Arizona Department of Administration
Benefit Services Division
2011 Benefit Guide

Retired Employees

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- Benefit Changes
- Benefit Eligibility
- Medical & Prescription Benefits
- Dental & Vision Benefits
- Legal Notices

Revised June 28, 2011

Benefit Options
Choice. Value. Health.

CONTACTS

ADOA Contacts
Benefit Services Division
100 N. 15th Ave #103
Phoenix, AZ 85007
602.542.5008 or
1.800.304.3687
www.benefitoptions.az.gov
BenefitsIssues@azdoa.gov

Benefit Options Wellness
602.771.9355
www.benefitoptions.az.gov/wellness

Medical Plans
Aetna
1.866.217.1953
www.aetna.com
Policy Number 476687

Blue Cross Blue Shield of Arizona network administered by AmeriBen
1.866.955.1551
https://services.ameriben.com
Policy Number 1009013

CIGNA
1.800.968.7366
www.cigna.com/stateofaz
Policy Number 3331993

UnitedHealthcare
1.800.896.1067
www.myuhc.com
Policy Number 705963

Pharmacy Plan
MedImpact
1.888.648.6769
www.benefitoptions.az.gov
ADOAcustomerservice@medimpact.com

Dental Plans
Delta Dental
602.588.3620
1.866.9STATE9
www.deltadentalaz.com
Policy Number 7777-0000

Total Dental Administrators Health Plans, Inc. (TDAHP)
602.381.4280
1.866.921.7687
www.totaldentaladmin.com
Policy Number 680100

Vision Plan
Avesis, Inc.
1.888.759.9772
www.avesis.com
Policy Number 10790-1040
Discount Policy # 9000

Long-Term Disability Plans
Sedgwick CMS
(ASRS participants)
1.800.495.9301
www.sedgwickcms.com/calabasas

The Hartford
(PSPRS, EORP, CORP, and ORP, retirement participants)
1.866.712.3443
http://groupbenefits.thehartford.com/arizona/
Policy Number 395211

Retirement Systems
Arizona State Retirement System (ASRS)
3300 N. Central Ave, Lobby
Phoenix, AZ 85012
602.240.2000 or
1.800.621.3778
www.azasrs.gov

Public Safety Personnel Retirement System (PSPRS); Elected Officials' Retirement plan (EORP); Corrections Officer Retirement Plan (CORP)
3010 E. Camelback Rd, #200
Phoenix, AZ 85016
602.255.5575
www.psprs.com

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Welcome to the 2011 Retired Employee Benefit Guide!

This guide describes the benefits offered by the State of Arizona, Department of Administration, Benefit Services Division's comprehensive benefits package "Benefit Options", effective January 1, 2011. Included in this reference guide, are explanations of the benefits programs, important plan information, contact addresses, phone numbers, web addresses, and comparison charts. This guide is intended to help you understand your benefits.

The guide is divided into chapters, each covering a specific benefits program or important information. We encourage you to review each section before making your benefit elections. For more information please refer to your plan descriptions. If you need additional information please visit our website *benefitoptions.az.gov* or call us at 602.542.5008 or toll free at 1.800.304.3687.

