

Employee Benefits Enrollment Guide

Plan Year: 2026 - 2027

PHOENIX PXU UNION

Your enrollment period will begin on the 1st day of your contract and extend through 30 days. Your benefits effective date will depend upon your date of employment and will be assigned to you during your New Hire Orientation.

The Phoenix Union High School District (PXU) offers you and your eligible family members a comprehensive and valuable benefits program. We encourage you to take this opportunity to educate yourself about your options and choose the best coverage for you and your family for the upcoming plan year.

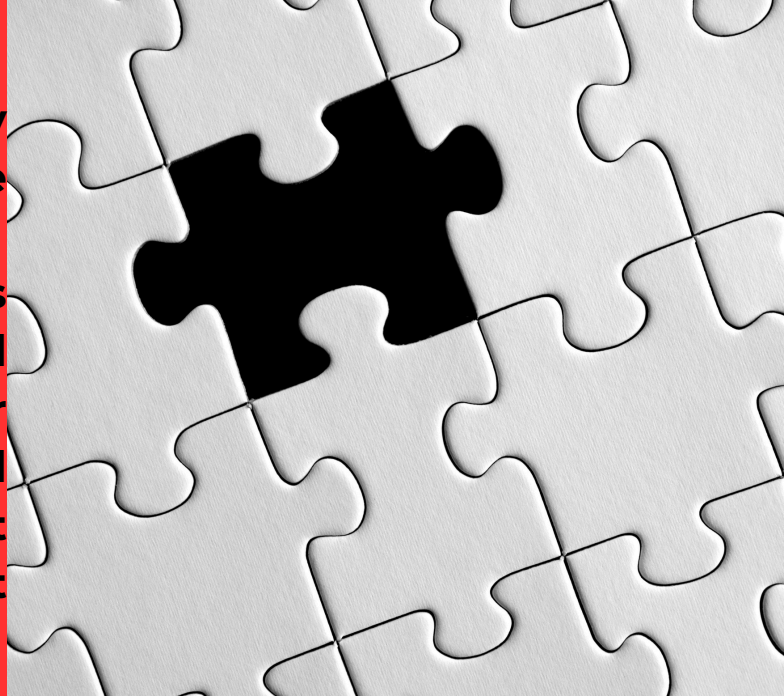
Included in this Guide are summaries of the different benefit options and costs for the period of July 1, 2026, through June 30, 2027. For detailed information, please refer to the PXU Insurance Options webpage @ https://www.pxu.org/o/pusd-210/page/insurance-options. This Guide also includes important Notices regarding your PXU benefits.

Please review the Guide carefully and contact the District's Employee Benefits Coordinators if you have any questions or concerns:

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Non-Compliance Alert
Benefits Enrollment is mandatory for all eligible employees for the 2026-2027 SY.
If you do not complete Benefits Enrollment, you will be defaulted into the Alliance Low Option for your medical plan and Basic Life; you will not have the opportunity to elect any other insurances until the next scheduled Open Enrollment Period.



How to enroll

Read through this Guide carefully. This Guide gives you important information to help you understand your benefit options. If you need more information, be sure to contact the District's Employee Benefits Coordinators using benefits@phoenixunion.org.

- Decide which benefits are best for you and your family. The District offers you a choice of three medical plan options, a health savings account (HDHP only), two dental plan options, vision insurance, voluntary life insurance, a short-term disability (STD) plan, and pre-tax flexible spending accounts.

- Complete your Enrollment on the Employee Access/iVisions web portal- detailed instructions will be emailed to you on your first day.

- Note: All medical, dental and vision benefit deductions from your paycheck will be on a pre-tax basis. If you want to pay your premiums with after-tax dollars, please contact the District's Employee Benefits Coordinators using benefits@phoenixunion.org and ask for the "Flex Plan Option Form". The completed Form is due back to PXU Benefits 1st Floor, FAX: 602-274-0484 within 30 days of submitting your elections.

- Exception: If you are enrolling a domestic partner and/or domestic partner's child(ren) into your medical/dental/vision plans and they do not qualify as tax dependents under IRS rules, the corresponding paycheck deduction must be post-tax. If this does not apply to your situation, please notify the District's Employee Benefits Coordinators using benefits@phoenixunion.org.

Do not forget, your enrollment deadline is 30 days from your contract start day.



Who is eligible?

You are eligible to elect benefits if you are:

- A permanent classified or contracted employee of the District working a minimum of 24 hours of service per week.

- If you are eligible to elect benefits, you are also eligible to elect benefits for your eligible dependents. Under our plan, eligible dependents include your:
  - Lawful spouse (marriage certificate required for mid-year enrollment); and
  - Domestic partner (affidavit required); and

The following children under age 26 whether married or unmarried:

- Natural children
- Adopted children or children placed for adoption,
- Stepchildren
- Domestic partner children
- Children under a QMCSO
- Children under a legal guardianship order and/or foster children.
- Disabled adult children who are age 26 or older and unmarried can continue coverage if they otherwise meet the eligibility requirements of the plan.

Note: If a child whose coverage has already terminated under this Plan due to reaching the age limit becomes disabled, said child is not eligible to re-enroll as a disabled adult dependent child under this Plan.

Post Enrollment

- For new hire voluntary life insurance applications above the guaranteed issue (GI) maximum amounts of $150,000 for employee and $50,000 for spouse/DP, please make sure to complete the Evidence of Insurability (EOI) questionnaire on-line @ https://www.sunlife-usa.net/eoi/ within 30 days of your election. Failure to do so or a denial will result in the cancellation of your new supplemental life elections above the GI maximums.
- If you are enrolling a domestic partner and/or a domestic partner's child(ren), please complete and return the Domestic Partner Affidavit to the District's Employee Benefits Coordinators using benefits@phoenixunion.org within 30 days of your election. Failure to do so will result in the disqualification of said dependents.
  Note: this is required each year even if you are already covering said dependents.
- Verify that all applicable benefit deductions are being taken from your paycheck. Please contact the Employee Benefits office with any discrepancies.

Changing your coverage during the year



Medical, dental and vision premiums are deducted from your paycheck on a pre-tax basis —giving you the advantage of not paying tax on your healthcare premium dollars (unless you let us know that you want to pay premiums with after tax dollars by completing the Flex Plan Options form or you are enrolling a domestic partner and/or domestic partner's child(ren) who do not qualify as tax dependents under IRS rules).

With the pre-tax feature, IRS rules require that you cannot change your elections until the Open Enrollment period unless you have a qualified mid-year change in status event (or HIPAA Special Enrollment event). You must notify the Plan in writing within 31 days of certain changes in you or your family's status. For more information review the Important Employee Benefit Program Notices at the end of this guide or contact the District Employee Benefits Office.



Medical Plans

The District gives you a choice of three medical plan options. Understanding the differences between the medical plan options can help you decide which plan is best for you and your dependents.

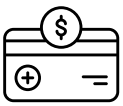
All our plan options are preferred provider organization (PPO) plans accessing the Blue Cross Blue Shield of Arizona (BCBSAZ) network of providers. With PPO plans, you can see any provider you wish, but you get greater cost savings by using in-network PPO physicians, hospitals, labs and urgent care centers. This is important to consider since you share in the cost of care in the form of deductibles, co-pays and coinsurance.

Note: All our plans utilize BCBSAZ networks, but only our Choice PPO uses the full Statewide/National PPO network. Our Alliance and HDHP plan utilize the smaller Alliance PPO/EPO network for in-network services in the state of Arizona.

The 2026-2027 Summaries of Benefits and Coverage (SBC) and other important information is available online @ www.pxu.org. You can also request hard copies of these, as well as the Plan Document, by contacting the PXU Employee Benefits Coordinators at benefits@phoenixunion.org.

