%	100%	100%
Basic Services (Plan Pays)	80%	80%	80%
Major Services (Plan Pays)	Not covered	80%	80%
Orthodontia (Plan Pays)	Not covered	Not covered	80% up to $1,500/year; $3,000 lifetime

DENTAL PLAN RATES PER PAY PERIOD (FT AND PT)

Single	**$0.00**	**$4.75**	**$12.25**
Family	**$3.00**	**$17.00**	**$57.00**

VISION CARE BENEFIT HIGHLIGHT AND RATES

VSP is our vision care insurance provider for annual eye exams/refractions and vision materials purchases. You can choose one of three plans offered that will best meet your needs: Basic Vision, Vision Plus or Vision Premium Plus.

The three plans differ primarily in the frequency with which you can receive materials purchases and some differences in allowances and copays or enhancements on vision materials.

Vision Plan Highlights

	Basic Plan		**Plus Plan**		**Premium Plus Plan**
	In-Network	Out-of-Network	In-Network	Out-of-Network	Premium Plus Plan offers same features as Plus Plan, but with enhanced options to include higher allowances or zero cost upgrades. One enhancement per member per year, and applied at the time of making purchase of prescription glasses and/or contact lenses: • $250 frame allowance • $300 contact lens allowance • Fully covered anti-reflective coating • Fully covered progressive lenses • Fully covered photochromic lenses. *Enhancement options are not available at Walmart, Sam's Club or Costco.*
Eye Exams • Covered every calendar year for all three plans					
Wellvision Exam	$10 copay	Up to $7o for Wellvision and Retinal Screening combined	$10 copay	Up to $7o for Wellvision and Retinal Screening combined	
Retinal Screening	$20 copay		$20 copay		
Prescription Glasses • Covered every OTHER year for Basic Plan, every calendar year for Plus and Premium Plus Plans					
Frames	$170 Allowance on wide selection of frames $190 on featured frame brands $95 at Walmart, Sam's Club, Costco	Up to $70 allowance	$170 Allowance on wide selection of frames $190 on featured frame brands $95 at Walmart, Sam's Club, Costco	Up to $70 allowance	
Single Lenses	$10 copay	$40 allowance	$10 copay	$40 allowance	
Bifocal Lenses	$10 copay	$60 allowance	$10 copay	$60 allowance	
Trifocal Lenses	$10 copay	$80 allowance	$10 copay	$80 allowance	
Contact Lenses • Covered every OTHER year on Basic Plan, every calendar year on Plus and Premium Plus Plans • Contact lenses are instead of prescription glasses on Basic plan, and in addition to a frames purchase in the Plus and Premium Plus Plans					
Fitting & Evaluation	Up to $60 allowance	Up to $60 allowance	Up to $60 allowance	Up to $60 allowance	
Elective	Up to $220 allowance	Up to $200 allowance	Up to $220 allowance	Up to $200 allowance	
Medically Necessary	$10 copay	$10 copay	$10 copay	$10 copay	

VISION RATES PER PAY PERIOD

	Basic Plan	Plus Plan	Premium Plus Plan
Single	$0.50	$2.58	$3.68
Family	$4.08	$9.78	$12.82

FLEXIBLE SPENDING ACCOUNTS (FSA) – HEALTH AND DEPENDENT CARE

FSA's are an opportunity for you to have pre-tax dollars withheld from your paycheck every pay period to pay for eligible healthcare or dependent care (child daycare or dependent elder care) expenses. These accounts administered by Navia Benefit Solutions, are a great way to save money for eligible expense reimbursements and lower your taxable income.

Participation in FSA's **requires enrollment during initial enrollment eligibility, and each year thereafter during the Open Enrollment period**. Enroll in the Healthcare FSA if you want to use the account to pay for eligible out-of-pocket medical expenses. Enroll in the Dependent Care FSA if you want to use the account to pay for eligible dependent care expenses.