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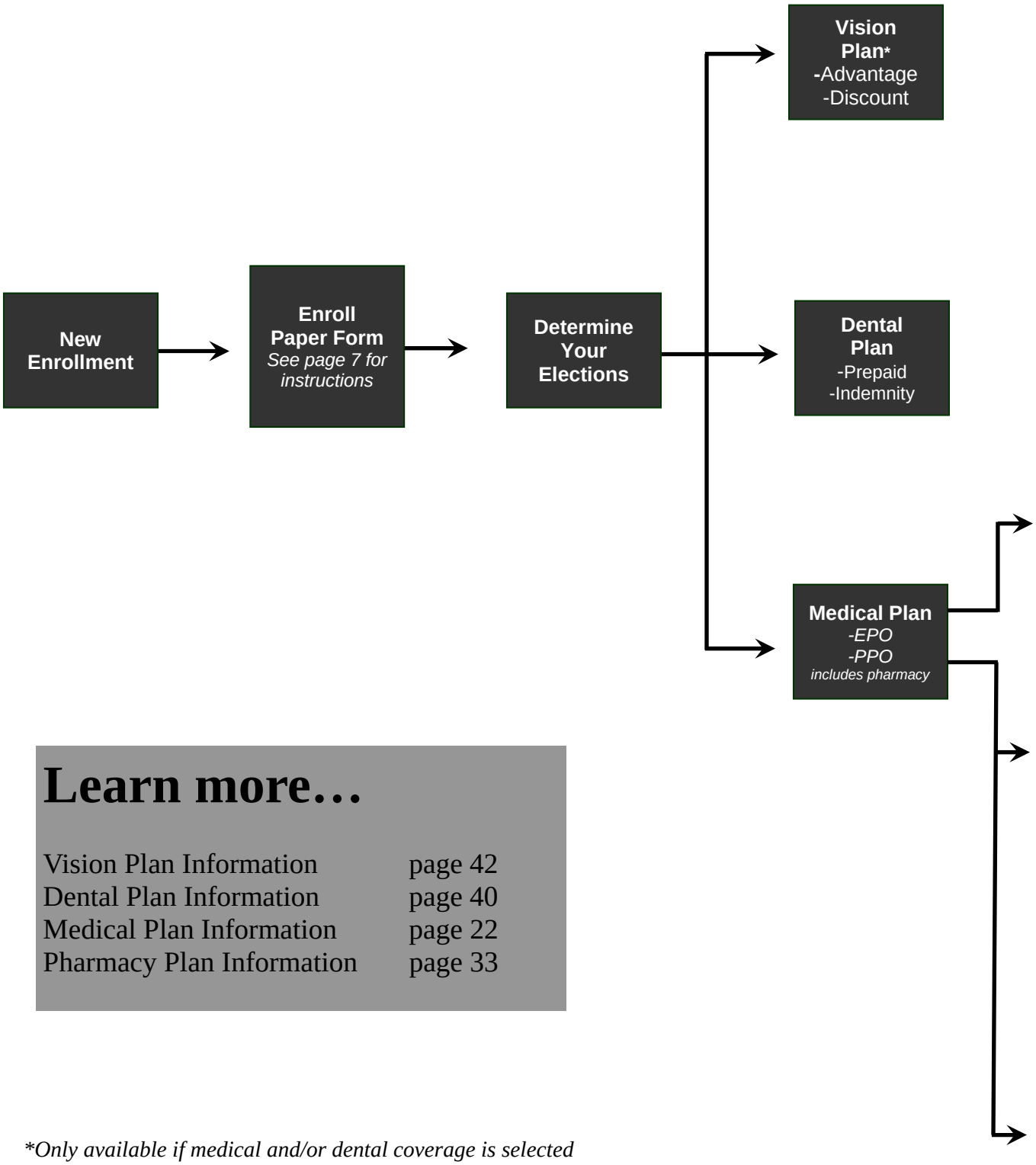
This Benefit Options guide is designed to provide an overview of benefits offered through the State of Arizona Benefit Options Program. The actual benefits available to you and the descriptions of these benefits are governed in all cases by the relevant Plan Descriptions and contracts. The State of Arizona reserves the right to modify, change, revise, amend or terminate these benefits plans at anytime.

