



CITY OF MESA HEALTH PLAN Retiree Enrollment Workbook 2012 Summary of Benefits

2012 Open Enrollment starts October 24 and ends November 4, 2011

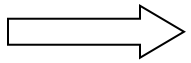
Open Enrollment changes are effective 1/1/2012

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What's New For 2012



The following changes are effective January 1, 2012

Descriptions of these changes are found in the Enrollment Workbook

Pharmacy Plan

For the 2012 plan year, Medco Health will continue their services as the prescription drug provider for both in-state and out-of-state members. They will provide dedicated customer service, including a phone line, and an overall cost savings to the City of Mesa members. Although some brand name copays will increase (see Prescription Drug Plan), effective mid-January, members will now have the option of filling 90 day generic prescriptions at retail pharmacies for two months' copay. In addition 30 day generic prescriptions will be filled at the monthly copay, without the "retail penalty" increase in cost.

The copays for brand name prescriptions filled under the Copay Plan have increased for 2012, but the copay for generics has decreased. While the coinsurance plans are self-adjusting as the costs of medications go up because the applicable percentage of the higher cost results in a higher coinsurance, the copays have not been adjusted to keep pace with the increase in medication costs.

In some cases, the minimums and maximums have increased, as well, to keep pace with increases in medication costs. The minimum cost will also be calculated differently in 2012. Currently, the cost for the medication is the greater of the minimum coinsurance or the cost of the medication. For the 2012 plan year, the prescription cost is now the lesser of the minimum coinsurance or the cost of the medication.

There are no significant changes to either the Medco network or the formulary for 2012 at this point. However, formulary changes occur during the year, and we expect there will be some in 2012 as a result of several brand names going generic throughout the year. You can visit the Medco website, www.medcohealth.com, for the most current formulary listing.

Premiums

Last year at this time, we anticipated that after three years of not having health insurance premium increases and significant increases in plan utilization and health care costs, premium increases would be required. An additional goal was to establish consistency in the City's contribution to each plan and coverage level of 80%, based on the Choice PPO plan. A plan was developed to phase in scheduled gradual increases in premiums with the City providing the majority of the additional revenues.

Due to cost savings in the plan and the premium increases for 2012, we project achieving our three year goal in two years. Many retirees will have no increase in premiums and others will experience an increase equal to or less than the scheduled increase. The family coverage premiums under the Copay Choice plan will have premiums higher than anticipated due to increases in plan utilization and realignment of family plans to single plans.

Retiree premiums are based on the plan and coverage level, number of years of service, ASRS/PSPRS subsidy, and Medicare discount. Individual premium notifications will be mailed to retirees during open enrollment.

[Dental plan](#) premiums will not increase and [vision](#) premiums will increase only slightly.

Social Security Number Requirement

To comply with [federal law](#), social security numbers for retirees, their spouses, and their children **must** be entered in the online enrollment system to complete enrollment. If you are planning to add dependents, be sure to have their social security numbers before starting online enrollment.

Improved network for members living out of the state of Arizona

For those of you who reside or who have dependents who reside all or part of the year outside the state, including at school or on a mission, you'll be glad to know that the City has expanded the Blue Cross Blue Shield network for you. To enroll in the [out-of-state BCBS plan](#) you must submit the enrollment form (available on www.mesaaz.gov/benefits) and provide documentation of out-of-state address to the Benefits Office by the end of open enrollment at 6:00 p.m. on Friday, November 4.

There is no additional charge for eligible members to enroll in the out-of-state network plan, but any out-of-state member who is not enrolled will only be covered under the out-of-network benefit. The member will be responsible for the out-of-network deductible and co-insurance. *Note: out-of-network co-insurance does not apply to emergency care in a life or limb threatening situation.*

The HealthSmart network will be replaced with BCBS and will no longer be available effective January 1, 2012. **You will receive new ID cards** with your out-of-state member number from Blue Cross Blue Shield. Your out-of-state member ID number may be different than your employee ID #. This new card **must** be presented to your health care provider and retail pharmacy after January 1, 2012, whether it is a new provider or one you have seen before. If you do not present your new card, your claim may be denied. ***Please destroy your previous card*** to prevent unauthorized use.

24 Hour Nurse Line 866-422-2729 (Available 1/1/12)

Did you ever have a time when you weren't quite sure whether you needed to go to see your doctor or not? Or whether the symptoms you were having meant you needed to go to the emergency room, or if urgent care – or maybe even calling your doctor the next morning – would be OK? Starting on January 1, 2012, you won't have to wonder anymore, because you can call a Blue Cross Blue Shield professional nurse, 24 hours a day, 7 days a week, to talk over your symptoms and situation, and get professional advice on what your next steps should be. All you have to do is pick up the phone and dial, whenever it is or wherever you are.

Changes to 2012 Plan Document

- Chiropractic and physical therapy visits will be limited to a total of 25 per year unless additional visits are determined to be medically necessary through the utilization review program.
- Including the basis for allowable charges in the definition.
- Clarification of medical necessity requirements – adding medical necessity determination by utilization review to physician ordered treatment and including language that specifies that costs incurred as a result of provider error are not covered under the plan.
- In the copay plan, deletion of the \$20 copay for dialysis.
- Clarification of Medicare coordination of benefits requirements to specify that disabled dependent children must apply for Medicare when the parent is no longer an active employee and that members who are diagnosed with end stage renal disease must apply for Medicare when they become eligible.

REMINDER Retirees and their dependents are required to enroll in Medicare Part A and Part B when eligible, at age 65 or earlier if eligible due to disability. Failure to enroll in Medicare will result in termination of City of Mesa health insurance coverage without option to re-enroll.

Open Enrollment Instructions

Open Enrollment begins October 24 and ends on November 4, 2012 at 6:00 P.M. The online system will open on October 24.

IMPORTANT!!! READ THIS BEFORE YOU BEGIN THE ONLINE PROCESS

Review the workbook. Premiums for some plans are changing for the 2012 plan year and there are prescription drug plan design changes, as well. You need to consider these changes to make the best health plan choices for yourself and your family.

Retirees who have or who anticipate a status change (e.g., newborn, marriage, divorce, or adoption) that becomes effective in October or November 2011, please contact the Employee Benefits Office **before** doing your on-line enrollment. Do not try to add or drop your dependents online until you have contacted either Laura Kolsrud at (480) 644-5837 or Leslie Rogers at (480) 644-2648. For example, if you are getting married on October 22, 2011, contact us before adding your new spouse online.

1. Access the Internet, and type www.mesaaz.gov/benefits in the web browser window.
2. Click on the "OPEN ENROLLMENT ENTER HERE" button to access the Open Enrollment System. Do **not** click on "Member Login."
3. In the Insured ID field, type your 5-digit ID number found on your health insurance card. If you don't have an insurance card and don't know what your Insured ID number is, contact Benefits.
4. In the Password field, type the following **Initial Password** scheme: The first four letters of your last name* (in upper or lower case) plus the last four digits of your Social Security Number (SSN).

*If your last name contains:	Last Example Name	Your SSN is:	Your password is:
Four or more letters	JONES	987654321	JONE4321
Two or three letters	COX	987634321	COX4321
More than one name	DE LA TORRE	987654321	DE L4321 (System reads space as a character)
An apostrophe	O'MEARA	987654321	OMEA4321 (System does not read apostrophes)
A hyphen after the first 3 letters	DEL-MONTE	987654321	DEL 4321 (Substitute a space for the hyphen)

You have five chances to enter your Insured ID and Password correctly. **After the fifth try, you will be locked out of the system.** After 10 minutes, you can attempt to login again.