FSA's are "use it or lose it" accounts, which means you'll forfeit any amount left in the account at the end of the plan year. ***This means you must plan and estimate your enrolled amounts with care.*** Healthcare FSA's have limited rollover eligibility from one plan year to the next, but to rollover eligible amounts from a prior plan year, you must be enrolled in a current year plan.

You cannot transfer funds from a Dependent Care FSA account to a Healthcare FSA account or vice versa.

HEALTHCARE FSA

With the Healthcare FSA, you can use funds to pay for eligible out-of-pocket expenses for medical, dental and vision care such as copays, coinsurance, and deductibles for you and your dependents. You may also pay for medical supplies and equipment, prescription drugs, orthodontia, eyeglasses, contact lenses and more. Exceptions – you cannot use FSA funds for cosmetic or general health and well-being services.

Your Healthcare FSA debit card will be loaded with your annual election amounts on January 1st. Any eligible rollover amounts are loaded generally by late February each year. The minimum annual election amount for Healthcare FSA is $100, and the maximum is $3,050. Eligible expenses for 2024 must be incurred from January 1, 2024 through December 31, 2024. This means that you can only use your Healthcare FSA debit card to pay for services that occur in 2024. If you are on a payment plan for a surgery or procedure that occurred in 2023 or earlier, you cannot use 2024 funds for this payment plan. The deadline to submit receipts for reimbursement for expenses incurred in 2024, is March 31, 2025.

Remember, plan carefully because unused funds at the end of the plan year will be forfeited. One exception to this rule is the $610 healthcare FSA rollover feature. This feature allows you to carry over up to $610 of unused funds from the 2024 plan year into the 2025 plan year, providing you enroll for a Health FSA Account for the 2025 calendar year.

An important FSA responsibility you need to keep in mind if you have a Health FSA account is substantiation requirements. This means action is required on your part to prove/document that your Healthcare FSA debit card purchases are true eligible expenses under IRS guidelines for yourself and your

qualified tax dependents. You will need to substantiate to Navia Benefit Solutions when they alert you. A substantiation request means you need an itemized statement/bill/invoice or EOB from your provider that includes all the following elements:

1. Date and place of service/product purchase
2. Description of services/products provided
3. To whom the services/products were provided
4. Cost/Charge for those services.

Documentation that does not provide all four elements is not adequate substantiation (e.g., a cash register receipt). If you do not effectively substantiate your FSA debit card purchases, you will be required to pay the money back to Navia Benefit Solutions so that you and the Plan remain compliant with IRS regulations. Note: For most major pharmacies, prescription drug purchases that you use your debit card to pay, are generally "auto substantiated" at time of purchase.

DEPENDENT CARE FSA

The Dependent Care FSA is a separate account in which you enroll every year to set aside pre-tax money from your paycheck to pay for dependent care expenses. Expenses could include childcare or qualified elder care expenses. The minimum annual amount to enroll is $100 and the maximum is $5,000 (depending upon your Federal tax filing status). You may use your Navia debit card to pay for dependent care expenses if your balance meets or exceeds your purchase. Check your dependent care balance on the Navia portal or mobile app, then swipe your card for not more than your balance. Your Navia debit card may be declined at some daycare providers because they are not an approved vendor. There is no roll-over feature for the Dependent Care FSA, so plan carefully because any unused funds will be forfeited. Pay attention to changes in your dependent care needs throughout the year and if you are no longer paying for childcare or your children age-out of childcare eligibility etc. be sure to complete a timely drop of your dependent care election, so deductions can cease going forward.

GROUP TERM LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

BASIC GROUP TERM LIFE AND BASIC AD&D

The City of Mesa, through MetLife, helps protect your beneficiaries by providing full-time employees with free Basic Life insurance coverage equal to your annual base salary rounded up to the next higher $1,000. The maximum amount of basic coverage provided is $500,000.