Terms to Know

Below are commonly used terms to become familiar with when reviewing your plan summaries

	**Co-pay** **A set amount you pay for a covered health-related service or supply**
	**Access Fees** **Like a co-pay, this is a specific dollar amount you pay at the point of care at provider facilities, such as emergency room visits at hospitals**
	**Co-Insurance** **Co-insurance is how you and the plan split the cost for covered services. For example, 80% co-insurance means the plan pays 80% and you would be responsible for 20%**
	**Deductible** **The amount you must pay each plan year for certain covered services/supplies before benefits are paid by the plan**
	**Out-of-Pocket Maximum (OOP Max)** **The amount you must pay each plan year for certain covered services/supplies before benefits are paid by the plan**

Prescription drug benefits
(Retail & Mail Order)

- For each medical plan except the HDHP, you have outpatient prescription drug coverage utilizing the BCBSAZ tiered co-pay pharmacy benefit. BCBSAZ classifies outpatient prescription drugs in 4 levels. Your co-pay is lowest at Level 1. For the HDHP, you will pay a percentage.

- **Tip: For the greatest cost savings:**
  - Verify that your prescribed medication is on the Prescription Medication Guide (a formulary of preferred drugs). A copy of the listing is available online at www.azblue.com.
  - Also, remember to discuss generic equivalents with your provider; they are your least expensive drug option.

The health and well-being of our employees are important, and we encourage you to make sure your benefits work for you. Stay informed and be sure you understand your choices and how the different types of health plans work.

Alliance Option

This plan option follows the same plan design as the Choice PPO Option but utilizes the smaller Alliance network for in-network services thereby reducing the monthly dependent premium substantially. The District pays 100% of the employee premium and you will have an annual deductible to meet, and you share in the cost via coinsurance and co-pays.

Choice PPO Option

This plan option may be preferred if you need access to the full Statewide/National PPO network. You have a monthly premium and an annual deductible to meet, and you share in the cost via coinsurance and co-pays.

This is the only plan that uses the full BCBSAZ network

High Deductible Health Plan (HDHP) with Health Savings Account (HSA)

This plan also utilizes the smaller Alliance network and pays nothing toward health care services, except for in-network preventive care, until the deductible has been met. To offset the higher deductible, under IRS regulations, a Health Savings Account (HSA) may be opened to set aside money to pay for eligible health care expenses.

The District pays 100% of the employee premium and contributes $75 per check up to $1,500 annual to the corresponding HSA.

Health Savings Account (HSA)

An HSA is an account that lets you set aside money on a pre-tax basis to pay for qualified medical expenses, as defined in the tax law. See IRS Publication 502 (PDF) for more information.

By using pre-tax dollars in an HSA to pay for deductibles, copayments, coinsurance, and other qualified expenses, including some dental, drug, and vision expenses, you can lower your overall health care costs. PXU will contribute up to $1,500 into your HSA and you can contribute more if you choose. Your enrollment portal will apply limits automatically.

You can also invest the funds in your HSA and any unused funds from the plan year will carry-over indefinitely. Note: this account is not tied to your PXU employment and you can contribute to an HSA only if you have an HSA-eligible HDHP.

Note: Employees who elect the HDHP with HSA option can not also elect a Medical Flexible Spending Account (see page 19). Instead, they have the option of electing a Limited Care Flexible Spending Account (FSA).The Limited Care FSA is limited to Dental and Vision expenditures only (no medical); please plan accordingly.

The IRS has strict guidelines for who is eligible to open and contribute to a health savings account. Under the law, an eligible individual:

- Must be 18 years of age or older
- Must be covered under a qualified high-deductible health plan (HDHP) on the first day of a certain month
- May not be covered under any health plan that is not a qualified HDHP
- Must not be enrolled in Medicare (the healthcare component of the Social Security program)
- May not be claimed as a dependent on another individual's tax return
- Please see IRS Publication 969 for more information.

Paying for your medical benefits

The following chart shows what you would pay in premiums for medical coverage for the 2026-2027 plan year. Note: the biweekly payroll deduction amount is based on 24 deductions per plan year if you are a 12 month employee and 21 deductions per plan year if you have a less than 12 month work contract.

2026-2027 EMPLOYEE PREMIUMS FOR MEDICAL PLANS			
	Employee Monthly Premium	Biweekly Deduction 12 Month Contracts	Biweekly Deduction < 12 Month Contracts
Alliance			
Employee Only	-	-	-
Employee + Spouse	$963.70	$481.85	$550.69
Employee + Child(ren)	$569.48	$284.74	$325.42
Employee + Spouse & Child(ren)	$1,971.16	$985.58	$1,126.38
Choice			
Employee Only	$288.76	$144.38	$165.01
Employee + Spouse	$1,570.00	$785.00	$897.14
Employee + Child(ren)	$1,045.88	$522.94	$597.65
Employee + Spouse & Child(ren)	$2,909.58	$1,454.79	$1,662.62
HDHP W/HSA			
Employee Only	-	-	-
Employee + Spouse	$921.54	$460.77	$526.59
Employee + Child(ren)	$544.54	$272.27	$311.17
Employee + Spouse & Child(ren)	$1,884.92	$942.46	$1,077.10

Medical Plan Comparisons

The following charts compare the highlights of our three plan options. For more detailed information, please refer to the 2026-2027 Summaries of Benefits and Coverage (SBC) on the District website @ www.pxu.org.

THIS IS WHO WE ARE PXU

In-Network Only	ALLIANCE *No monthly premium for employee*	CHOICE *Monthly premium*	HDHP W/HSA *No monthly premium for employee*
Individual Annual Deductible	$1000	$1000	$3,400
Office Visit Co-Pays: PCP/Specialist	$25/$35	$25/$35	Subject to deductible then 20%
OOP Max Individual/Family	$3000/$6000	$3000/$6000	$6000/$12000
Emergency Room Co-Pay	$150	$150	Subject to deductible then 20%
Urgent Care Co-Pay	$50	$50	Subject to deductible then 20%
Coinsurance (Plan pays 80%)	20%	20%	20%
Prescription drugs (retail)	$10/$40/$60/$80	$10/$40/$60/$80	Subject to deductible then 20%
Network	Limited network	Broad network	Limited network

Medical Insurance FAQs

Q: Do I need to accept Medical Insurance from PXU?

A: No, our Medical Insurance and our other benefits with premiums can be declined.

Q: Can I just insure my dependents without getting coverage for myself?

A: No, the employee is the subscriber and must be enrolled to extend benefit coverage for dependents, spouses and/or domestic partners.

Q: Which plan covers the most?

A: All of the District Medical options cover the same services, only the member cost-sharing such as deductibles, co-pays, maximums etc. are different. Please refer to the applicable benefit summary for specifics.

Q: How can I check to see if my doctor is in the limited or broad network?

A: Use the following link: https://www.pxu.org/o/pxu/page/video-library - there is a video called Searching the Network that will show you step by step how to search the BCBS of AZ Network.

Q: Medical Insurance is too expensive for my dependents, what are my other options for obtaining medical insurance for them in the upcoming year?

A: Use the Health Insurance Marketplace, this service was created by the Affordable Care Act to help families shop for private health insurance. It is the only place where you can apply for credits/savings to lower your monthly private health insurance costs.









How can you be a wise Health Care Consumer and get the most value out of the Medical Plan?

Below are ways you can be a wise health care consumer and get value out of the medical plan you elect.

- Use in-network BCBSAZ (PPO) providers. They charge less, and you pay less. And, Preventive Care is free when provided by in-network PPO providers.

- Choose Generic drugs when possible. Ask your Doctor if a generic drug is appropriate for you. You'll pay less for generic drugs than for brand name drugs.

- Have a chronic health condition like diabetes, asthma, arthritis, heart disease, etc.? One of the best things you can do for that condition is to take the medication your Doctor recommends for you. Make medication compliance your habit to a healthier life.