5. On the next screen, follow these steps:
 - a. Enter your 5-digit Insured ID (see above).
 - b. Re-enter the Initial Password scheme (see Step 4)
 - c. In the next box, create an entirely new password of at least six letters and numbers.
 - d. Re-enter the New Password.
 - e. Click the "Save Password" button.

Write your New Password here: _____

NOTE: This password is for the Open Enrollment system *only*; it is not your mesaaz.gov/benefits login.

6. Carefully follow the instructions for each portion of the Open Enrollment System.
7. When you complete the check out process, print a copy of your confirmation for your records. **Please review your confirmation sheet to make sure you have enrolled correctly.**
8. Sign out when your session is complete.

Need assistance?
Review "Helpful Hints for Online Enrollment" on the next page, or call us at (480) 644-2299

On Friday, November 4, our phones will be answered from 7:00 a.m. to 6:00 p.m., although the office will be closed to walk in traffic

MESA HEALTH PLAN Enrollment Workbook 2012 Benefits Package

All benefits described in this summary of benefits document are for general information only. The [Plan Document](#) describes in detail the benefits covered under the plan.

OPEN ENROLLMENT

Although retirees are not required to participate in open enrollment, this is your opportunity to make changes to your current benefit plan options for the coming year. The annual Open Enrollment period allows you to reevaluate current benefits and decide if a change should be made. You may add, delete, or change coverage or dependents once each year during open enrollment.

Open Enrollment begins October 24 and ends on November 4, 2011 at 6:00 P.M.
The online system will open October 24.

Who needs to participate in open enrollment?

- **Retirees** who wish to make changes to their health plans.
- **EVERYONE** who wants to participate in our satisfaction survey (See below for more information)

Retirees whose address is outside the state of Arizona will automatically be enrolled in their current plan in the out-of-state network.

REMEMBER: Currently enrolled retirees who do not make any changes to benefit selections and/or change who is covered during the Open Enrollment period or within 31 days of a change in status must wait until the next year's open enrollment to make a change.

AT TIME OF RETIREMENT

New retirees must be enrolled in a plan on the date of retirement to continue on that plan as a retiree. Retirees may not make plan changes at the time of retirement; those changes may not be made until the open enrollment following their retirement.

ARE YOU PAYING TOO MUCH FOR HEALTH INSURANCE?

If you are on Medicare and are enrolled in the Choice Plus plan, you're probably paying too much for your health insurance. Medicare pays most of your costs. The difference between the costs that the City will cover under the Choice and Choice Plus plans is only 10%. For example, on \$10,000 in costs, you'd only pay about \$1,000 more on the Choice 80/20 plan, but you could be paying up to \$441 *each month* more in premiums.

When you use out-of-network providers, you are paying much more for your health insurance coverage than you need to. If you are on the Copay or Choice plans, your out-of-network deductible is \$1,000 and your co-insurance is 40%. In 2012, medical out-of-network services will be subject to allowable costs which may also increase out of pocket costs. **You** are responsible for making sure all your providers are in-network. Ask your doctor to save you money by referring you to in-network providers.

**Open Enrollment closes promptly at 6:00 p.m.
on Friday, November 4, 2011!**

**The Benefits Office will answer calls on Friday, Nov. 4
from 7:00 a.m. to 6:00 p.m.**

CHANGING ENROLLMENTS IN CITY OF MESA BENEFIT PLANS

Enrolling Dependents for the First Time

Members who enroll in family coverage and whose eligible dependents have never been enrolled in one of the City-sponsored plans before MUST submit copies of the following documents, as applicable, to the Employee Benefits Office BEFORE coverage begins:

- Marriage Certificate, if enrolling a spouse or stepchildren
- Birth Certificates, adoption documents or other court documentation verifying legal guardianship, if enrolling one or more children
- Natural parent's divorce decree (if applicable) and the stepchild(ren)'s birth certificate(s) if enrolling one or more stepchildren
- Proof of insurance if you or your dependents are covered under another health insurance plan

Who Are My Eligible Dependents?

- Legal spouse
- Natural children and stepchildren under age 26
- Legally adopted children, foster children, or children for whom you/your spouse are a court-appointed guardian under age 26

When Can I Add or Drop a Dependent?

The IRS has certain rules governing employer sponsored group health benefits.

- Benefit elections can only be changed during the year if there is a Qualified Status Change
- Changes that are consistent with the status change may be made mid-year
- Enrolling in or opting out of coverage
- Adding or removing dependents
- Changing your FSA election.
- Employee Benefits must be contacted within 31 days of the event or the change must wait until the next open enrollment

MID YEAR QUALIFIED STATUS CHANGES

Change in status is the only time currently enrolled retirees can change their coverage, including Flexible Spending Account deductions, during the year, other than open enrollment. Any time life circumstances change, **the retiree is responsible** for making appropriate benefit enrollment changes within 31 days of the qualifying event. These changes in status include:

- Marriage
- Divorce
- Birth, adoption or legal custody of a child
- Dependent no longer eligible under the plan due to age
- Death of dependent (spouse or child)
- Spouse loses or gains coverage eligibility due to change in employment
- Spouse's open enrollment period

Retirees must notify the Benefits office within 31 calendar days of the date of the change for dependents to be added to or deleted from coverage.

Helpful Hints for Online Enrollment

1. Use the Action Checklist as you review the Open Enrollment/Benefits Package to mark your coverage selections before you begin the Online Enrollment process.
2. Can't get into the Open Enrollment system? Did you click on the blue button labeled, "OPEN ENROLLMENT ENTER HERE"? If you clicked on "Member Login," you are not in the right area. The Member Login is different from the Open Enrollment System Login.
3. Member ID not being accepted? Did you type in 4 digits instead of 5? The old 4-digit IDs require a leading zero. For example, if your employee ID is 1001, enter it as 01001.
4. If you enter the system for a second time, remember that you changed your password after you entered the initial password scheme. The new password is a combination of letters and numbers, at least six characters long. Did you write your new password on the Open Enrollment Instructions page in the space provided? If you did not and you can't remember what you changed your password to, use the "Change Password" link on the first screen of the Open Enrollment system.
5. Carefully follow the instructions on each portion of the Online Enrollment screens.
6. Going from single coverage to family coverage? Be sure to click on Family Coverage for each plan (medical, dental, vision) you wish to switch to family coverage. A new section will appear asking you to add your dependents. Going from family to single coverage? Be sure to click on Single Coverage.
7. Remember to submit any [verification paperwork](#) to the Benefits Office no later than 6 pm on Monday, November 11, 2011. Failure to comply with this requirement may result in a change in your elected coverage.
8. If you have questions on any of these tips or if you are still experiencing problems with your online enrollment, please contact us at (480) 644-2299 during business hours, M-Th, 7:00 a.m. to 6:00 p.m.



WE WANT TO KNOW!

At the end of the online open enrollment there will be a link to our survey. We hope you will take the time to complete it and let us know how we can better serve you!