AD&D insurance provides your beneficiaries with additional protection if loss of life is due to an accident, in which case coverage doubles (an additional amount equal to your Basic Life amount is paid to your beneficiaries). Basic AD&D coverage premiums are paid by the City of Mesa at no cost to you.

You are automatically enrolled in Basic Life and AD&D if you are eligible. Your only responsibility is to keep your beneficiaries current in the eBenMesa application for Beneficiary Designations. Open Enrollment is an ideal time to review and update beneficiaries.

Note: If you are an Elected Official, City Manager or an Executive Pay Plan employee, your coverage levels may vary. See the City of Mesa's Plan Document, MetLife Certificate of Coverage, or contact the Employee Benefits department for more information.

SUPPLEMENTAL LIFE AND AD&D
If you would like to purchase additional protection, MetLife offers Supplemental Life and AD&D Insurance to full-time and part-time benefit eligible employees for you, your spouse/committed partner, and your children.

Supplemental Life insurance coverage for you and your spouse/committed partner is available in $10,000 increments up to a maximum of $300,000. Coverage amounts for your spouse/committed partner cannot exceed your own Basic and Supplemental Life coverage amounts combined. For example, if you have $50,000 basic life coverage provided by the City and you are enrolled in Supplemental Life for $100,000 coverage, then your total amount of life insurance coverage = $150,000. This $150,000 is the maximum amount of Supplemental Life Insurance coverage that you can elect for your spouse or committed partner. Some or all your election for your spouse/committed partner is subject to evidence of insurability requirements with MetLife depending upon the timing of when you are enrolling a spouse/committed partner in coverage.

Supplemental Life Insurance for your dependent children up to 26 years of age (age 18 if legal guardian or foster children) can be purchased in increments of $2,500 up to a maximum of $10,000. Note: If a life insurance claim is filed for covered child under 6 months of age, the maximum life insurance amount is limited to $500 even if you elected a higher amount of coverage.

If you enroll in Supplemental Life Insurance coverage, you and each of your covered family members are automatically enrolled in an equal amount of Supplemental AD&D Insurance coverage. This doubles the coverage if loss of life is due to an accident and provides even more protection for you or your beneficiaries under these circumstances.

EVIDENCE OF INSURABILITY REQUIREMENTS
New hires to the City can purchase Supplemental Life insurance up to $150,000 (this is called the Guaranteed Issue amount - GI) with no evidence of insurability requirements (a Statement of Health Form and process) for MetLife. For spouse/committed partner, a new hire can purchase up to $30,000 coverage without the spouse/committed partner satisfying evidence of insurability. For dependent children, evidence of insurability is not required for any amount of coverage.

During Open Enrollment, you can increase your Supplemental Life insurance coverage without completing a Statement of Health Form/process with MetLife, up to a total of $20,000 providing the total Supplemental Life coverage amount remains below $150,000 and providing you had at least $10,000 coverage already in place. If your increment amount is more than $20,000, or your total coverage amount is more than $150,000, or if you are a late entrant with $0 Supplemental Life coverage currently, you will need to satisfy evidence of insurability requirements (Statement of Health Form and process with MetLife) before the increased coverage amounts can be activated. Any amount of increase in spouse/committed partner Supplemental Life Insurance coverage during Open Enrollment requires a Statement of Health Form/process. For your dependent children, a Statement of Health form is not required if you choose to add or increase their coverage during Open Enrollment.

SUPPLEMENTAL LIFE & AD&D RATES
Supplemental Life and AD&D rates for you and your spouse/committed partner are based on age as of the first of a calendar year (or age at the time of a new hire enrollment activation).

Age Band	Monthly Cost per $10,000 of Supplemental Life/AD&D Coverage for Employee/Spouse/Committed Partner
<29	$0.80
30-34	$1.00
35-39	$1.20
40-44	$1.40
45-49	$2.60
50-54	$3.40
55-59	$5.40
60-64	$7.60
65-69	$13.20
70+	$21.00

Supplemental Life and AD&D rates for children are not based on age, but rather based upon the amount of coverage you select.