- Keep current with your Preventive/Wellness care to help identify any health risk factors (like high blood pressure, high blood sugar, weight creeping above the recommended range) and to stay current on recommended immunizations.

- Not feeling well? Call your in-network Doctor's office for help. Or, use an in-network Urgent Care facility instead of an emergency room (ER), if medically appropriate.

- Precertify your elective hospital admission, certain prescription drugs, and other services, as explained in the BCBSAZ medical plan booklets to help avoid a financial penalty.

Dental Insurance Plans

The District gives you a choice of two dental plans via Solstice; the DMHO 800B (Basic DMHO) and the Solstice PPO (Premium PPO). Understanding the differences between the dental plans can help you decide which plan is best for you and your dependents.

Basic DMHO – The DHMO plan has an extensive network of dental providers throughout Arizona plus access to the nationwide provider network. The Prepaid Dental Plan provides coverage for services and treatment for diagnostic, preventive, restorative, and routine oral surgery. There is no co-pay for most preventive and diagnostic services. Additional services are paid according to the Solstice DHMO fee schedule.For more detailed information on the fee schedule, please refer to Solstice Benefits Guide on the District website @ www.pxu.org. **Note: To receive benefits, you must use in-network Solstice dental providers.**

Solstice Premium PPO - The PPO plan utilizes the Solstice network of dentists, or you can see any dentist and submit a claim form for reimbursement. Reimbursement is based on Solstice fee schedule. This plan covers preventive dental services such as oral cleanings, examinations, and X-rays. Preventive care is covered at 100% with no deductible. Basic services are covered at 80% and major services are covered at 50%. Orthodontic services are available for children up to 19 years old. This plan does have a deductible and out-of-pocket maximum, but no waiting periods. For more information refer back to the Solstice Benefits Guide on the District website @ www.pxu.org.

The following chart shows the Dental coverage premiums for the 2026-2027 plan year. Note: the biweekly payroll deduction amount is based on 24 deductions per plan year if you are a 12 month employee and 21 deductions per plan year if you have a less than 12 month work contract.

2026-2027 EMPLOYEE PREMIUMS FOR DENTAL PLANS			
	MONTHLY	Biweekly Deduction 12 Month Contracts	Biweekly Deduction < 12 Month Contracts
Basic DHMO - Single	$9.73	$4.87	$5.56
Basic DHMO - 2-Party	$19.46	$9.73	$11.12
Basic DHMO - Family	$25.69	$12.85	$14.68
Premium PPO - Single	$32.00	$16.00	$18.29
Premium PPO - 2-Party	$63.98	$31.99	$36.56
Premium PPO - Family	$84.45	$42.23	$48.26

Avēsis Vision Insurance Plan

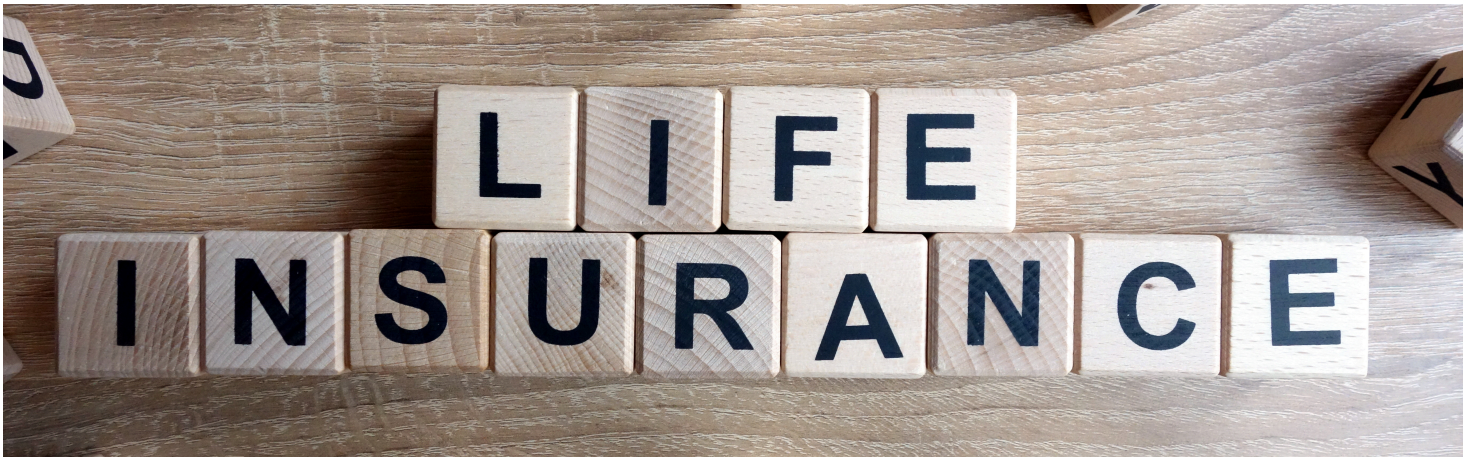
The District offers one vision plan via Avēsis. Avēsis is a leading managed care vision insurance company. Providing outstanding customer service has been their top priority for over 40 years, and their core values help them deliver innovative and valued benefit programs to our members. A strong provider network, a user-friendly website for member self-service, and LASIK benefits make this a plan you can keep.
Understanding what's available to you and how to get the most out of your vision plan helps keep your out-of-pocket expenses low. The following chart highlights the benefits of our vision insurance via Avēsis. For more detailed information, please refer to the Avēsis Benefit Summary on the District website @ www.pxu.org.

Plan Name Avesis **Network -Avēsis** Providers	**Frequency of Benefits** Eye Exam..... once every 12 months Lenses ..... once every 12 months Frame..... once every 12 months
Copays Total (eye exam/glasses) ..... $10 Materials $25	**Allowances** (glasses or contacts) Frame..... $175 Basic Frame..... Additional 20% may apply Contact Lenses ..... $150 Selected Retail Providers ..... See fee schedule
Out-of-Network Schedule	
Exam: Lenses: Single vision bifocal trifocal Lenticular Frame Elective contact lenses (in lieu of lenses & frame)	Up to $35 Up to $25 Up to $40 Up to $50 Up to $80 Up to $60 Up to $128
Additional Plan Features: Lasik and Hearing discounts available	

The following chart shows the vision coverage premiums for the 2026-2027 plan year. Note: the biweekly payroll deduction amount is based on 24 deductions per plan year if you are a 12 month employee and 21 deductions per plan year if you have a less than 12 month work contract.

2026-2027 EMPLOYEE PREMIUMS FOR VISION			
	MONTHLY	Biweekly Deduction 12 Month Contracts	Biweekly Deduction < 12 Month Contracts
Avēsis - Single	6.75	$3.38	$3.86
Avēsis - 2-Party	14.72	$7.36	$8.41
Avēsis - Family	24.18	$12.09	$13.82

Life and AD&D Insurance



Life insurance is an important part of your financial security, especially if others depend on you for support. Accidental Death & Dismemberment (AD&D) is designed to provide a benefit to you and/or your beneficiaries in the event of accidental death or dismemberment.

Basic Life Insurance

Basic life insurance coverage via Symetra is provided to all eligible employees. This coverage is automatic and paid 100% by the District. You receive one times your base annual earnings with a minimum benefit of $25,000 (maximum benefit restrictions may apply).

Note: This policy has an automatic age reduction provision whereby the payable benefit referenced above will be reduced to the following percentages:

Age of Employee	Payable Percentage
70	65%
75	45%
80	30%

***Minimum benefit of $25,000 still applies**

Note: The District's Life Insurance Certificate is available on the District's website @ www.pxu.org.

Beneficiary Designation

The beneficiary you designate for your Basic Life insurance will also be the beneficiary for your Voluntary Life insurance if applicable - see next section for details on our voluntary policy.