IMPORTANT NOTICE REGARDING ONLINE ENROLLMENT

If you have or anticipate a status change (i.e., newborn, marriage, divorce, or adoption) that becomes effective in October or November, please contact Laura Kolsrud at (480) 644-5837 or Leslie Rogers at (480) 644-2648 in the Employee Benefits Office **before** doing your on-line enrollment. For example, if you are getting married on October 22, contact us before adding your new spouse online.

Mesa Health Plan Highlights 2012

	CHOICE PPO PLAN 80/20		CHOICE PLUS PPO PLAN 90/10		BASIC CHOICE PLAN 50/50		COPAY CHOICE	
Medical Services	In-Network PPO & Par Providers	Out-of- Network*	In-Network PPO & Par Providers	Out-of- Network*	In-Network PPO Providers Only	Out-of – Network*	In- Network PPO Provider s Only	Out-of- Network*
Deductible per calendar year	\$300 per person; \$900 per family	\$1000 per person; \$3000 per family	\$200 per person; \$600 per family	\$1000 per person; \$3000 per family	\$550 per person; \$1650 per family	\$1000 per person; \$3000 per family	None	\$1000 per person; \$3000 per family
Hospital Services	After deductible, 80%	After deductible, 60%	After deductible, 90%	After deductible, 70%	After deductible, 50%	After deductible, 25%	\$100 copay OP; \$200 copay IP	After deductible, 60%
Physician & Health Care Practitioner Services	After deductible, 80%	After deductible, 60%	After deductible, 90%	After deductible, 70%	\$20 copay for sick OV, all other 50% after deductible	After deductible, 25%	\$20 copay	After deductible, 60%
Chiropractic visits – 25/calendar year	After deductible, 80%	After deductible, 60%	After deductible, 90%	After deductible, 70%	After deductible, 50%	After deductible, 25%	\$20 copay	After deductible, 60%
Rehabilitation Services	Rehabilitation Services include physical therapy, occupational therapy, and speech therapy as defined in and covered under the plan							
	After deductible, 80%	After deductible, 60%	After deductible, 90%	After deductible, 70%	After deductible, 50%	After deductible, 25%	\$20 copay	After deductible, 60%
X-Ray, Diagnostic	After deductible, 80%	After deductible, 60%	After deductible, 90%	After deductible, 70%	After deductible, 50%	After deductible, 25%	No deductible, 100%	After deductible, 60%
Emergency Room	After deductible, 80%	After deductible, 80%	After deductible, 90%	After deductible, 90%	After deductible, 50%	After deductible, 50%	\$100 copay, (\$200 copay if admitted)	\$100 copay, (\$200 copay if admitted)
Urgent Care Facility	After deductible, 80%	After deductible, 60%	After deductible, 90%	After deductible, 70%	After deductible, 50%	After deductible, 25%	\$50 copay	After deductible, 60%
Durable Medical Equipment (DME)	Includes durable medical equipment rentals and purchases as defined in and covered under the plan							
	After deductible, 80%	After deductible, 60%	After deductible, 90%	After deductible, 70%	After deductible, 50%	After deductible, 25%	\$20 copay	After deductible, 60%
Preventive Care and Immunizations	In network preventive immunizations and other services as required by federal guidelines are payable at 100%, no deductible, copay, coinsurance, or maximum. See plan document for details.							
	100%	Not Covered	100%	Not Covered	100%	Not Covered	100%	Not Covered
Behavioral/ Mental Health Office Visits	After deductible, 80%	After deductible, 60%	After deductible, 90%	After deductible, 70%	After deductible, 50%	After deductible, 25%	\$20 copay	After deductible, 60%
Alternative Health Care (Acupuncturists, Naturopaths, Homeopaths) office visits	After deductible, 80% up to \$1,000/year	After deductible, 60% up to \$1,000/year	After deductible, 90% with no annual max	After deductible, 70% with no annual max	Not Covered	Not Covered	Not Covered	Not Covered
Out of Pocket Maximum	\$2,000 per person	None	\$1,000 per person	None	\$5,000 per person	None	None	None

This chart is a **summary** of how eligible services will be covered. For a complete list of services and more detailed information, please refer to the City of Mesa Health Plan Document available at www.mesaaz.gov/benefits or from Employee Benefits.

*Allowable costs will be applied to out-of-network services in addition to the deductibles and co-insurance specified.

Prescription Plan Highlights 2012

Prescription drug benefits are available through the Plan's prescription drug network, Medco. For locations of the network pharmacies or information on which types of drugs are covered contact Medco at 1(877)476-9270 or visit their website at www.medcohealth.com.

Generic Drugs

- If a generic drug is available and the member or physician refuses substitution to generic
 - The member will pay the appropriate percentage or copay PLUS
 - The difference in cost between the generic and brand name drug
- Choose generic medications whenever possible.
 - You can now get a 90 day supply of generic medication at a retail pharmacy for twice the copay. In addition 30 day generic prescriptions will be filled at the monthly copay, without the "retail penalty" increase in cost.

Certain Maintenance Medications

- After the third refill at retail
 - Medco may send the member a letter recommending that maintenance medications be filled through the Mail Order Pharmacy
 - Members who do not want to use the Mail Order Pharmacy for these medications will pay double the Retail copay and the coinsurance will increase by 5%
 - Minimum and Maximum copays will also be increased

Choice, Basic, and Choice Plus Plans

- Brand name drugs for which there is no generic equivalent will be subject to the appropriate brand name coinsurance
- These drugs will not be payable at the Generic rate.

Prescription Drugs Covered Under this Plan

- Most drugs, including injectable and specialty medications, are covered
- Some drugs require prior authorization. Members who have questions about whether specific drugs are covered should contact Medco at (877) 476-9270
- Members should purchase all prescriptions, especially injectable and specialty medications, through Medco whenever possible

Generic Medications for \$4 per Month

- Many retail pharmacies offer 30 day supplies of generics for \$4 and \$10 for 90 days
- These pharmacies include **Wal-mart, Target, Fry's and Basha's**
- We highly recommend you take advantage of these low-cost prescriptions whenever possible
- The cost of these discounted prescriptions **IS NOT** reimbursable through the Employee Benefit Trust Fund, using them will save you and the Fund money

For detailed information on prescription drug coverage refer to the City of Mesa Plan Document at www.mesaaz.gov/benefits.

**MESA PRESCRIPTION BENEFIT 2012
(effective mid-January)**

Choice and Choice Plus Plans	Annual Deductible per Person	Generic		Formulary Brand**		Non-Formulary Brand**	
		2011	2012	2011	2012	2011	2012
RETAIL – Up to 30-day Supply							
Member Pays	\$50.00*	20%	20%	25%	25%	40%	40%
Minimum Copay per Rx		\$5.00	\$5.00	\$25.00	\$30.00	\$35.00	\$50.00
Maximum Copays per Rx		\$50.00	\$50.00	\$100.00	\$100.00	\$100.00	\$150.00
*Deductible waived on generic							
MAIL ORDER – Up to 90-Day Supply							
Member Pays	\$ 0.00	20%	20%	25%	25%	40%	40%
Minimum Copay per Rx		\$10.00	\$12.50	\$50.00	\$75.00	\$80.00	\$125.00
Maximum Copays per Rx		\$100.00	\$100.00	\$200.00	\$200.00	\$200.00	\$300.00
** Medications with no generic alternative are covered as Formulary or Non-Formulary Brand							