2011 RETIREE NEW



Learn more…

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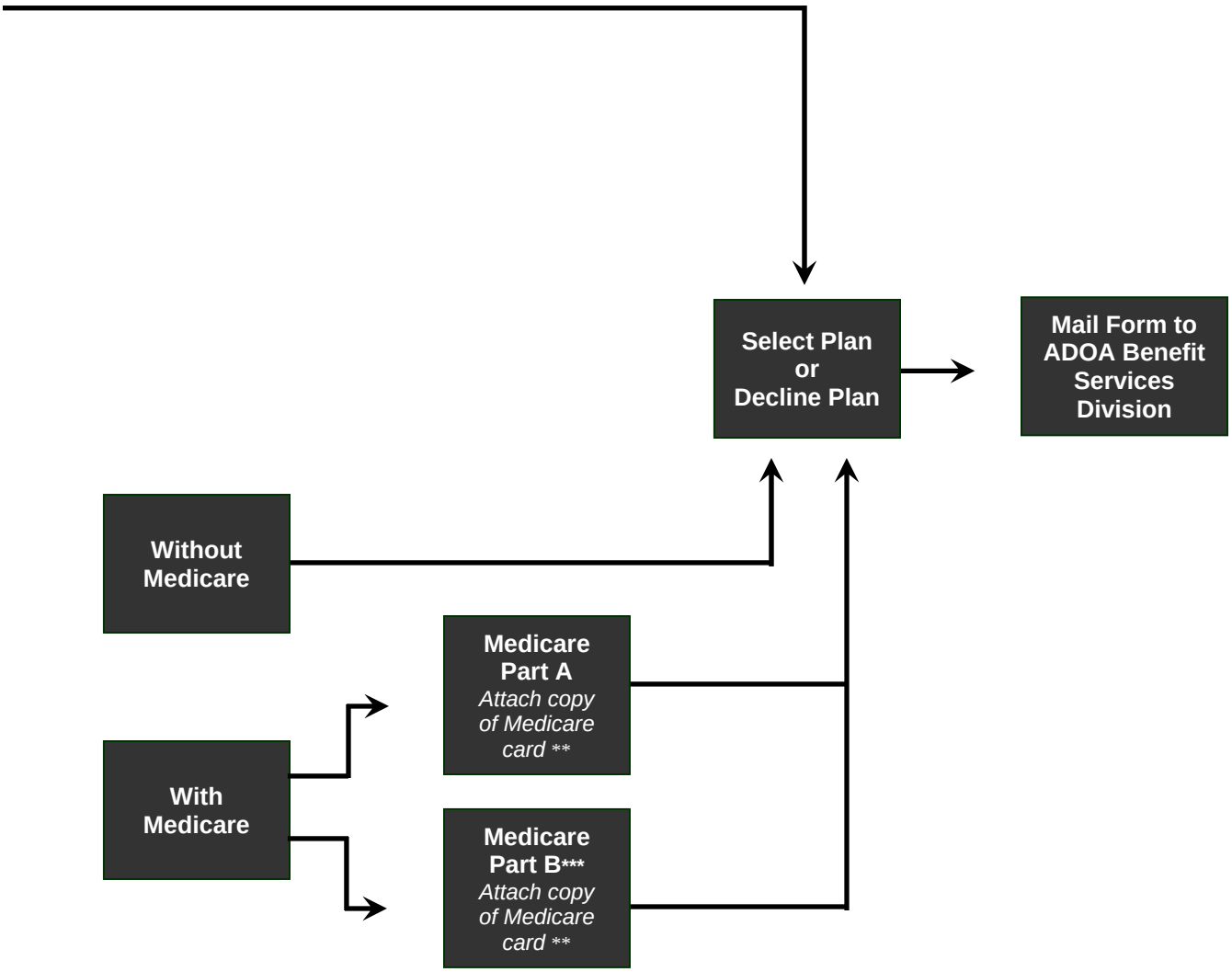
**Only available if medical and/or dental coverage is selected*
***Medicare card required if eligible for Medicare.*
****If you are eligible for Medicare Part B and choose not to elect it, you will be responsible for the cost of services covered by Medicare Part B.*

ENROLLMENT AT-A-GLANCE



ELIGIBILITY

Eligible Retirees

The following persons are eligible to participate in the Arizona Benefit Options program:

A. Retirees receiving a pension under a state-sponsored retirement plan and continuing enrollment in the Retiree health and/or dental plan.

B. Long-Term Disability (LTD) participants collecting benefits under a state-sponsored plan.

C. Eligible former elected officials and their qualified dependents if the elected official has at least 5 years of credited service in the Elected Officials Retirement Plan; was covered under a group health or accident plan at the time of leaving office; served as an elected official on or after January 1, 1983; and applies for enrollment within 31 days of leaving office or retiring.