Voluntary Life Insurance

In addition to your District-paid life insurance, you have the option to purchase additional (voluntary/supplemental) life insurance, underwritten by the Sun Life Insurance Company. You can purchase coverage for yourself, your spouse and your dependent child(ren).

Paying for your Voluntary Life Insurance

Voluntary life insurance rates for you and your spouse are based on your age as of July 1st. The monthly rates are listed below. Premiums for voluntary life insurance benefits are set up through payroll deductions on an after-tax basis. The monthly premiums for each age band and insurance level are available on the District website @ www.pxu.org.

2026-2027 Voluntary Life Insurance Rates	
Employee Age	Employee Rate
Under 30	$0.04
30-34	$0.05
35-39	$0.06
40-44	$0.09
45-49	$0.14
50-54	$0.23
55-59	$0.35
60-64	$0.52
65-69	$0.74
70+	$0.74

2026-2027 Voluntary Life Insurance Rates	
Employee Age	Spouse Rate
Under 30	$0.06
30-34	$0.08
35-39	$0.09
40-44	$0.10
45-49	$0.15
50-54	$0.23
55-59	$0.43
60-64	$0.66
65-69	$1.27
70+	$2.06

2026-2027 Supplemental Life Insurance Rates	
Child(ren) Rate	
Benefit Amount	
$2,500.00	$0.13
$5,000.00	$0.27
$7,500.00	$0.40
$10,000.00	$0.53

Coverage options for Voluntary Life Insurance

Voluntary life insurance coverage is available for you in increments of $10,000, to a maximum of $600,000; for Spouse Life insurance coverage is available in increments of $10,000, to a maximum of $300,000. Note: You must have employee coverage to elect spouse coverage and your spouse cannot have higher coverage than you. Also, employees cannot have personal coverage and be covered as a spouse through another District employee. Voluntary life insurance coverage is available for your dependent Child(ren) up to age 26: $2,500, $5,000, $7,500 or $10,000. You must have employee coverage to elect Child(ren) coverage. You pay only one premium to cover all your children.

Note: You can apply for voluntary life insurance only as a new hire or during the annual open enrollment period.

Evidence of Insurability (EOI)

If you apply for more than the guaranteed issue amount of $150,000 for employee, $50,000 for spouse or domestic partner (DP), you must provide proof of good health (evidence of insurability) and be approved for the additional coverage.

If your election is subject to EOI, the EOI questionnaire is available on-line @ https://www.sunlife-usa.net/eoi/ and should be completed within 30 days of your election.

Note: This policy has an automatic age reduction provision whereby the insurance amount elected will be reduced to the following percentages:

Age of Employee	Payable Percentage
70	65%
75	45%
80	30%

*Minimum benefit of $25,000 still applies



Disability Insurance

Disability Insurance provides income replacement should you become disabled and unable to work due to a personal illness or injury.

Short Term Disability

Short-term disability (STD) insurance through Symetra provides you with a weekly check of $100 to $1,900, in any $100 increment you choose, to replace a portion of your income-up to two-thirds of your total base weekly salary if you are totally disabled and unable to work. Benefits start on the sixth day of illness/disability and are payable for up to 12 weeks. This benefit has a workers' compensation exclusion and pre-existing condition limitations apply to all applications.

2026-2027 Employee Premiums for STD Plan				
Minimum Salary	Weekly Benefit	Monthly Premium	Biweekly Deduction 12 Month Contract	Biweekly Deduction <12 Month Contract
$7,800.00	$100.00	$5.52	$2.76	$3.15
$15,599.00	$200.00	$11.04	$5.52	$6.31
$23,399.00	$300.00	$16.56	$8.28	$9.46
$31,198.00	$400.00	$22.08	$11.04	$12.62
$38,998.00	$500.00	$27.60	$13.80	$15.77
$46,798.00	$600.00	$33.12	$16.56	$18.93
$54,597.00	$700.00	$38.64	$19.32	$22.08
$62,387.00	$800.00	$44.16	$22.08	$25.23
$70,196.00	$900.00	$49.68	$24.84	$28.39
$77,996.00	$1,000.00	$55.20	$27.60	$31.54
$85,796.00	$1,100.00	$60.72	$30.36	$34.70

Short Term Disability cont.

2026-2027 Employee Premiums for STD Plan				
Minimum Salary	Weekly Benefit	Monthly Premium	Biweekly Deduction 12 Month Contract	Biweekly Deduction <12 Month Contract
$93,595.00	$1,200.00	$66.24	$33.12	$37.85
$101,395.00	$1,300.00	$71.76	$35.88	$41.01
$109,195.00	$1,400.00	$77.28	$38.64	$44.16
$116,994.00	$1,500.00	$82.80	$41.40	$47.31
$124,794.00	$1,600.00	$88.32	$44.16	$50.47
$132,593.00	$1,700.00	$93.84	$46.92	$53.62
$140,393.00	$1,800.00	$99.36	$49.68	$56.78
$148,193.00	$1,900.00	$104.88	$52.44	$59.93

Mid-Term Disability

Mid-term disability insurance through the Symetra provides a weekly income of up to 66 2/3% of your base weekly pay (maximum of $2,500) for a maximum of 90 calendar days if you cannot work due to a non-occupational, accidental injury or illness (including pregnancy). Benefits are available after a 90-day waiting period.

This coverage is provided automatically for employees and paid for by the District.

Long-Term Disability

Long-term disability (LTD) insurance provides a weekly income of up to 66 2/3% of your base monthly pay if you are disabled and unable to work. Coverage is provided through the Arizona State Retirement System (ASRS) and is available after six months of disability and after you have exhausted any remaining sick leave.

This coverage is provided automatically for employees as part of their ASRS enrollment.
Please call Broadspire with any questions you have regarding LTD benefits at 1-877-232-0596.

Note: Employees who are already retired with the ASRS are not eligible for LTD benefits since they are already receiving their pension.



Flexible Spending Accounts (FSAs)

Flexible Spending Accounts (FSAs) allow you to set aside a portion of your pay on a pre-tax basis to be used later to reimburse yourself for certain out-of-pocket expenses. By taking advantage of pre-tax deductions, you minimize your taxes paid thereby maximizing your take-home pay.

You must use the Online system and enroll/re-enroll each year if you want this coverage.

FSA Options

- Medical Reimbursement Account (MRA) – a general purpose account to pay for eligible health care expenses (medical, dental, vision and/or hearing).
- Dependent Care Spending Account (DCA) – an account to pay for eligible dependent care (day care) expenses.
- Limited Care Reimbursement Account (Limited) - an account to pay for eligible dental and/or vision expenses only (no medical) for use with an HSA. This will be offered to HDHP participants in lieu of a MRA.

Eligible Expenses

The following are some examples of eligible medical and dependent care expenses that can be reimbursed from your Medical Reimbursement Account (MRA), Limited FSA or Dependent Care Spending Account (DCA):

Medical:

- Annual deductibles for medical, dental, and vision plans
- Coinsurance
- Co-pays for medical care and prescription drugs
- Dental expenses that are not covered by the Dental plan (excluding cosmetic services)
- Vision expenses that are not covered by the Vision plan
- Hearing aid expenses
- Over the counter (OTC) drugs/medications
- Special equipment for the handicapped that are not covered under the medical plan

Dependent Care:

- Child Day Care or elder care, when care is provided to allow you to work

Limited Care:

- Annual deductibles for dental and vision plans only
- Coinsurance for dental and vision plans only
- Dental expenses that are not covered by the Dental plan (excluding cosmetic services)
- Vision expenses not covered by the Vision plan
- No Medical

How FSAs work

You contribute with pre-tax deductions from your pay into one or both accounts up to the maximum permitted (as outlined below). Then you use the money in your accounts to reimburse yourself for eligible expenses you incur between your benefits effective date and 06/30/2027.

