



CITY OF MESA OPEN ENROLLMENT
BENEFITS GUIDE FOR ACTIVE
EMPLOYEES
-FOR 2021 BENEFIT PLANS-

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2020 OPEN ENROLLMENT FOR 2021 BENEFIT PLANS

OPEN ENROLLMENT PERIOD

Open Enrollment starts on Wednesday October 7, 2020 and ends on Wednesday October 21, 2020 at 6 pm for 2021 benefit programs. Now is the time to review your benefits and enroll or make any changes that best meet your 2021 needs - think FSA, opting-out or opting-in, adding or deleting dependents, changing from one plan to another! You cannot change your benefit enrollments or who is covered during 2021 after Open Enrollment is closed, unless you have a qualifying event occur that would warrant a "Special Qualifying Event Enrollment". See that section later in this Guide for more information.

YOUR OPEN ENROLLMENT BENEFITS GUIDE

The employee benefit programs described in this Guide are effective January 1, 2021. Please take the time to familiarize yourself with benefit options, eligibility rules and costs. This Guide provides you with important summary and highlights information about the City's benefit programs - so you can make the best plan choices for you and your family's needs in 2021.

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 of Mesa members. All information is subject to change and is not a guarantee of benefits. For more information about the plans, including eligibility, what is covered, and exclusions and limitations, please refer to the City of Mesa Plan Document available at www.mesaaz.gov/benefits. If there is a difference between the Guide, our benefits website and any other benefits-related publications and the City of Mesa Plan Document (or underlying policies/certificates), the Plan Document (or underlying policies/certificates) will prevail.

HOW TO LOGON/ENROLL USING EBENMESA

1. How you logon to eBenMesa depends on where you are logging on from. If you are using a City workstation (PC or laptop) and are connected to the City network go to: <https://ebenmesa.mesaaz.gov/openenrollment>.
2. If you are using a personal workstation or are not connected to the City network, use a Google Chrome browser to go to: <http://www.mesaaz.gov> and complete an Employee Login using the link at the bottom of the City website home page. Insert your City Username, Password and answer a security question if prompted and verify/sign in.

3. Once the login screen for Mesa domains comes up from either of the above routes, you will need to provide your Domain\Username and Password again, to access the eBenMesa enrollment application
 - a. If you do not know your Domain, access the Phonebook in InsideMesa, enter your name, and your domain is listed in towards the bottom, left-hand corner of the page in the Name Details section
 - b. Your username is the same as your City issued username, which in many cases is your first initial and most of your last name, all lowercase, and no spaces
4. When you have completed logging in, you will either have Inside View or Inside Mesa homepage on your screen and a prominent Open Enrollment Banner just below the top of the screen. Click on "Open Enrollment" in that banner. Now you are in eBenMesa with a home screen and tabs to review and enroll or make changes for dependents and each benefit plan for which you are eligible.
5. Links on the eBenMesa Home Screen:
 - a. **Open Enrollment – click this when you are ready to proceed**
 - b. Upload Benefit Forms and Documents – click this when you need and are ready to upload dependent verification documents (can also link to Upload from the Check Out tab at the end of the application)
 - c. Current Enrollment – click to view or print your Current Enrollment
 - d. Beneficiary Designations – click to establish or update Beneficiaries for Basic and/or Supplemental Life/AD&D Insurance if you are eligible and enrolled in these programs – you will also see a Beneficiary designation tab as you browse the plan tabs and you can enter/edit and save data from there as well
 - e. Community Spirit – click to establish next year's contributions
6. You may return to eBenMesa as many times as you want during the Open Enrollment period (i.e. until 6pm on October 21).

PLAN AND RATE CHANGES FOR 2021

RATE CHANGES

Look for rate charts in the sections of the Guide that describe each of the benefit programs in detail, but take note that the following rate changes will be activated in 2021:

- Medical plans – rate increases on Choice and Copay plans for full and part-time employees; increases on the Basic Plan for part-time employees
- Vision Care plans – rate decreases on all three plans
- Voluntary Short-Term Disability Insurance – rate increase on 7-day waiting period plan; 29 and 44-day waiting period plans have no rate changes

SUMMARY PLAN CHANGES

Medical/Prescription Drug Plans

- Covid-19 testing and diagnosis covered 100% in all three medical plans
- Telehealth Connection Services consolidated to MDLive for Cigna at continuing 100% benefit levels in 2021
- Other virtual telephone/video professional office visit services' coverage at regular benefit levels in each plan (i.e. deductibles, copays or coinsurance as may apply)