Copay Choice Plan	Generic		Formulary Brand**		Non-Formulary Brand**	
	2011	2012	2011	2012	2011	2012
RETAIL – Up to 30-day Supply						
Member Pays	\$15.00	\$10.00	\$35.00	\$40.00	\$65.00	\$75.00
MAIL ORDER – Up to 90-Day Supply						
Member Pays	\$30.00	\$20.00	\$70.00	\$80.00	\$130.00	\$150.00
** Medications with no generic alternative are covered as Formulary or Non-Formulary Brand						

Basic Choice Plan	Annual Total Deductible per Person (mail+retail)	Generic		Formulary Brand**		Non-Formulary Brand**	
		2011	2012	2011	2012	2011	2012
RETAIL – Up to 30-day Supply							
Member Pays	\$250.00	20%	20%	25%	25%	40%	40%
Minimum Copay per Rx		\$5.00	\$5.00	\$25.00	\$30.00	\$35.00	\$50.00
Maximum Copays per Rx		\$50.00	\$50.00	\$100.00	\$100.00	\$200.00	\$200.00
MAIL ORDER – Up to 90-Day Supply							
Member Pays	\$250.00	20%	20%	25%	25%	40%	40%
Minimum Copay per Rx		\$10.00	\$10.00	\$50.00	\$50.00	\$80.00	\$80.00
Maximum Copays per Rx		\$100.00	\$100.00	\$200.00	\$200.00	\$300.00	\$300.00

Mesa Dental Plan 2012

The Dental Plans available under the Mesa Choice Plan are self-insured and self-administered. You may choose any dental care provider. There are no in-network or out-of-network provisions under these plans. Claims are processed by the City of Mesa Benefits office.

Members have three plans from which to choose based upon their individual and family needs. The dental plans are:

- **Preventative Choice Plan** – Preventative services and basic restorative care to \$500 annually
- **Dental Choice Plan** – Preventative, basic, and major restorative coverage to \$1,200 annually
- **Dental Choice Plus Plan** – Coverage to \$1,500/year; orthodontia for children under age 19

Dental Premiums

Premiums for the three dental plans have been determined based upon the value of the individual plan. Premiums are deducted one month ahead on a pre-tax basis.

MESA CHOICE DENTAL PLAN HIGHLIGHTS 2012			
DENTAL SERVICES	PREVENTATIVE CHOICE PLAN	DENTAL CHOICE PLAN	DENTAL CHOICE PLUS PLAN
Deductible per calendar year	\$100/person; \$300/family Restorative care only	\$100/person;\$300/family Restorative care only	\$100/person; \$300/family Restorative care only
Preventative visits Include exam, tooth cleaning, periodic x-rays (excludes periodontal)	Not subject to deductible 100%	Not subject to deductible 100%	Not subject to deductible 100%
Basic Restorative, sealants* (under 19) fluoride, fillings, extractions)	After deductible, 80%	After deductible, 80%	After deductible, 80%
Major Restorative (crowns, bridges, root canals, dentures, oral surgery, periodontal, & endodontic)	Not Covered	After deductible, 80%	After deductible, 80%
Orthodontia coverage applies only to dependent children under age 19	Not Covered	Not Covered	No Deductible, 80% Coverage, \$1,200 Max. Payable/Year \$2,400 Maximum Payable Lifetime
Annual Maximum Payable	\$500 per person	\$1,200 per person	\$1,500 per person

This chart is a summary of how eligible services will be covered. For a complete list of services and more detailed information, please refer to the City of Mesa Health [Plan Document](#) available at www.mesaaz.gov/benefits or from Employee Benefits.

Non-Covered Dental Services

As with the medical plan, there are certain services that are not covered under any of the dental plans. They include:

- Expenses exceeding the Allowed amount (see below)
- Orthodontia for children under age 19 that started **before** benefits began with the City of Mesa
- Analgesia, sedation, hypnosis, nitrous oxide and/or related services provided for apprehension or anxiety, except when medically necessary
- General anesthesia, except for impacted teeth or as necessary for teeth covered partially or totally by bone, root canal treatment or gingivectomy.
- Cosmetic services, including but not limited to veneers and facings
- Drugs and medicines (these may be covered under the prescription plan)
- Dental implants
- Athletic mouth guards

For more information about these and other services that are not covered, please refer to the [Plan Document](#) or contact Employee Benefits at (480) 644-2299.

Allowed Charges

ALL dental charges that are submitted to the Benefits Office are compared to a schedule of allowed charges before they are processed.

- When the billed charge for services is higher than the amount allowed for the provider's location (by zip code), benefits will be paid based on the allowed amount
- The member is responsible for paying the difference between the billed charge and the allowed amount
- To avoid paying more than the allowed charges for dental services, members should have providers submit a Predetermination of Dental Benefits form to the Employee Benefits Office **BEFORE** services are rendered
 - The Benefits Office will indicate any costs over the allowed charges
 - Deductibles and coinsurance will be determined based upon the provider's estimate of costs

The dental rates for 2012 have not increased.

2012 DENTAL CHOICE PLAN			
	Total Premium	City Contribution	Retiree Contribution
Single	\$95.00	\$85.50	\$9.50
Family	\$170.00	\$136.00	\$34.00

DENTAL CHOICE PLUS PLAN			
	Total Premium	City Contribution	Retiree Contribution
Single	\$110.00	\$85.50	\$24.50
Family	\$250.00	\$136.00	\$114.00

PREVENTIVE CHOICE PLAN			
	Total Premium	City Contribution	Retiree Contribution
Single	\$85.50	\$85.50	\$0.00
Family	\$142.00	\$136.00	\$6.00

Mesa Choice Vision Plan 2012

Vision care benefits are provided by Vision Service Plan (VSP). The City offers its members two types of plans:

- **Basic Vision** – Offers basic coverage at a nominal cost.
- **Vision Plus** – Offers additional coverage for a higher monthly premium.

Select a Participating Provider at www.vsp.com or call 1-800-877-7195.

VSP IN-NETWORK PLAN HIGHLIGHTS

	BASIC VISION PLAN 12/24/24	VISION PLUS PLAN 12/12/12
Comprehensive Vision Exam	\$10 copay, once every 12 months	\$10 copay, once every 12 months
Materials	\$10 copay, once every 24 months	\$10 copay, once every 12 months
The materials copay is a single payment that applies to the entire purchase of eyeglasses (lenses and frames), or contacts in lieu of eyeglasses.		
Pair of Lenses for Eyeglasses	Once every 24 months	Once every 12 months
<ul style="list-style-type: none"> • Standard single vision • Standard lined bifocal • Standard lined trifocal 	Covered in Full Covered in Full Covered in Full	Covered in Full Covered in Full Covered in Full
Lens Options		
<ul style="list-style-type: none"> • Standard Scratch Coating • Tints • Polycarbonate Lenses* • UV Coating • Basic Progressive Lenses *Covered in Full for Children under 18	Available at a discount Available at a discount Available at a discount Available at a discount Available at a discount	Available at a discount Available at a discount Available at a discount Available at a discount Available at a discount
Lens options not covered by the plan may be available at a discount		
Eyeglass Frames	Once every 24 months receive a \$130 retail frame allowance PLUS 20% discount off amounts over the retail allowance.	Once every 12 months receive a \$130 retail frame allowance PLUS 20% discount off amounts over the retail allowance.
Contact Lenses in lieu of Eyeglasses (Lenses & Frames)	Once every 24 months	Once every 12 months
Covered in full elective contact lenses <ul style="list-style-type: none"> • \$200 Allowance in lieu of lenses and frames • Member receives 15% discount off doctor's professional fees for Contact Lens fitting and evaluation 	\$200 allowance once every 24 months. Fitting/evaluation is offered at a 15% discount. If a member chooses a contact lens not currently part of the Contact Lens Care Program, they have the flexibility to use their elective contact lens allowance any way they choose. The allowance can go toward contact lens services and contact lenses. Members will always receive 15% off all contact lens services from their VSP doctor. VSP covered contact lenses may vary by provider.	\$200 allowance once every 12 months. Fitting/evaluation is offered at a 15% discount. If a member chooses a contact lens not currently part of the Contact Lens Care Program, they have the flexibility to use their elective contact lens allowance any way they choose. The allowance can go toward contact lens services and contact lenses. Members will always receive 15% off all contact lens services from their VSP doctor. VSP covered contact lenses may vary by provider.
Medically Necessary Contacts Lenses <ul style="list-style-type: none"> • \$250 Allowance 	Applies to individuals who cannot wear eyeglasses because of a medical condition, allergy, etc. Covered once every 24 months	Applies to individuals who cannot wear eyeglasses because of a medical condition, allergy, etc. Covered once every 12 months
Refractive Eye Surgery- Member may receive approximately 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities. Many other services are available at discounted rates. Check with your vision care provider or the Vision Service Plan website at www.vsp.com .		