Medical Reimbursement Account or Limited Flexible Spending Account Max: $2,500/year

Dependent Care Spending Account Max: $5,000/year

Because FSA deductions are taken from your pay before taxes are withheld, you avoid paying taxes on that money.



MRA/HSA Warning

Note: if your spouse has an active HSA via their employer, you can not have an MRA. If applicable, please contact the Benefits Department so that your MRA can be converted to a Limited Care Account which is compatible with a spouse's HSA.

Debit Card

The District will be utilizing the Debit Card Option for the 2026-2027 plan year administered through Basic. This card will enable you to pay for certain eligible expenses up-front rather than going through the claim reimbursement process.

Note: If you enroll in an MRA, DCA or Limited FSA for the 2026-2027 plan year and will be re-enrolling for the 2027-2028 plan year, please do not destroy your Debit Card once your funds are exhausted. You will be using the same card for future years.

Use the app

Basic uses an application available to be downloaded from the Google Play Store and Apple App Store. The application allows you to:

- View balance
- Upload receipts
- See contributions
- View transactions
- Access digital wallet
- Submit for Reimbursements
- Obtain support from Basic

Employee Assistance Program

The employee assistance program (EAP) is an employer-paid benefit for employees and their family members. Jorgensen Brooks Group (JBG) is our EAP provider, with professionals available throughout Arizona.

The EAP provides a full range of counseling, educational, and referral services for individuals and families, such as:

- marriage concerns
- stress and job-related issues
- child and domestic abuse issues
- substance abuse assessments

You receive up to six (6) free counseling sessions per person per problem per plan year. Any services you receive are kept strictly confidential. JBG professional counselors can help. You can reach JBG 24 hours a day, seven days a week, toll free at 888-520-5400 or find information online at https://jorgensenbrooks.com/.





This Enrollment Guide contains highlights of the Phoenix Union High School District benefits program. Complete information can be found in the plan's legal documents (Plan Document). If there is a conflict between this Guide and the plan's legal document(s), the legal documents will prevail. Phoenix Union High School District reserves the right to amend, replace or terminate any benefit program at any time for any reason. If one of these events occurs, you will be notified. Receipt of this Guide does not guarantee benefits eligibility.



For More Information

PXU Employee Benefits Office
4502 N. Central Avenue, Phoenix, AZ 85012
(602) 764-1548
benefits@phoenixunion.org

Blue Cross and Blue Shield of Arizona (BCBSAZ) Medical Plan Provider Network
(PPO Preferred and Participating Only In-Network Providers)
(602) 864-4861
www.azblue.com

Solstice
(602) 938-3131
www.solsticebenefits.com

Avesis
(800) 877-7195
www.avesis.com

District Life Insurance – Employee Benefits Office
(602) 764-1548
www.pxu.org

Voluntary Life Insurance - Sun Life
(602) 764-1538
www.sunlife-usa.net

Mid-term Disability Coverage – Employee Benefits Office
(602) 764-1538
www.pxu.org

Short-term Disability Coverage - Symetra
(602) 263-9265
www.symetra.com

Long-term Disability Coverage - Broadspire through the ASRS
(877) 232-0596
www.azasrs.gov

Flexible Spending Accounts - BASIC
(800) 444-1922 Ext 1
www.basiconline.com

Employee Assistance Program (EAP) Jorgensen Brooks Group (JBG)
(888) 520-5400
https://jorgensenbrooks.com/

Union High School District (PUHSD)

Important Employee Benefit Program Notices

Updated 5/1/2026

This document contains important employee benefit program notices of interest to you and your family. Please share this information with your family members. Some of the notices in this document are required by law and other notices contain helpful information. These notices are updated from time to time and some of the federal notices are updated each year. Be sure you are reviewing an updated version of these important notices document.

MID-YEAR CHANGES TO YOUR HEALTH CARE BENEFIT ELECTIONS

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

- ***Special Enrollment Event:***

  Loss of Other Coverage Event: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if your employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within **31 days** after your or your dependents' other coverage ends (or after the employer stops contributing towards the other coverage).

  Marriage, Birth, Adoption Event: In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within **31 days** after the marriage, birth, adoption, or placement for adoption.

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

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

  To request special enrollment or obtain more information, contact the District's Employee Benefits Coordinator at 602-764-1548 or Benefits@phoenixunion.org.

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

  Because the District pre-taxes benefits for active employees, we are required to follow Internal Revenue Service (IRS) regulations on if and when benefits can be changed in the middle of a plan year. The following events **may** allow certain changes in benefits mid-year, **if** permitted by the IRS:

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

You must notify the plan in writing within **31 days** of the mid-year change in status event by contacting the District's Employee Benefits Coordinator at 602-764-1548 or Benefits@phoenixunion.org.

The Plan will determine if your change request is permitted and if so, changes become effective prospectively, on the first day of the month, following the approved change in status event (except for newborn and adopted children, who are covered back to the date of birth, adoption, or placement for adoption).

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

Employers are required by law to collect the taxpayer identification number (TIN) or social security number (SSN) of each medical plan participant and provide that number on reports that will be provided to the IRS each year. Employers are required to make at least two consecutive attempts to gather missing TINs/SSNs.

If a dependent does not yet have a social security number, you can go to this website to complete a form to request a SSN: http://www.socialsecurity.gov/online/ss-5.pdf. Applying for a social security number is FREE.

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

If you have not yet provided the social security number (or other TIN) for each of your dependents that you have enrolled in the health plan, please contact the District's Employee Benefits Coordinator at 602-764-1548 or Benefits@phoenixunion.org.

IRS FORMS TO BE PROVIDED TO YOU IN 2026

Under the Affordable Care Act, employers (and in some cases insurance companies) are required to provide full-time employees, as well as other employees enrolled in a medical plan, with IRS Form 1095. The 1095 form should be provided to you annually.

For each month of the calendar year that you were enrolled in a medical plan, this 1095 form documents that you (and any enrolled family members) met the federal requirement to have "minimum essential coverage or MEC," meaning group medical plan coverage.

If you receive a 1095 form this year, **you should keep it in a safe place** with your other tax records because you may need to produce it if requested by the IRS. (For large employers, a copy of the form 1095 will also be provided to the IRS.)

Reminder: if you have not been covered by a medical plan during the calendar year you will not receive a Form 1095-B. If you have been covered by various medical plans during the calendar year, you may receive more than one IRS form.

MEDICARE NOTICE OF CREDITABLE COVERAGE REMINDER

If you or your eligible dependents are currently Medicare eligible, or will become Medicare eligible during the next 12 months, you need to be sure that you understand whether the prescription drug coverage that you elect under the Medical Plan options available to you are or are not creditable with (as valuable as) Medicare's prescription drug coverage.

To find out whether the prescription drug coverage under the medical plan options offered by the District are or are not creditable you should review the Plan's

Medicare Part D Notice of Creditable Coverage available in this enrollment guide and available from the District's Employee Benefits Coordinator at 602-764-1548 or Benefits@phoenixunion.org.

PRIVACY NOTICE REMINDER

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires health plans to comply with privacy rules. These rules are intended to protect your personal health information from being inappropriately used and disclosed. The rules also give you additional rights concerning control of your own healthcare information.

This Plan's HIPAA Privacy Notice explains how the group health plan uses and discloses your personal health information. You are provided a copy of this Notice when you enroll in the Plan and the Notice is also in this enrollment guide. You can get another copy of this Notice from the District's Employee Benefits Coordinator at 602-764-1538.

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

You or your dependents may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles, copayments, and coinsurance applicable to other medical and surgical benefits provided under the various medical plans offered by the District. For more information on WHCRA benefits, contact the District's Employee Benefits Coordinator at 602-764-1548 or Benefits@phoenixunion.org.