D. Surviving spouses and qualified dependents provided they were covered at the time of the Retiree's death.

E. Surviving spouses of former elected officials provided they were covered at the time of the official's death.

Eligibility Rules

A. As an eligible retiree, if you elected ADOA's medical or dental insurance, you may make changes to your plan(s) during Open Enrollment or changes consistent with a Qualified Life Event (QLE).

B. If you have declined or cancelled ADOA's medical and/or dental coverages in the past, but have maintained either coverage through ADOA, you may re-elect medical and/or dental coverages during the Open Enrollment period.

C. If you have a qualified dependent that is not currently enrolled in Arizona Benefit Options, he or she may be added during the Open Enrollment period. Dependents not enrolled during Open Enrollment cannot be added until the next Open Enrollment, unless there is a Qualified Life Event (QLE). You have 31 days from the QLE to change your enrollment through the ADOA Benefit Services Division. The change must be consistent with the event. Please refer to the Benefit Services Division website for more information about QLEs.

Eligible Dependents

At Open Enrollment you may add the following dependents to your plans. Proper documentation may be required.

A. Your legal spouse

B. Your same-sex domestic partner subject to the following qualifications and proper documentation:

Important Disclosure and Disclaimer:

The State of Arizona is not offering benefits to opposite-sex domestic partners. As a result of the U.S. District Court preliminary injunction (described in detail on page 6) the State of Arizona is compelled at this time to continue offering benefits to qualified same-sex domestic partners. Qualified same-sex domestic partners are ADVISED and CAUTIONED that the preliminary injunction possibly could be lifted after open enrollment or during the 2011 Plan Year. If that were to occur, the State of Arizona would no longer

be compelled by the U.S. District Court injunction and the State of Arizona reserves the right to immediately discontinue offering benefits to qualified same-sex domestic partners during the 2011 Plan Year and thereafter. This also would include dependent children of the non-employee qualified same-sex domestic partner unless those individual(s) were an actual dependent of the State employee as defined under the State's benefit plan. **Qualified same-sex domestic partners and their dependents should not have an expectation that coverage will continue or an expectation that the benefits have vested for an entire plan year because the preliminary injunction may be lifted in the future**.

a. Shares the employee's or retiree's permanent residence;
b. Has resided with the employee or retiree continuously for at least 12 consecutive months before filing an application for benefits and is expected to continue to reside with the employee or retiree indefinitely as evidenced by an affidavit filed at the time of enrollment;
c. Has not signed a declaration or affidavit of domestic partnership with any other person and has not had another domestic partner within the 12 months before filing an application for benefits;
d. Does not have any other domestic partner or spouse of the same or opposite sex;
e. Is not legally married to anyone or legally separated from anyone else;
f. Is not a blood relative any closer than would prohibit marriage in Arizona;
g. Was mentally competent to consent to the contract when the domestic partnership began;
h. Is not acting under fraud or duress in accepting benefits;
i. Is at least 18 years of age; and
j. Is financially interdependent with the employee or retiree in at least three of The following ways:
   i. Having joint mortgage; joint property tax identification, or joint tenancy on a residential lease;
   ii. Holding one or more credit or bank accounts jointly, such as a checking account, in both names;
   iii. Assuming joint liabilities;
   iv. Having joint ownership of significant property, such as real estate, a vehicle, or a boat;
   v. Naming the partner as beneficiary on the employee's life insurance, under the employee's will, or employee's retirement annuities and being named by the partner as beneficiary of the partner's life insurance, under the partner's will, or the partner's retirement annuities; and
   vi. Each agreeing in writing to assume financial responsibility for the welfare of the other, such as durable power of attorney; or
   vii. Other proof of financial interdependence as approved by the Director

C. Your child defined as:
   a. Your or your qualified same-sex domestic partner's natural, adopted and/or stepchild who is under 26 years old

ELIGIBILITY Continued

b. A person under the age of 26 for whom you or your same-sex domestic partner have court-ordered guardianship
c. Your or your same-sex domestic partner's foster children under the age of 26
d. A child placed in your home by court order pending adoption
e. Your or your same-sex domestic partner's natural, adopted and/or stepchild;
   i. Who was disabled as defined by 42 U.S.C. 1382C before the age of 19;
   ii. Who continues to be disabled as defined by 42 U.S.C. 1382c;
   iii. Who is dependent for support and maintenance upon you or your same-sex domestic partner;
   iv. For whom you or your same-sex domestic partner had custody before the child was 19.