VSP OUT-OF-NETWORK PLAN HIGHLIGHTS

SERVICE	AMOUNT	SERVICE	AMOUNT
Exam		Lenses	
<ul style="list-style-type: none"> • Optometrist Up to \$40 • Ophthalmologist Up to \$40 		<ul style="list-style-type: none"> • Single Vision Up to \$40 • Bifocal Up to \$60 • Trifocal Up to \$80 • Lenticular Up to \$100 	
Contact Lenses (in lieu of eyeglasses)		Frames	Up to \$45
<ul style="list-style-type: none"> • Elective Up to \$200 • Necessary Up to \$250 			

TO FILE AN OUT OF NETWORK CLAIM:

Submit an itemized receipt with the covered member's ID number, name, address, phone number, patient's date of birth and relationship to member to the following address: VSP

Attn: Out-of-Network Claims
 PO Box 997105
 Sacramento, CA 95899-7105
 Be sure to write on your receipt "City of Mesa Vision Plan"

Limitations and Exclusions

This plan is designed to cover eye examinations and corrective eyewear. Benefits are payable only for expenses incurred while the group and individual member's coverage is in force.

The following services and materials are not covered under the Vision Service Plan

- Orthoptics or vision training and any associated supplemental testing
- Plano lenses (i.e. refractive error less than +/- 0.50 diopter power)
- Two pairs of glasses instead of bifocals
- Medical or surgical treatment of the eyes
- Replacement of lenses and frames furnished under this program, except at the normal intervals when services are available

The following items are not covered under the VSP Plan contact lens coverage

- Corneal Refractive Therapy (CRT) or Orthokeratology
- Replacement of lost or damaged lenses
- Insurance policies or service agreements
- Plano lenses (i.e. refractive error less than +/- 0.50 diopter power)
- Additional office visits associated with contact lens pathology
- Contact lens modification, polishing or cleaning

The vision plan premiums have increased less than \$.50 per pay check for 2012.

2012 BASIC VISION PLAN

		Total Premium	City Contribution	Retiree Contribution
Single		\$5.06	\$4.53	\$.53
Family		\$13.98	\$7.08	\$6.90

VISION PLUS PLAN

		Total Premium	City Contribution	Retiree Contribution
Single		\$8.65	\$4.53	\$4.12
Family		\$23.84	\$7.08	\$16.76

Choosing the Best Plan for You and Your Family

How do I know which plan to choose?

Although the City of Mesa Benefits Office cannot recommend a specific plan, this section includes some information for you to consider as you make your health insurance plan decisions.

Member premium costs

- Which of the plans will fit best within your family's budget?
 - Do you have the immediate financial resources to handle the deductible?
- Keep in mind that health insurance premiums are deducted on a pre-tax basis
 - The premium does not equal a reduction in your take home pay

Medicare enrollment

- Are you are enrolled in Medicare, so the City's coverage is secondary?
- The City only pays what Medicare doesn't about 20% of the cost.
- If you are enrolled in Choice Plus, you may be "overinsured"- that is, you're paying too much for what you're getting back. You may want to consider enrolling in Choice 80/20 to save on premiums.

Health care expense history

- What was your out of pocket expense during the last calendar year?
- How much are you actually USING your benefits?
- How much do you think you will use them in the future?
- What is your network utilization like? Does it have to be that way?

Do the math!

- Add how much you pay in premiums
- Add how much you pay for medical out of pocket expenses
- Add how much you pay for prescription medication out of pocket expenses
- Add naturopath or homeopath expenses

Compare

- How much are you paying under your current plan?
- How much would you paying under the other current plans?

Consider

- Are you enrolled in the most expensive plan just because it's convenient or because it gives you a feeling of security?
- How likely are you to spend more than the out-of-pocket or annual maximums?
- Are you or one of your family members quite ill with a chronic condition?
- Have you, or has someone in your family made numerous visits to the hospital?
- Are you, or is someone in your family, likely to need surgery, or perhaps a crown or root canal, in the coming year?
- Is one of the children going to need of braces for their teeth?
- Do you want to change vision plans so that you can have more or less frequent benefits?

Use Available Resources

- The Explanation of Benefits forms that we send to your home every time we process a claim
- Look up your claims online at www.mesaaz.gov/benefits
- Pharmacy receipts from both the local retail and mail order pharmacies
- Get a list of your prescriptions online at www.medcohealth.com
- An excel worksheet to help you estimate your annual uncovered medical expenses (deductibles, copays, and coinsurance). The worksheet can be printed and used as a hard copy or copied and used online.
- The [comparisons](#) for medical, dental, and vision plan benefits
- The [contact information](#) for the plans to answer coverage questions.

Getting the Best Bang for Your Health Care Buck

How to Maximize Your Benefits and Save Money for Yourself and the Employee Benefit Trust

Choose In-Network PPO providers

- Make sure **ALL** providers involved in your care are in the Blue Cross Blue Shield of Arizona PPO network if you live in Arizona
- If you live outside of Arizona, enroll in the out-of-state BCBS network and use the in-network providers in that network
- Ensure that **ALL** providers involved (such as the surgeon, anesthesiologist, assistant surgeons, and the healthcare facility) are in-network providers

Use the Prescription Plan Wisely

- Choose generic medications whenever possible. You can now get a 90 day supply of generic medication at a retail pharmacy for two month's copay. Not only will you get a better benefit, but it will also help keep premiums down by being less expensive for the plan.
- Use the mail order pharmacy for the medications you take regularly
 - The mail order pharmacy is easy to use and saves everybody money
- Ask your doctor about possible alternatives to the more expensive brand name medications
- Do cost comparisons. If there is a less expensive medication that could give you the same results, try it.
- Do cost comparisons. If there is a less expensive medication that could give you the same results, try it.

Out-of-Network Coverage

The Medical Plan offers out-of-network coverage for those members who choose to use a provider who is not in the Blue Cross Blue Shield of Arizona network. However, in every plan, out of pocket costs for using non-network providers are substantially more for the member and for the Employee Benefit Trust.