Amount of Coverage	Monthly Cost of Supplemental Life/AD&D Coverage for Dependent Children
$2,500	$0.30
$5,000	$0.60
$7,500	$0.90
$10,000	$1.20
***Monthly rates cover all eligible children-whether 1 or multiple children.**	

BUSINESS TRAVEL ACCIDENT/COMMUTER TRAVEL ACCIDENT (BTA) INSURANCE

Business Travel Accident/Commuter Travel Accident Insurance is another protection the City of Mesa provides to full-time, active employees free of charge. The coverage is through New York Life Group Benefit Solutions. Eligible employees receive the following:

$200,000 of coverage for accidental death while traveling on City business locally, out of town, or out of state, or commuting to and from work.

Eligible employees are automatically enrolled in this benefit. Your beneficiary designation is automatically the same as your Basic Life beneficiary designation, so be sure to keep this current.

SHORT TERM DISABILITY (STD) INSURANCE

STD voluntary insurance coverage is available for purchase through Unum. This benefit provides 66.66% of your base salary to a maximum weekly benefit of $2,000, if you become unable to work due to a covered injury, illness, or pregnancy. With STD plans, you must satisfy a waiting period after a covered disability commences before benefits can start to pay. Unum offers three different waiting period options. Premiums vary based on the waiting period you select – the shorter the waiting period, the higher the premium rate you will pay.

Waiting Period	Monthly Cost per $10 of Weekly Disability Benefit
14 day	$0.675
29 day	$0.1777
44 day	$0.146

Take a moment to review the rates for each plan and consider whether you're in the plan most appropriate for you. Questions to ask yourself include:

1. Do I have any planned procedures, conditions, or circumstances that will require me to be out of work for up to six months, and will I have enough paid time off income from the City to get me through the work time I lost during the insurance waiting period?
2. For unplanned events, how much sick, vacation and other paid time off accruals do I have that will get me through the work time I lost during the insurance waiting period?
3. If I only plan to be out for a few days or weeks, am I better off using my paid time off accruals since it will cover my pay at 100% instead of using STD, which only covers a percentage of my pay?

The eBenMesa enrollment system Short Term Disability tab has a calculation tool you can use to determine your cost of STD coverage.

Note: When you enroll in STD Plans for the first time or change to an STD plan with a shorter waiting period, you will have a pre-existing limitation of benefits applied to you. A pre-existing condition is any medical condition for which you were diagnosed, treated, or experienced symptoms of before the coverage effective date. This means for any claim that you file during the first six months after your coverage is effective, if that condition arose or was treated by a provider during the three-month period prior to your coverage effective date, your disability benefit may be reduced. The pre-existing limitation will no longer apply after you have been enrolled in the plan for 6 months.

LINKS TO REQUIRED NOTICES

Healthcare Exchange Letter

HIPAA Privacy Notice

Medicare Notice of Credible Coverage

Newborns' and Mothers' Health Protection Act

Children's Health Insurance Program (CHIP)

Women's Health and Cancer Rights Act of 1998

COBRA Initial Notification

Summary Benefit Comparisons (SBC's)

- Basic Medical Plan | Choice Medical Plan | Copay Medical Plan

Plan Document

CONTACTS

Administrator	Customer Service	Web Portal
Cigna	**800-244-6224**	www.mycigna.com
MedImpact	**866-387-3537**	www.medimpact.com
PaydHealth	**877-869-7772**	
Delta Dental	**602-588-3981**	www.deltadentalaz.com
Vision Service Plan (VSP)	**800-877-7195**	www.vsp.com
Navia Benefit Solutions	**800-669-3539**	www.naviabenefits.com
Unum	**888-673-9940**	www.unum.com
ComPsych	**866-519-7415**	www.guidanceresources.com
LegalShield/IDShield	**480-695-0501**	www.legalshield.com/info/cityofmesa
United Pet Care	**877-872-8800**	www.unitedpetcare.com