Dependent Documentation Requirements

If your dependent child is approaching age 26 and is disabled, application for continuation of dependent status must be made within 31 days of the child's 26th birthday. You will need to provide verification that your dependent child has a qualifying permanent disability, that occurred prior to his or her 19th birthday, in accordance with 42 U.S.C 1382c.

Qualified Medical Child Support Order (QMCSO)

You may not terminate coverage for a dependent covered by a QMCSO.

If You and Your Spouse are both State Retirees

You cannot enroll as a single subscriber and be enrolled as a dependent on your spouse's policy simultaneously. If you do enroll in this manner, no refunds will be made for the premiums paid.

Subrogation

Subrogation is the right of an insurer to recover all amounts paid out on behalf of you, the insured. In the event you, as a Benefit Options member, suffer an injury or illness for which another party may be responsible, such as someone injuring you in an accident, and Benefit Options pays benefits as a result of that injury or illness, Benefit Options has the legal right to recover against the party responsible for your illness or injury or from any settlement or court judgment you may receive, up to the amount of benefits paid out by Benefit Options. As a Benefit Options member you are required to cooperate with the ADOA during subrogation process. Failure to do so may result in legal action by the State to recover funds received by you.

Return to Work Retirees

Former retired State employees returning to Active State Employment can receive health benefits through the Benefit Options Health Plan. If a retiree returns to work and meets the eligibility guidelines, they can elect to enroll in Active benefits and decline retiree benefits. Leaving state service is considered a Qualified Life Event (QLE). The QLE then allows them to enroll in retiree benefits again.

DOMESTIC PARTNERS

Domestic Partners

Pursuant to a change in Arizona law, A.R.S § 38-651(O), domestic partners are not eligible dependents under the State of Arizona's benefit plan. As a result, this Arizona law precludes previously qualified same-sex and opposite-sex domestic partners from receiving benefits that were created by administrative rulemaking in Arizona Administrative Code § R2-5-101(22).

Accordingly, the State of Arizona will not be offering benefits to opposite-sex domestic partners.

The State of Arizona intended that this law apply equally to same-sex domestic partners, but an United States Federal District Court judge, in *Collins v. Brewer, et al.* (2:09-cv-02402 JWS), recently entered a preliminary injunction preventing, at this time, the State of Arizona from implementing A.R.S § 38-651(O) as applied to qualified same-sex domestic partners. The State of Arizona has appealed the preliminary injunction order and will defend its position regarding its right to fully implement A.R.S § 38-651(O) and discontinue offering benefits to all domestic partners.

Important Disclosure and Disclaimer to Qualified Same-Sex-Domestic Partners:

As a result of the U.S. District Court preliminary injunction described above, the State of Arizona is compelled at this time to continue offering benefits to qualified same-sex domestic partners. Qualified same-sex domestic partners are herein ADVISED and CAUTIONED that the preliminary injunction possibly could be lifted after open enrollment or during the 2011 Plan Year. If that were to occur, the State of Arizona would no longer be compelled by the U.S. District Court injunction and the State of Arizona reserves the right to immediately discontinue offering benefits to same-sex domestic partners during the 2011 Plan Year and thereafter. This also would include dependent children of the non-employee qualified same-sex domestic partner unless those individual(s) were an actual dependent of the State employee as defined under the State's benefit plan. **Qualified same-sex domestic partners and their dependents should not have an expectation that coverage will continue or an expectation that the benefits have vested for an entire plan year because the preliminary injunction may be lifted in the future**.

WHERE TO ENROLL
ENROLLMENT FORM

FOR INSTRUCTIONAL PURPOSES ONLY
PLEASE DO NOT COMPLETE THE FORM BELOW

1. Indicate your reason for completing the form.

- If you just retired and this is your first time enrolling in retiree/LTD coverage, please mark NEW RETIREE.
- If you recently started receiving LTD benefits and this is your first time enrolling in retiree/LTD coverage, please mark NEW LTD PARTICIPANT.
- If you are notifying ADOA of an address change, please mark ADDRESS CHANGE.
- If you are changing your enrollment options due to a qualified life event, please mark QUALIFIED LIFE EVENT.
- If you are terminating coverage, please mark TERMINATE INSURANCE.