Vision Plans

- Allowances increased:
 - Out-of-network exam allowance up to \$70
 - In-network frames allowances increased to \$170 or \$190 for featured frames and \$95 for Costco/Sam's Club/Walmart frames
 - In-Network contact lenses allowance up to \$220
- Vision Plus and Premium Plus Plans only – full contact lenses allowance available in same year as eyeglass frames purchase (at regular copay levels up to allowance amounts) - instead of previous "in lieu" benefit that remains in Basic Vision Plan

Health Flexible Spending Account Limits

The Health FSA annual election limit is increasing from \$2,700 to \$2,750 and the Health FSA maximum rollover amount from 2021 to 2022 is increasing from \$500 to \$550. Commencing in 2020 and ongoing, IRS regulations were relaxed on reimbursement rules for over-the counter (OTC) medicines and supplies – these no longer require a prescription or letter of medical necessity documentation from a physician in order to claim eligible OTC items under your Health FSA account, or use your Health FSA debit card with ConnectYourCare (CYC).

The dependent care FSA annual limit will remain \$5,000. See the Health and Dependent Care Flexible Spending Accounts section later in this Guide for more information.

ANNUAL HOUSEKEEPING REMINDERS

DEPENDENT ELIGIBILITY

During Open Enrollment, make sure you remove anyone who is no longer eligible for coverage – or anyone who may be eligible, but for whom you no longer need/want the City's coverage.

If you are eligible and enroll or continue your enrollment in a medical, dental or vision care plan, you may enroll or continue enrollment for your eligible dependents in these plans as well as enrolling or continuing dependent enrollment in Supplemental Life/AD&D coverage.

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 a dependent, you must provide proof of dependent status, which may include the following:

- For legal spouses: marriage certificate
- For Committed Partners: Affidavit of Committed Partnership and two documents that verify joint address and financial inter-dependence
- 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*

FLEXIBLE SPENDING ACCOUNTS (FSA) – HEALTHCARE AND DEPENDENT CARE – ENROLL FOR THE FIRST TIME OR RE-ENROLL, RE-ENROLL, RE-ENROLL!

You must enroll or re-enroll in your healthcare or dependent care FSA every year. If you do not re-enroll during the Open Enrollment period using the eBenMesa application, you will not have an FSA account or be in this plan and benefit for 2021. More importantly, if you don't re-enroll and have rollover funds up to \$500 remaining in your account from 2020, you will forfeit those funds - an example of "what you don't know (or don't take note of) can hurt you".

REVIEW AND UPDATE YOUR LIFE INSURANCE BENEFICIARIES

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 and even if you do not need to make changes to these benefits during Open Enrollment, do take a moment to review your beneficiaries and make any needed updates. This protects both you and your beneficiaries' rights under these various insurance programs. Remember, you can use eBenMesa to make beneficiary changes at any time throughout the year, but Open Enrollment is one of those times when your attention is focused and assures you have reviewed this important item at least annually.

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

If you do not enroll in benefits during an initial eligibility period or during Open Enrollment, 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 (unless there is an extension during declared national emergency periods). 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 BENEFITS/RATE CHART

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 CVS/Caremark (a division of CVS Health), 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.

Medical Plan Highlights	BASIC		CHOICE		COPAY	
	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 (You Pay)	50% after deductible	25% + balance billing to you after deductible	20% after deductible	50% + balance billing to you after deductible	N/A, you pay Copays depending on the service	50% + balance billing to you 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%	Not covered	100%	Not covered	100%	Not covered
Physician Office Visit (You Pay)	\$20 Copay	75% + balance billing to you after deductible	20% after deductible	50% + balance billing to you after deductible	\$20 Copay	50% + balance billing to you after deductible
Chiropractic or Rehabilitation Therapy (You Pay)	50% after deductible	75% + balance billing to you after deductible	20% after deductible	50% + balance billing to you after deductible	\$20 Copay	50% + balance billing to you 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

2021 MEDICAL RATES	BASIC (per pay period)	CHOICE (per pay period)	COPAY (per pay period)
FULL-TIME SINGLE	\$0.00	\$67.00	\$101.00
FULL-TIME FAMILY	\$0.00	\$149.50	\$304.50
PART-TIME SINGLE	\$48.50	\$168.00	\$202.00
PART-TIME FAMILY	\$107.50	\$374.00	\$529.00

Prescription Drug Highlights	BASIC	CHOICE	COPAY
Annual Deductible	\$250	\$50 (waived on generics and mail order)	None
Out-of-Pocket Maximum (separate from Medical)	\$2500/Single \$5000/Family	\$4550/Single \$9100/Family	\$3575/Single \$7150/Family

Retail – 30 Day Supply

(You Pay)

Generic	20% (min \$5, max \$50)	20% (min \$5, max \$50)	\$15
Preferred Brand	25% (min \$30, max \$100)	25% (min \$30, max \$100)	\$50
Non-Preferred Brand	40% (min \$50, max \$200)	40% (min \$50, max \$200)	\$85