In addition, there are other increased costs for using out-of-network providers:

- **No Out-of-Pocket Maximum** - members who choose out-of-network providers will pay **all** deductibles and **all** coinsurances, regardless of total cost
- **Coinsurance will be calculated based on allowable costs** for the out of network service.
- Members will pay any costs billed by out of network providers above the allowable cost in addition to their coinsurance
- **Out-of-network emergency room visits** will not be paid in network if not medically necessary
- **Any out-of-network post-emergency follow up care will be covered as out-of-network**
- **Out-of-network services will not be paid at the in-network rate** unless the City's independent medical review has determined that there is not an appropriate provider in the network, based on medical necessity



Important Phone Numbers and Websites

Contact	Website / Telephone	Description
Blue Cross Blue Shield of Arizona	www.azblue.com	Find an in-network medical provider in Arizona .
Blue Cross Blue Shield Nurse Line	(866) 422-2729 Available 1/1/12	Call a Blue Cross Blue Shield professional nurse, 24 hours a day, 7 days a week
Medco	www.medcohealth.com	Find information about your prescription drug benefit, locate a pharmacy, and order prescriptions from the home delivery pharmacy.
	1(877) 476-9270	
VSP	www.vsp.com	Find a Vision Service Plan provider and other coverage information.
	(800) 877-7195	
Employee Benefits	www.mesaaz.gov/benefits	View the City of Mesa Plan Document, get benefit forms, and your benefit information and claim history. Eligibility and Benefits Verification.
	(480) 644-2299	
Blue Cross Blue Shield Out-of-State Network	(866) 288-5788 Available 1/1/12	Get information about the Out-of-State Network

ACTION CHECKLIST

Complete this checklist before accessing the online open enrollment system.

COVERAGE OPTIONS – Check the level of coverage you want to enroll in

MEDICAL PLAN OPTIONS

Choice PPO – 80/20 Plan

- Member Only (Single Coverage)
- Member and Family (Family Coverage)

Copay Choice – Copay for most services

- Member Only (Single Coverage)
- Member and Family (Family Coverage)

Choice Plus PPO – 90/10 Plan

- Member Only (Single Coverage)
- Member and Family (Family Coverage)

Basic Choice PPO – 50/50 Plan

- Member Only (Single Coverage)
- Member and Family (Family Coverage)

Opt Out –If you opt out of medical coverage as a retiree, you are no longer eligible for medical benefits in the future.

DENTAL PLAN OPTIONS

Preventative Choice – 80/20 Plan, \$500 annual max., no orthodontia or other major services

- Member Only (Single Coverage)
- Member and Family (Family Coverage)

Dental Choice – 80/20 Plan, \$1200 annual max., no orthodontia

- Member Only (Single Coverage)
- Member and Family (Family Coverage)

Dental Choice Plus – 80/20 Plan, \$1500 annual max., orthodontia for children under age 19

- Member Only (Single Coverage)
- Member and Family (Family Coverage)

Opt Out – If you opt out of dental coverage as a retiree, you are no longer eligible for dental benefits in the future.

VISION PLAN OPTIONS

Basic Vision – annual exam, glasses/contacts every 24 months

- Member Only (Single Coverage)
- Member and Family (Family Coverage)

Vision Plus - annual exam, glasses/contacts every 12 months

- Member Only (Single Coverage)
- Member and Family (Family Coverage)

- Opt Out** –If you opt out of vision coverage as a retiree, you are no longer eligible for vision benefits in the future.

DEPENDENT INFORMATION

Spouse Name _____ date of birth _____

Spouse social security number (required) _____

Child Name _____ date of birth _____

Child social security number (required) _____

Child Name _____ date of birth _____

Child social security number (required) _____

DOCUMENTATION REQUIRED FOR NEW DEPENDENTS OR A CHANGE IN STATUS

- Add Spouse** – marriage certificate
- Add child** – birth certificate; foster, adoption, or legal custody papers
- Add stepchild** – birth certificate, natural parent’s divorce decree, retiree’s marriage certificate
- Delete spouse** due to divorce – copy of divorce decree (you must delete spouse if divorced)
- Delete stepchildren** due to divorce - copy of divorce decree (you must delete stepchildren if divorced)
- Proof of insurance**/insurance card for dependents covered under another health insurance plan

*NOTE: If you have or anticipate a status change (e.g., newborn, marriage, divorce, or adoption) that becomes effective in October or November 2009, please contact Laura Kolsrud at (480) 644-5837 or Leslie Rogers at (480) 644-2648 **before** doing your on-line enrollment.*

Mesa Medical Plan Information

Our entire health insurance program is self-insured and self-administered, with Blue Cross Blue Shield of Arizona (BCBSAZ) continuing as our network provider. Claims are sent to and processed by the City of Mesa Employee Benefits Office.

Members may choose between four different medical plans depending upon their individual needs for a comparison of coverage under the plans). Please refer to the City of Mesa [Plan Document](#) for detailed descriptions of covered and non-covered services.

Medical Premiums

Premiums for the four medical plans have been determined based upon the value of the individual plan.

In Network Coverage

It is important that members choose in-network providers in order to get the best benefit. When an individual uses a provider who is in the Blue Cross Blue Shield of Arizona network, the health plan and the member receive discounts. To use the network benefits under the plan most effectively:

- Check the Blue Cross Blue Shield of Arizona, www.azblue.com, for participating providers
- Make sure **ALL** providers involved in your care (such as the surgeon, anesthesiologists, assistant surgeons, and the healthcare facility) are in-network providers. You are responsible for making sure that all providers are in-network, so ask your doctor to help you avoid additional costs by referring you only to in-network providers.

Annual Out of Pocket Maximum (In-Network)

- The total amount a member must pay, not including deductibles, copays, and prescription drug costs before the health plan covers expenses at 100%
- Each time an in-network claim is processed by the health plan, coinsurance paid by the member is applied to the out of pocket maximum amount
- When the in-network out-of-pocket maximum is reached, covered medical claims will be paid at 100% for the rest of the calendar year

Instructions for Locating a Blue Cross Blue Shield of Arizona Provider

Members enrolled in any of the Choice Medical Plans may choose a Blue Cross Blue Shield of Arizona contracted provider. Provider discounts vary based upon the provider's contract with BCBSAZ.

To use the Blue Cross Blue Shield of Arizona Website follow the instructions below to locate a medical provider in the Blue Cross Blue Shield network.

1. On the web go to the Blue Cross Blue Shield of Arizona website at www.azblue.com
2. A Guest page will appear. Click on "Search the Provider Directory" link.
3. On the "Health & Dental Provider Directory" page, under the ID card sample that says "Acme Company," click on the "Search the Provider Directory" link.

4. You will see three tabs entitled "Providers", "Facilities" and "Urgent Care". Select the tab that applies to your search.
5. Under "Search by Network", click on the drop down arrow and select "PPO".
6. You can then enter your address, provider name or specialty to define your search. Once done, click on the "Search" button.

The website is updated monthly by BCBSAZ, listing any new providers, or removing those who have terminated recently.