AVAILABILITY OF SUMMARY HEALTH INFORMATION: THE SUMMARY OF BENEFIT AND COVERAGE (SBC) DOCUMENT(S)

The health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

As required by law, across the US, insurance companies and group health plans like ours are providing plan participants with a consumer-friendly **Summary of Benefits and Coverage (SBC)** as a way to help understand and compare medical plan benefits. Choosing a health coverage option is an important decision. To help you make an informed choice, the SBC summarizes and compares important information in a standard format.

Each SBC contains concise medical plan information, in plain language, about benefits and coverage, including, what is covered, what you need to pay for various benefits, what is not covered and where to go for more information or to get answers to questions. SBC documents are updated when there is a change to the benefits information displayed on an SBC.

Government regulations are very specific about the information that can and cannot be included in each SBC. Plans are not allowed to customize very much of the SBC documents. There are detailed instructions the Plan had to follow about how the SBCs look, how many pages long the SBC should be, the font size, the colors used when printing the SBC and even which words were to be bold and underlined.

A Uniform Glossary that defines many of the terms used in the SBC is available at https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-uniform-glossary-of-coverage-and-medical-terms-final.pdf.

To get a free copy of the most current Summary of Benefits and Coverage (SBC) documents for our medical plan options, go to www.phoenixunion.org or for a paper copy, contact the District's Employee Benefits Coordinator at 602-764-1548 or Benefits@phoenixunion.org.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

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

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

In addition, the Plan may not, under federal law, require that a Physician or other Health Care Practitioner obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification for a length of stay longer than 48 hours for vaginal birth or 96 hours for C-section, contact Blue Cross Blue Shield of Arizona (BCBSAZ) at 877-864-4899 to precertify the extended stay. If you have questions about this Notice, contact the District's Employee Benefits Coordinator at 602-764-1548 or Benefits@phoenixunion.org.

FAMILY AND MEDICAL LEAVE ACT (FMLA) REMINDER

The FMLA entitles eligible employees of covered employers to take unpaid, job-protected leave for specified family and medical reasons with continuation of group health insurance coverage under the same terms and conditions as if the employee had not taken leave. Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles. Eligible employees are entitled to twelve (12) workweeks of leave in a 12-month period for:

- the birth of a child and to care for the newborn child within one year of birth;
- the placement with the employee of a child for adoption or foster care and to care for the newly placed child within one year of placement;
- to care for the employee's spouse, child, or parent who has a serious health condition;
- a serious health condition that makes the employee unable to perform the essential functions of his or her job;

- any qualifying exigency arising out of the fact that the employee's spouse, son, daughter, or parent is a covered military member on "covered active duty;" or

Twenty-six (26) workweeks of leave during a single 12-month period to care for a covered servicemember with a serious injury or illness if the eligible employee is the servicemember's spouse, son, daughter, parent, or next of kin (military caregiver leave).

All covered employers are required to display and keep displayed a poster prepared by the Department of Labor summarizing the major provisions of The Family and Medical Leave Act (FMLA) and telling employees about their rights and responsibilities and how to file a complaint. We display the FMLA poster at our worksite. More information on FMLA is available at: http://www.dol.gov/whd/fmla/ or contact the District's Employee Benefits Coordinator at 602-764-1548 or Benefits@phoenixunion.org.

Certain Employee Responsibilities Related to FMLA: Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When a 30-day notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave.

Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

COBRA COVERAGE REMINDER

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

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

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

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

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

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

If you have questions about COBRA contact the District's Employee Benefits Coordinator at 602-764-1548 or Benefits@phoenixunion.org.

FLEXIBLE SPENDING ACCOUNT PLAN DOCUMENT/SUMMARY PLAN DESCRIPTION

The Flex Plan Documents and Summaries of Benefits and Coverage for each medical plan option are available on the Employee Benefit Documents page of the District website @ www.pxu.org. You can also request a copy of any of the above and/or a copy of the Summary Plan Description from the District's Employee Benefits Coordinator at 602-764-1548 or Benefits@phoenixunion.org.

KEEP THE PLAN NOTIFIED OF CHANGES IN ELIGIBILITY FOR BENEFITS

YOU ARE REQUIRED TO PROVIDE TIMELY NOTICE

You or your Dependents must promptly furnish to the District information regarding change of name, address, marriage, divorce or legal separation, death of any covered family member, birth and change in status of a Dependent Child, change in Domestic Partner status, Medicare enrollment or disenrollment, an individual no longer meeting the eligibility provisions of the Plan, or the existence of other coverage. Proof of legal documentation will be required for certain changes.

Notify the District of any of these changes within 31 days. Note that for certain changes, like divorce or a child reaching the limiting age, if you do not notify the Plan within 60 days of that change, the opportunity to elect COBRA will not apply.

Failure to give your employer (the District) a timely notice of the above noted events may:

a. cause you, your Spouse and/or Dependent Child(ren) to lose the right to obtain COBRA Continuation Coverage,

b. cause the coverage of a Dependent Child to end when it otherwise might continue because of a disability,

c. cause claims to not be able to be considered for payment until eligibility issues have been resolved,

d. result in your liability to repay the Plan if any benefits are paid to an ineligible person. The Plan has the right to offset the amounts paid against the participant's future medical, dental, and/or vision benefits.

In accordance with the requirements in the Affordable Care Act, your employer will not retroactively cancel coverage (a rescission) except when premiums are not timely paid, or in cases when an individual performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact that is prohibited by the terms of the Plan. Keeping an ineligible dependent enrolled (for example, an ex-spouse, overage dependent child, etc.) is considered fraud. If you have questions about eligibility contact District's Employee Benefits Coordinator at 602-764-1548 or Benefits@phoenixunion.org.

IMPORTANT NOTICES ATTACHED

The following pages include important notices for you and your family:

- Health Insurance Marketplace Notice
- Medicare Part D Notice
- The District's HIPAA Privacy Notice
- Premium Assistance Under Medicaid and CHIP Notice

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026))

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1,2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact the District's Employee Benefits Coordinator at 602-764-1538.
The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name	4. Employer Identification Number (EIN)	
Phoenix Union High School District	86- 6000534	
5. Employer address	**6. Employer phone number**	
4502 N. Central Ave.	602-764-1548	
7. City	**8. State**	**9. ZIP code**
Phoenix	AZ	85012
10. Who can we contact at this job?		
Raul Padilla		
1 . Phone number (if different from above)	**12. Email address**	
	rpadilla@phoenixunion.org	

If you are not eligible for health insurance coverage through this employer. You and your family may be able to obtain health coverage through the Marketplace, with a new kind of tax credit that lowers your monthly premiums and with assistance for out-of-pocket costs.

Important Notice from Phoenix Union High School District about Prescription Drug Coverage for People with Medicare

This notice is for people with 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 Phoenix Union High School District and the prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare's prescription drug coverage and can help you decide whether or not you want to enroll in that Medicare prescription drug coverage. At the end of this notice is information on where you can get help to make a decision about Medicare's prescription drug coverage.

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

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

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

Phoenix Union High School District has determined that the prescription drug coverage is "creditable" under the following medical plan options: Choice PPO Option Plan, Alliance Low Medical Plan and High Deductible Health Plan (HDHP).

"Creditable" means that the value of this Plan's prescription drug benefit is, on average for all plan participants, expected to pay out as much as or more than the standard Medicare prescription drug coverage will pay.

Because the plan options noted above are, on average, at least as good as the standard Medicare prescription drug coverage, **you can elect or keep prescription drug coverage under the Choice PPO, Alliance Low and HDHP Option plans and you will not pay extra if you later decide to enroll in Medicare prescription drug coverage**. You may enroll in Medicare prescription drug coverage at a later time, and because you maintain creditable coverage, you will not have to pay a higher premium (a late enrollment fee penalty).