Mail Order – 90 Day Supply

(You Pay)

Generic	20% (min \$10, max \$100)	20% (min \$10, max \$100)	\$25
Preferred Brand	25% (min \$50, max \$200)	25% (min \$50, max \$200)	\$90
Non-Preferred Brand	40% (min 125, max \$300)	40% (min 125, max \$300)	\$160

DENTAL BENEFITS/RATE CHART

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	DENTAL CHOICE	DENTAL CHOICE PLUS
ANNUAL DEDUCTIBLE	No deductible for preventive and diagnostic services \$50 deductible per individual on basic and major services Family deductible will not exceed \$150		
PREVENTIVE SERVICES (Plan Pays)	100%		
BASIC SERVICES (Plan Pays)	80%		
MAJOR SERVICES (Plan Pays)	Not covered	80%	
ORTHODONTIA SERVICES (Plan Pays)	Not covered		80% up to \$1,500 per year (no deductible); \$3,000 lifetime; must be enrolled in Plus Plan before banding occurs and for the entire period (up to 2 years) during which Orthodontia annual benefits are paid
ANNUAL MAX BENEFIT	\$1,000/person	\$2,000/person	\$2,300/person
2021 RATES (per pay period)			
Full-Time Single	\$0.00	\$4.75	\$12.25
Full-Time Family	\$3.00	\$17.00	\$57.00
Part-Time Single	\$19.00	\$23.75	\$31.25
Part-Time Family	\$28.50	\$42.50	\$82.50

VISION CARE BENEFITS/RATE CHART

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. Note: use your medical plan benefits for medical services for the eyes due to disease, injury or illness etc. One exception to this is the Diabetic Eyecare Plus Program with VSP which does allow for medically necessary eye exams/services related to diabetic eye disease, glaucoma and age-related macular degeneration with in-network providers.

The Vision Plus and Vision Premium Plus Plans offer the same frequency and amount of covered services. The difference between the two plans is that the Premium Plus Plan offers a choice of one of five upgrade options at the time of each covered member's vision materials purchase. Each member of your family has the option to choose an upgrade at the time of service.

The five upgrade options include:

- Increase in frame allowance from \$170 to \$250
- Increase in contact lens allowance from \$220 to \$300
- Adding anti-reflective coating
- Adding custom or premium progressive lenses
- Adding photochromic lenses

Additionally, commencing in 2021 all three vision plans have enhanced allowances for frames, contact lenses and out-of-network exam allowance – see the chart below for more information.

Vision Plan Highlights	BASIC		PLUS		PREMIUM PLUS	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Net-work	Out-of-Net-work
FREQUENCY (Exam, glasses, contact lenses)	Every other calendar Year	Every other calendar Year	Every calendar Year	Every calendar Year	Same as Plus Plan, but with one of the following enhancement options per member at time of service: \$250 frame allowance \$300 contact allowance (instead of glasses)	
Frames (Allowances)	Up to \$170; \$190 featured; \$95 Costco, Sam's Club & Walmart	Up to \$70	Up to \$170; \$190 featured; \$95 Costco, Sam's Club & Walmart	Up to \$70	Anti-reflective coating Custom/premium Progressive lenses Photochromic lenses	
Lenses Single/Bifocal/Trifocal/Standard Progressive	\$10 copay	\$40/\$60/\$80 allowance	\$10 copay	\$40/\$60/\$80 allowance		
Contact Lenses (instead of glasses in Basic Plan or in addition to frames purchase in Plus and Premium Plus Plans)						
Fitting & Evaluation						
Elective	Up to \$60	Up to \$60	Up to \$60	Up to \$60		
Medically Necessary	Up to \$220	Up to \$200	Up to \$220	Up to \$220		
	\$10 copay	\$10 copay	\$10 copay	\$10 copay		
PER PAY PERIOD RATES FOR FULL AND PART TIME EMPLOYEES						
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 to pay for eligible healthcare or dependent care (meaning child daycare or dependent elder care) expenses. These accounts administered by ConnectYourCare (CYC), are a great way to save money for eligible expenses and lower your taxable income.

You must enroll in the Healthcare FSA if you want to use the account to pay for eligible medical expenses and 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 (except for any limited

rollover eligibility you may have in a Health FSA account). ***This means you must plan and estimate your enrolled amounts with care.***

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, deductibles and expenses that are your or your eligible family member's liability to pay for medical supplies and equipment, mental health and substance abuse treatment, orthodontia, eyeglasses, contact lenses and more. Exceptions – you cannot make FSA healthcare claims or use your CYC debit card for cosmetic or general health and well-being services (even if recommended by a health care professional), supplies or equipment and expenses for purchases or services that occurred outside the calendar year for which you make the annual election.