Precertification

- Required under all City of Mesa Medical Plans for certain covered services
- Ensures that hospitalizations, surgeries, and other procedures are medically necessary
- The physician's office will contact the plan on your behalf to pre-certify required services
- **Members are responsible for making sure services have been pre-certified. Services that are not pre-certified will not be covered.**
- Some procedures that require precertification:
 - All elective non-emergency admissions, except for birth of a baby (not including post-natal)
 - All elective admissions to specialized facilities, including outpatient surgical centers, hospice, skilled nursing facilities, and sub-acute care facilities
 - All admissions to inpatient or day treatment rehab facilities for both medical and mental health services
 - Colonoscopies, except those covered under the preventive care benefit
 - Other invasive diagnostic tests
 - Sleep studies
 - Durable Medical Equipment with a cost of \$1000 or more;
 - **Emergency hospital admissions within 48 hours after admission**

Utilization (or Concurrent) Review/Case Management

- Ensures that services and treatment are medically necessary
- Coordinates member care with other health care providers, such as home health agencies, durable medical equipment vendors, and others
- May also assist with discharge planning and advising medical providers of various options available under the plan

Non-Covered Services

Services that are not covered under the City of Mesa Medical Plans include, but are not limited to:

- Cosmetic surgery or related expenses
- Fertility treatment, except limited services available under the Choice Plus PPO Plan
- Health club memberships

- Massage therapy, except when performed by a physical therapist, chiropractor, or medical doctor
- Medications not approved by the FDA
- Nutritional supplements and/or vitamins (except certain prenatal vitamins)
- Services that are experimental and/or investigational in nature
- Vision services, except exams and lenses required following cataract surgery (vision services are covered under a separate optional plan)
- Weight management programs.

For more detailed information about services that are not covered, please contact Employee Benefits at (480) 644-2299 or refer to the [Plan Document](#).

Other Insurance Coverage

- Member and dependents who are covered by another health insurance policy must submit a copy of the insurance card from the other carrier or other documentation to the Employee Benefits Office
- If other coverage has been terminated, documentation of the termination date must be submitted
- Certain rules determine which plan is primary (i.e., which plan pays first)
- The City of Mesa plan does not coordinate benefits with primary plans that have co-pays.
- For assistance with determining which of your insurance carriers is primary, please contact Employee Benefits at (480) 644-2299.

Your Insurance Card and ID Number

Remember: If your residence is in AZ, your medical card is combined with your prescription drug card and comes to you from Medco

- Always take your healthcare ID card with you when visiting a healthcare provider office
- The 5-digit ID number found on your Medco insurance card is the medical plan Insured ID number and should be used when filling out forms at a healthcare provider's office
- Claims submitted with incorrect information may be denied
- Please order replacement cards through the Medco website

Medical Coverage for Out-of-State Members

Effective January 1, 2012, Blue Cross Blue Shield has replaced HealthSmart as the out-of-state network for those City of Mesa health plan members who live outside the state of Arizona. BCBS allows eligible City members to use their providers throughout the United States, including hospitals, urgent care centers, doctors and specialists. The network is only for those covered persons who regularly live outside Arizona. ***It is not for members who reside in Arizona who are traveling outside the state.***

The Benefits Office must be notified if a member or an eligible dependent is moving out-of-state, or will be residing outside the state for four months or more of the year. Members who do not enroll in the BCBS out-of-state network will have all non-life or limb-threatening services covered at the out-of-state network benefit, including routine and urgent care, scheduled surgeries, etc. Life or limb-threatening services will be reviewed to determine if emergency care was medically necessary.

Out-of-state members will receive new ID cards with the out-of-state member number from Blue Cross Blue Shield. This new card must be presented to your health care provider and retail pharmacy effective January 1, 2012, whether it is a new provider or one you have seen before. If you do not present your new card, your claim may be denied. Please destroy your previous card to prevent unauthorized use.

There is no additional charge to enroll in the out-of-state network plan. Out-of-state members not enrolled will only be covered under the out-of-network benefit. For out-of-state members who use a BCBS contracted provider, services will be processed as in-network for the plan selected. For example, if a member is enrolled in the Choice 80/20 plan, services rendered by a BCBS provider will first be subject to a \$300 per person annual deductible, and then paid at 80%. If a non-network provider is used by a Choice member, or if the member is not enrolled in the BCBS out-of-state plan, services will be processed as out-of-network (subject to a \$1,000 deductible, then paid at 60%).

Your provider will need to pre-certify services outlined in the plan document with the Arizona Foundation for Medical Care, the City's medical management company.

If the City of Mesa is your primary or only carrier, present your BCBS card to the provider at the time of your appointment. If you did not receive a card, contact BCBS at 1-866-288-5788 (effective January 1, 2012). Give your provider the member number on your BCBS out-of-state network ID card as the Insured ID-number. **If the City of Mesa is your secondary carrier** (for example, if you are on Medicare), inform the provider that you have primary insurance. The itemized bill with the primary carrier's Explanation of Benefits should be sent to BCBS. ***Claims should not be sent to the City of Mesa Employee Benefits***, as that will delay payment. Members and providers should call BCBS, not the City of Mesa, with questions or to verify coverage.

To Find an Out-of-State BCBS Provider, call Blue Cross Blue Shield at 1-866-288-5788 and state your member ID number and group number as it is printed on your card. You can also log in to Blue Cross Blue Shield's web site at provider.bcbs.com to do a provider search:

- Enter your Member ID Alpha Prefix "MDK"
- Click "Find Providers" Orange Button
- You have the option to enter your address (Not required)
- Enter your zip code (Required)
- You have the option to enter a provider name (Not required) or
- Select a type of provider by clicking the checkbox next to the listed specialties
- Click "Search" button at the bottom of the screen.
- A list of BCBS providers will be displayed.

Affordable Care Act Changes

Children to Age 26 May be Covered under the Plan

Individuals whose coverage ended, who were denied coverage or who were not eligible for coverage because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in the City of Mesa group health plan. No coverage is extended to son-in-law, daughter-in-law, or grandchildren, except in the case of legal custody.

No Retroactive Cancellation of Coverage

In accordance with the requirements of the Affordable Care Act, the plan will not retroactively cancel coverage except for non-payment of premium or in the case of fraud or intentional misrepresentation of material fact and with at least a 30-day advanced written notice for fraud or misrepresentation. Retroactive terminations of coverage may be made for ineligibility under the requirements of the Plan Document and no advanced written notice will be required.

Annual Notification - Women's Health and Cancer Rights Act of 1998

Federal law requires the following notification: Group health plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive breast surgery. This Plan complies with the Women's Health and Cancer Rights Act (WHCRA) that indicates that for any covered individual who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with it, coverage will be provided in a manner determined in consultation with the attending physician and the patient, including:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and physical complications for all stages of mastectomy, including lymphedemas.

Coverage is subject to the Plan's normal rules, including in-network co-payments or out-of-network annual deductibles and coinsurance provisions. If you have any questions about this law, including Plan benefits for mastectomies or reconstructive surgery, please contact Margie Ward, Employee Benefits Administrator at (480) 644-4421.

HIPAA – Health Insurance Portability and Accountability Act of 1996

Effective April 14, 2003, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a federal law, requires that health plans like the City of Mesa Health Plan (hereafter referred to as the “Plan”), maintain the privacy of your personally identifiable health information (called Protected Health Information or PHI).

- 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 the City of Mesa in its role as an employer, including but not limited to health information related to disability, work-related illness/injury, sick leave, Family or Medical leave (FMLA), life insurance, dependent care FSA, drug testing, etc.
- A complete description of your rights under HIPAA can be found in the Plan’s Notice of Privacy Practices, which was previously distributed to you or distributed to you upon enrollment in the Plan and is also available from the Employee Benefits Office or at www.mesaaz.gov/benefits.