REMEMBER TO KEEP THIS NOTICE

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

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

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

- when they first become eligible for Medicare; or

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

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

YOUR RIGHT TO RECEIVE A NOTICE

You will receive this notice at least every 12 months and at other times in the future such as if the creditable/non-creditable status of the prescription drug coverage through this plan changes. You may also request a copy of a Notice at any time.

WHY CREDITABLE COVERAGE IS IMPORTANT (When you will pay a higher premium (penalty) to join a Medicare drug plan)

If you do not have creditable prescription drug coverage when you are first eligible to enroll in a Medicare prescription drug plan and you elect or continue prescription drug coverage under a non-creditable prescription drug plan, then at a later date when you decide to elect Medicare prescription drug coverage you may pay a higher premium (a penalty) for that Medicare prescription drug coverage for as long as you have that Medicare coverage.

Maintaining creditable prescription drug coverage will help you avoid **Medicare's late enrollment penalty**. This **late enrollment penalty** is described below:

If you go 63 continuous days or longer without creditable prescription drug coverage (meaning drug coverage that is at least as good as Medicare's 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 either Medicare prescription drug coverage or coverage under a creditable prescription drug plan. You may have to pay this higher premium (the penalty) as long as you have Medicare prescription drug coverage.

For example, if 19 months pass where you do not have creditable prescription drug coverage, when you decide to join Medicare's drug coverage your monthly premium will always be at least 19% higher than the Medicare base beneficiary premium. Additionally, if you go 63 days or longer without prescription drug coverage you may also have to wait until the next October to enroll for Medicare prescription drug coverage.

WHAT ARE MY CHOICES?

You can choose any **one** of the following options:

Your Choices:	What you can do:	What this option means to you:
Option 1	You can select or keep your current medical and prescription drug coverage with Choice PPO, Alliance Low or HDHP Medical plans, and **you do not have to enroll in a Medicare prescription drug plan.**	You will continue to be able to use your prescription drug benefits through Choice PPO, Alliance, or HDHP Medical plans. • You may, in the future, enroll in a Medicare prescription drug plan during Medicare's annual enrollment period (during October 15th -December 7th of each year). • As long as you are enrolled in creditable drug coverage you will not have to pay a higher premium (a late enrollment fee) to Medicare when you do choose, at a later date, to sign up for a Medicare prescription drug plan.
Option 2	You can select or keep your current medical and prescription drug coverage with Choice PPO, Alliance Low or HDHP Medical plans and also enroll in a Medicare prescription drug plan. If you enroll in a Medicare prescription drug plan you will need to pay the Medicare Part D premium out of your own pocket.	Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. Having dual prescription drug coverage under this Plan and Medicare means that this Plan will coordinate its drug payments with Medicare, as follows: • for Medicare eligible Retirees and their Medicare eligible Dependents, Medicare Part D coverage pays primary and this group health plan pays secondary. • for Medicare eligible Active Employees and their Medicare eligible Dependents, this group health plan pays primary and Medicare Part D coverage pays secondary. Note that you may not drop just the prescription drug coverage under the Choice PPO, Alliance Low or HDHP Medical plans. That is because prescription drug coverage is part of the entire medical plan. Generally, you may only drop medical plan coverage at this Plan's next Open Enrollment period. Note that each Medicare prescription drug plan (PDP) may differ. Compare coverage, such as: • PDPs may have different premium amounts • PDPs cover different brand name drugs at different costs to you; • PDPs may have different prescription drug deductibles and different drug copayments; • PDPs may have different networks for retail pharmacies and mail order services.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE'S PRESCRIPTION DRUG COVERAGE

More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You" handbook. A person enrolled in Medicare (a "beneficiary") will get a copy of this handbook in the mail each year from Medicare. A Medicare beneficiary may also be contacted directly by Medicare-approved prescription drug plans.

For more information about Medicare prescription drug plan coverage:

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see 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.

Para más información sobre sus opciones bajo la cobertura de Medicare para recetas médicas.

Revise el manual "Medicare Y Usted" para información más detallada sobre los planes de Medicare que ofrecen cobertura para recetas médicas. Visite www.medicare.gov por el Internet o llame GRATIS al 1 800 MEDICARE (1-800-633-4227). Los usuarios con teléfono de texto (TTY) deben llamar al 1-877-486-2048. Para más información sobre la ayuda adicional, visite la SSA en línea en www.socialsecurity.gov por Internet, o llámeles al 1-800-772-1213 (Los usuarios con teléfono de texto (TTY) deberán llamar al 1-800-325-0778).

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

For more information about this notice or your current prescription drug coverage contact:

Phoenix Union High School District
ATTN: Employee Benefits Coordinator
4502 N. Central Ave., Phoenix, AZ 85012
Phone Number: 602-764-1548

As in all cases, Phoenix Union High School District reserves the right to modify benefits at any time, in accordance with applicable law. This document (dated May 1, 2026) is intended to serve as your Medicare Notice of Creditable Coverage, as required by law.

Phoenix Union High School District: HIPAA Notice of Privacy Practices

Este aviso está disponible en Español si lo solicitas. Por favor contacte el oficial de privacidad indicado a continuación.

Purpose of This Notice

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

This Notice is required by law.

The Phoenix Union High School District group health plan, including the administration of the self-funded Medical Plan options, Medical/Health Reimbursement Account (also known as a Health Flexible Spending Account) and COBRA benefit, (hereafter referred to as the "Plan"), is required by law to take reasonable steps to maintain the privacy of your personally identifiable health information (called **Protected Health Information or PHI**) and to inform you about the Plan's legal duties and privacy practices with respect to protected health information including:

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

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

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

You may receive a Privacy Notice from a variety of the insured group health benefit plans offered by the District. Each of these notices will describe your rights as it pertains to that plan and in compliance with the Federal regulation, HIPAA. This Privacy Notice however, pertains to your protected health information related to the District's self-funded medical plan options, administration of the Medical/Health Reimbursement Account (also known as a Health Flexible Spending Account) and COBRA benefit (the "Plan") and outside companies contracted to help administer Plan benefits, called "business associates."

Effective Date

The effective date of this Notice is **May 1, 2026,** and this notice replaces notices previously distributed to you.

Privacy Officer

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

Privacy Officer for Phoenix Union High School District (PUHSD)
Attn: Human Resources Department
4502 N. Central Ave. Phoenix, AZ 85012
Telephone: 602-764-1548 Confidential fax #: 602-274-0484

Your Protected Health Information

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

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

PHI also does not include health information that has been de-identified. **De-identified information** is information that does not identify you and there is no reasonable basis to believe that the information can be used to identify you.

When the Plan May Disclose Your PHI

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

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

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

Definitions and Examples of Treatment, Payment and Health Care Operations	
Treatment is health care.	Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to coordination of benefits with a third party and consultations and referrals between one or more of your health care providers. • ***For example:*** The Plan discloses to a treating specialist the name of your treating primary care physician so the two can confer regarding your treatment plan.
Payment is paying claims for health care and related activities.	Payment includes but is not limited to making payment for the provision of health care, determination of eligibility, claims management, and utilization review activities such as the assessment of medical necessity and appropriateness of care. • ***For example:*** The Plan tells your doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan. If we contract with third parties to help us with payment, such as a claims payer, we will disclose pertinent information to them. These third parties are known as "business associates."

Health Care Operations keep the Plan operating soundly.	Health care operations includes but is not limited to quality assessment and improvement, patient safety activities, business planning and development, reviewing competence or qualifications of health care professionals, underwriting, enrollment, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs and general administrative activities. • *For example:* The Plan uses information about your medical claims to refer you to a health care management program, to project future benefit costs or to audit the accuracy of its claims processing functions.