Your Healthcare FSA debit card will be loaded with your annual election amounts on January 1 (and any eligible rollover amounts generally by late April each year). The minimum annual election amount for Healthcare FSA is \$100, and the maximum in 2021 is \$2,750. Eligible expenses for 2021 must be incurred from January 1, 2021 through December 31, 2021. This means that you can only use your Healthcare FSA debit card to pay for services that occur in 2021. If you are on a payment plan for a surgery or procedure that occurred in 2020 or earlier, you cannot use 2021 funds for this payment plan. The deadline to submit receipts for reimbursement for expenses incurred in 2021 is March 31, 2022 (unless that deadline is extended due to changing IRS guidelines).

Remember, plan carefully because unused funds at the end of the plan year will be forfeited. One exception to this rule is the \$550 rollover feature. This feature allows you to carry over up to \$550 of unused funds from the 2021 plan year into the 2022 plan year, providing you enroll for a Health FSA Account in Open Enrollment of 2021 for the 2022 calendar year.

Another FSA feature you need to keep in mind each year you have a Health FSA account is substantiation requirements. This means there may be action required on your part to prove/document that your Healthcare FSA debit card purchases are true healthcare "medically necessary" and eligible expenses under IRS guidelines. You will need to substantiate to ConnectYourCare when CYC alerts you to this need. This will happen for any expense that is not auto substantiated by claims files that CYC receives or by the pharmacy or retail location business coding if that is the source of the CYC debit card usage. If you need to substantiate, you need more than a cash register or credit card receipt from the doctor, dentist or vision care provider. The purchase could have been for purchases like cosmetic surgery, cosmetic teeth whitening, non-prescription sunglasses, non-prescription, colored contact lenses or for someone who is not one of your eligible dependents for example – all of which are not eligible

FSA medical expense from the IRS point of view. If you do not substantiate your purchases, you will be required to pay the money back to ConnectYourCare so that you and the City remain compliant with IRS regulations. A substantiation request means you need an itemized statement/bill/invoice or EOB from your provider that lists the date and place of service, the services that were provided, to whom the services were provided and the amount of cost or liability you have for those services.

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. There is no debit card issued for the Dependent Care FSA Plan, which means you need to use your own funds to pay for your dependent care first, then submit itemized receipts to ConnectYourCare for reimbursement. 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 child care or your children age-out of child care eligibility etc. be sure to complete a timely drop of your dependent care election, so deductions can cease going forward. You cannot transfer funds from a Dependent Care FSA account to a Healthcare FSA account or vice versa.

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 is 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. 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 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 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 and this is the maximum amount of Supplemental Life Insurance coverage that you can elect for your spouse or committed partner (some or all of which may be 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 (or 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 children under 6 months of age, the maximum life insurance amount is limited to \$500 even though you may otherwise have elected children coverage in \$2,500 increments up to \$10,000.

If you, your spouse/committed partner or children are enrolled in Supplemental Life Insurance coverage, you and each of these 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 two \$10,000 increments (or 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 is activated at that time).

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 Life Insurance Company of North America (LINA), a Cigna affiliate. 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.

Dismemberment and Coma benefits

A variety of free financial services including secure travel, health rewards, ID theft, will preparation and beneficiary assistance – all of which can be accessed even if a BTA accident and claim has not occurred.

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 DISABILTY (STD) INSURANCE

STD 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
7 day	\$0.619
29 day	\$0.1777
44 day	\$0.146

When you enroll in any of the STD Plans for the first time, either as a new hire or during any subsequent Open Enrollment period, you will have a pre-existing limitation of benefits applied to you for any claim that you file during the first six months after your coverage is effective, if that disability condition arose or was treated by a provider (including medications) during the three month period prior to your coverage effective date. This means if your SDT coverage becomes effective January 1st, and you have a pre-existing condition that arose and was treated anytime during the period from October 1st of the preceding year, your disability benefit may be reduced or denied if your disability claim commences during the first 6-months of activated coverage. The pre-existing limitation will no longer apply after you have been enrolled in the plan for 6 months.

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

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](#)

CONTACTS

Cigna	800-244-6224	www.myCigna.com
CVS/Caremark	855-264-5048	www.caremark.com
Delta Dental	888-611-6711	www.deltadentalaz.com
Vision Service Plan (VSP)	800-877-7195	www.vsp.com
Connect Your Care	844-226-1872	www.connectyourcare.com
Unum	888-673-9940	www.unum.com
ComPsych	866-519-7415	www.guidanceresources.com Web ID: MESA
LegalShield/IDShield	800-654-7757	www.legalshield.com/info/cityofmesa