Medicaid & the Children’s Health Insurance Program (CHIP) Offer Free Or Low-Cost Health Coverage To Children And Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can 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, you can 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, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance. 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 September 1, 2010. You should contact your State for further information on eligibility.**

ALABAMA – Medicaid Website: http://www.medicaid.alabama.gov Phone: 1-800-362-1504	CALIFORNIA – Medicaid Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-866-298-8443
ALASKA – Medicaid Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	COLORADO – Medicaid and CHIP Medicaid Website: http://www.colorado.gov/ Medicaid Phone: 1-800-866-3513 CHIP Website: http:// www.CHPplus.org CHIP Phone: 303-866-3243
ARIZONA – CHIP Website: http://www.azahcccs.gov/applicants/default.aspx Phone: 1-877-764-5437	
ARKANSAS – CHIP Website: http://www.arkidsfirst.com/ Phone: 1-888-474-8275	FLORIDA – Medicaid Website: http://www.fdhc.state.fl.us/Medicaid/index.shtml Phone: 1-866-762-2237
GEORGIA – Medicaid Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150	MONTANA – Medicaid Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Telephone: 1-800-694-3084
IDAHO – Medicaid and CHIP Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	NEBRASKA – Medicaid Website: http://www.dhhs.ne.gov/med/medindex.htm Phone: 1-877-255-3092
INDIANA – Medicaid Website: http://www.in.gov/fssa/2408.htm Phone: 1-877-438-4479	NEVADA – Medicaid and CHIP Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900 CHIP Website: http://www.nevadacheckup.nv.org/ CHIP Phone: 1-877-543-7669
IOWA – Medicaid Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	
KANSAS – Medicaid Website: https://www.khpa.ks.gov Phone: 800-766-9012	NEW HAMPSHIRE – Medicaid Website: http://www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.htm Phone: 1-800-852-3345 x 5254

KENTUCKY – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-342-6207	
MAINE – Medicaid	NEW MEXICO – Medicaid and CHIP
Website: http://www.maine.gov/dhhs/oms/ Phone: 1-800-321-5557	Medicaid Website: http://www.hsd.state.nm.us/mad/index.html Medicaid Phone: 1-888-997-2583 CHIP Website: http://www.hsd.state.nm.us/mad/index.html Click on Insure New Mexico CHIP Phone: 1-888-997-2583
MASSACHUSETTS – Medicaid and CHIP	
Medicaid & CHIP Website: http://www.mass.gov/MassHealth Medicaid & CHIP Phone: 1-800-462-1120	
MINNESOTA – Medicaid	NEW YORK – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone (Outside of Twin City area): 800-657-3739 Phone (Twin City area): 651-431-2670	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MISSOURI – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.dss.mo.gov/mhd/index.htm Phone: 573-751-6944	Website: http://www.nc.gov Phone: 919-855-4100
NORTH DAKOTA – Medicaid	UTAH – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604	Website: http://health.utah.gov/medicaid/ Phone: 1-866-435-7414
OKLAHOMA – Medicaid	VERMONT – Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://ovha.vermont.gov/ Telephone: 1-800-250-8427
OREGON – Medicaid and CHIP	VIRGINIA – Medicaid and CHIP
Medicaid & CHIP Website: http://www.oregonhealthykids.gov Medicaid & CHIP Phone: 1-877-314-5678	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
PENNSYLVANIA – Medicaid	WASHINGTON – Medicaid
Website: http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm Phone: 1-800-644-7730	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-877-543-7669
RHODE ISLAND – Medicaid	WEST VIRGINIA – Medicaid
Website: www.dhs.ri.gov Phone: 401-462-5300	Website: http://www.wvrecovery.com/hipp.htm Phone: 304-342-1604
SOUTH CAROLINA – Medicaid	WISCONSIN – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm Phone: 1-800-362-3002

TEXAS – Medicaid	WYOMING – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493 Phone: 1-800-440-0493	Website: http://www.health.wyo.gov/healthcarefin/index.html Telephone: 307-777-7531

To see if any more States have added a premium assistance program since September 1, 2010, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
 Employee Benefits Security Administration
www.dol.gov/ebsa

U.S. Department of Health and Human Services
 Centers for Medicare & Medicaid Services
www.cms.hhs.gov

1-866-444-EBSA (3272)

1-877-267-2323, Ext. 6156

Medicare Mandatory Reporting Requirement

As a health plan payor, the City of Mesa is required to comply with a number of federal laws, including HIPAA (see above) and the new Medicare Mandatory Reporting Requirement. This new requirement came about because of increased misunderstandings by providers and Medicare recipients regarding the primary/secondary relationship between Medicare and their other Group Health Plan (like those offered by the City of Mesa).

When a person becomes eligible for Medicare, either because they have reached their Medicare-eligibility age OR they have been disabled in accordance with Medicare rules, they are automatically enrolled in Medicare Part A, which covers the person under Medicare for Hospitalizations. They will also have the option of enrolling in Medicare Part B (for professional services, such as doctor visits, lab and x-ray services), and there is a monthly premium. When a person is also covered by another insurance plan, such as those offered by the City of Mesa, both the City and Medicare must determine which plan is primary (i.e. which plan pays first when services are rendered) and which plan is secondary.

Many people assume that when they become eligible for Medicare that Medicare is automatically primary. This is not necessarily the case, especially if the person is still an active employee or is the spouse of an active employee. For this reason, the Centers for Medicare and Medicaid Services (CMS) has enacted the new Medicare Mandatory Reporting Requirement—to ensure those who are enrolled in both Medicare and another group health plan understand which plan is considered their primary insurance.

To facilitate this process, CMS is requiring all health insurance payors to submit the names and social security numbers of all of their members, regardless of their age or Medicare status. They will then verify which people are enrolled in Medicare and will communicate this information to the Employee Benefits Office, so we can notify the member which insurance coverage should be considered primary. As a result of this requirement, we are required to have all plan members (employees and retirees) provide us with the social security numbers of their dependents (spouses and children). We will then communicate this information to CMS as required by federal law.

Please note this information will be kept completely confidential and private, as the City of Mesa Employee Benefits Office is bound by HIPAA to maintain the privacy of all personal health information. If you have any questions or concerns about this new requirement, please contact Margie Ward, Employee Benefits Administrator at (480) 644-4421.

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The City of Mesa has determined that the prescription drug coverage offered by the City of Mesa Medical Plan, including the Basic Choice PPO, Choice PPO, Choice Plus PPO, and Choice Copay plans, is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if

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

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

If you decide to join a Medicare drug plan, your current City of Mesa coverage will not be affected. Under the prescription drug coverage plan provisions under the City of Mesa Choice Medical Plan that Medicare eligible individuals have available to them when they become eligible for Medicare Part D, they can keep this coverage if they elect part D but this plan will not coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current City coverage, be aware that you and your dependents will not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with the City of Mesa 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 person listed below for further information or call the City of Mesa Benefits Office at 480-644-2299.

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 the City of Mesa changes. You also may request a copy of this notice at any time,

Contact: Margie Ward
City of Mesa
Benefits Administrator
P.O. Box 1466
Mesa, AZ 85211-1466

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

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

Visit 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 (1-800-633-4227). TTY users should call 1-877-486-2048.

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