In addition, the Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending or terminating the group health Plan. **Summary health information** is information that summarizes claims history, claims expenses or type of claims experienced by individuals for whom the Plan Sponsor has provided health benefits under a group health plan. Identifying information will be deleted from summary health information, in accordance with HIPAA. The Plan may not (and does not) use your genetic information that is PHI for underwriting purposes.

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

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

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

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

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

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

- In the event of your death while you are covered by this Plan, when the Plan is notified it will automatically communicate this information to the following internal departments: Payroll, Human Resources, Technology and Community Relations.
- In the event the Plan is notified of a work-related illness or injury, the Plan will automatically communicate this information to the District's Workers' Compensation Insurance Carrier, District Workers' Compensation Coordinator, Site Workers' Compensation Coordinator and Safety Department to allow the processing of appropriate paperwork.
- In the event the Plan is notified of a condition that may initiate a short term disability benefit, the Plan will automatically communicate this information to the Employee Benefits Specialist to allow the processing of appropriate paperwork.
- In the event the Plan is notified of a situation where it may be possible to initiate a medical leave under the Family and Medical Leave Act (FMLA) benefit, the Plan will automatically communicate this information to the Assistants to the Human Resource Administrators to allow the processing of appropriate FMLA paperwork.

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

Substance use disorder treatment records

Substance use disorder treatment records (SUD Records) received from a program covered by 42 CFR Part 2 (a "Part 2 Program"), or testimony relaying the content of such records, shall not be used or disclosed in civil, criminal, administrative,

or legislative proceedings against the individual unless based on written consent, or a court order after notice and an opportunity to be heard is provided to the individual or the holder of the record, as provided under law. A court order authorizing use or disclosure must be accompanied by a subpoena or other legal requirement compelling disclosure before the requested SUD Record is used or disclosed.

If the Plan receives SUD Records about you from a Part 2 Program pursuant to a consent you provided to the Part 2 Program to use and disclose your SUD records for all future purposes of treatment, payment or health care operations, the Plan may use and disclose your SUD records for the purposes of treatment, payment or health care operations, as described above, consistent with such consent until the Plan receives notification that you have revoked such consent in writing. When disclosed to the Plan for treatment, payment, and health care operations activities, the Plan may further disclose those SUD records in accordance with HIPAA regulations, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against you.

Additional restrictions on use and disclosure

Some federal and state laws may require special privacy protections that restrict the use and disclosure of certain sensitive health information such as alcohol and substance use disorder, (including Part 2 Programs); biometric information; child or adult abuse or neglect, including sexual assault; communicable diseases; genetic information; HIV/AIDS; mental health; minors' information; prescriptions; reproductive health; and sexually transmitted diseases. In such case, the Plan will follow the more stringent or protective law, to the extent that it applies.

Note, information that is disclosed by the Plan in accordance with HIPAA's Privacy Rule is subject to redisclosure by the recipient and may no longer protected by the Privacy Rule.

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

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

1. When ***required by law***.
2. When permitted for ***purposes of public health activities***. This includes reporting product defects, permitting product recalls and conducting post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
3. To a school about an individual who is a student or prospective student of the school if the protected health information that is disclosed is limited to ***proof of immunization***, the school is required by State or other law to have such proof of immunization prior to admitting the individual and the covered entity obtains and documents the agreements to this disclosure from either a parent, guardian or other person acting in loco parentis of the individual, if the individual is an unemancipated minor; or the individual, if the individual is an adult or emancipated.
4. When authorized by law to report information about ***abuse, neglect or domestic violence*** to public authorities if a reasonable belief exists that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives, although there may be circumstances under Federal or state law when the parents or other representatives may not be given access to the minor's PHI.
5. To a public health oversight agency for ***oversight activities authorized by law***. These activities include civil, administrative or criminal investigations, inspections, licensure or disciplinary actions (for example, to investigate complaints against providers) and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
6. When required ***for judicial or administrative proceedings***. For example, your PHI may be disclosed in response to a subpoena or discovery request, provided certain conditions are met, including that:
    - the requesting party must give the Plan satisfactory assurances a good faith attempt has been made to provide you with written Notice, and

- the Notice provided sufficient information about the proceeding to permit you to raise an objection, and
- no objections were raised or were resolved in favor of disclosure by the court or tribunal.

7. When required for ***law enforcement health purposes*** (for example, to report certain types of wounds).
8. For ***law enforcement purposes*** if the law enforcement official represents that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and the Plan in its best judgment determines that disclosure is in the best interest of the individual. Law enforcement purposes include:
   - identifying or locating a suspect, fugitive, material witness or missing person, and
   - disclosing information about an individual who is or is suspected to be a victim of a crime.
9. When required to be given ***to a coroner or medical examiner*** to identify a deceased person, determine a cause of death or other authorized duties. When required to be given ***to funeral directors*** to carry out their duties with respect to the decedent; for use and disclosures for cadaveric ***organ, eye or tissue donation*** purposes.
10. For ***research***, subject to certain conditions.
11. When, consistent with applicable law and standards of ethical conduct, the Plan in good faith believes the use or disclosure is necessary to prevent or lessen a serious and ***imminent threat to the health or safety*** of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
12. When authorized by and to the extent necessary to comply with ***workers' compensation*** or other similar programs established by law.
13. When required, for ***specialized government functions***, to military authorities under certain circumstances, or to authorized Federal officials for lawful intelligence, counter intelligence and other national security activities.

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

Your Individual Privacy Rights

A. You May Request Restrictions on PHI Uses and Disclosures

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

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

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

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

B. You May Inspect and Copy Your PHI

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

G. *Breach Notification*

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

Your Personal Representative

You may exercise your rights to your protected health information (PHI) by designating a person to act as your Personal Representative. Your Personal Representative will generally be required to produce evidence (proof) of the authority to act on your behalf **before** the Personal Representative will be given access to your PHI or be allowed to take any action for you.

Under this Plan, proof of such authority will include (1) a completed, signed and approved Appoint a Personal Representative form; (2) a notarized power of attorney for health care purposes; (3) a court-appointed conservator or guardian; or, (4) for a Spouse under this Plan, the absence of a Revoke a Personal Representative form on file with the Privacy Officer.

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

If you wish to revoke your Spouse as your Personal Representative, please complete the Revoke a Personal Representative form and return it to the Privacy Officer and this will mean that this Plan will NOT automatically recognize your Spouse as your Personal Representative and vice versa.

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

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

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

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

The Plan's Duties

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

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

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

Material changes are changes to the uses and disclosures of PHI, an individual's rights, the duties of the Plan or other privacy practices stated in the Privacy Notice. Because our health plan posts its Notice on its website (www.phoenixunion.org), we will prominently post the revised Notice on that website by the effective date of the material change to the Notice. We will also provide the revised notice, or information about the material change and how to obtain the revised Notice, in our next annual mailing to individuals covered by the Plan.

Disclosing Only the Minimum Necessary Protected Health Information

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

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

Your Right to File a Complaint

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

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

If You Need More Information

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

- *Attachment (Form to Revoke a Personal Representative)*

Phoenix Union High School District
Form to Revoke a Personal Representative

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

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

I, _____ (*Name of Participant or Beneficiary)*

hereby revoke the authority of _____ (*Name of Personal Representative)*

☐ to act on my behalf,

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

_____,

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

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

_____ _____

Participant or Beneficiary's Signature Date

Acknowledgement by the Privacy Officer: _____ Date:_____, 20___

Once completed, please return this form to the:

Privacy Officer for Phoenix Union High School District (PUHSD)
Attn: Human Resources Department
4502 N. Central Ave. Phoenix, AZ 85012
Telephone: 602-764-1548 Confidential fax #: 602-274-0484

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2026. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**

Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**

Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**

Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2026, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)