Benefit Options Choice. Value. Health.

STATE OF ARIZONA BENEFIT OPTIONS RETIREE/LTD 2011 ENROLLMENT FORM

1.

☐ NEW RETIREE ☐ NEW LTD PARTICIPANT ☐ ADDRESS CHANGE
☐ QUALIFIED LIFE EVENT ☐ TERMINATE INSURANCE

2.

☐ RETIRED ☐ DISABLED
☐ SURVIVING SPOUSE

Retirement System
☐ ASRS (ZA) ☐ PSPRS, CORP, EORP (ZP) ☐ OPTIONAL (ZT)

EFFECTIVE DATE: | DECEASED MEMBER'S NAME: | DECEASED DATE:

3.

MEMBER IDENTIFICATION

LAST NAME, FIRST NAME, M.I. | EMPLOYEE EIN or SSN | ☐ MALE ☐ FEMALE | ☐ MARRIED ☐ SINGLE | DATE OF BIRTH
STREET ADDRESS | COUNTY OF RESIDENCE | CITY, STATE, ZIP CODE
LAST DAY WORKED | DATE RETIRED | MEDICARE ☐ YES | HOME PHONE NUMBER ( ) | AGENCY

4.

Are you enrolling a same-sex Domestic Partner? (circle one) Yes or No

To qualify a same-sex Domestic Partner for the first time, you will need to complete and submit the DOMESTIC PARTNER AFFIDAVIT FORM (this form must be notarized). This form can be found on the Benefit Options website at *www.benefitoptions.az.gov*.

5.

DEPENDENTS MUST BE LISTED FOR FAMILY COVERAGE

LAST NAME, FIRST NAME, MIDDLE INITIAL	DATE OF BIRTH (Required)	RELATIONSHIP CODE S=Spouse D=Same-Sex Domestic Partner C=Child G=Guardian P=Placed for adoption T=Stepchild	MEDICARE A=Medicare A B=Medicare B C=Medicare A & B D=Medicare Unknown E=No Medicare	SOCIAL SECURITY NUMBER (Required)	MALE OR FEMALE M OR F	ADD OR DELETE	Indicate Plan Type Medical(M) Dental(D) Vision(V)
MEMBER:							☐ M ☐ D ☐ V
SPOUSE OR SAME-SEX DOMESTIC PARTNER:							☐ M ☐ D ☐ V
							☐ M ☐ D ☐ V
							☐ M ☐ D ☐ V
							☐ M ☐ D ☐ V
							☐ M ☐ D ☐ V
							☐ M ☐ D ☐ V

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EXAMPLE

2. Indicate your current status (RETIRED, DISABLED, or SURVIVING SPOUSE), the effective date and the retirement system with which you are affiliated.

3. Complete the MEMBER IDENTIFICATION section.

4. Answer the question regarding enrollment of a same-sex domestic partner, please read the instructions printed on the enrollment form.

5. Complete the last section on page 1 if you are enrolling dependents.

Persons with a disability may request reasonable accommodation by contacting the Benefit Services Division. If you need this information in an alternate format, please call 602.542.5008, option 2.

WHERE TO ENROLL
ENROLLMENT FORM Continued

FOR INSTRUCTIONAL PURPOSES ONLY
PLEASE DO NOT COMPLETE THE FORM BELOW

6. Select your vision plan. You may only elect vision coverage if medical and/or dental coverage is also elected. If declining vision coverage, please mark DECLINE VISION COVERAGE.

7. Select your dental plan. If declining dental coverage, please mark DECLINE DENTAL COVERAGE.

IF YOU DO NOT HAVE MEDICARE, PROCEED TO STEP 8. IF YOU HAVE MEDICARE, PROCEED TO STEP 10.

Benefit Options Choice. Value. Health.

STATE OF ARIZONA BENEFIT OPTIONS RETIREE/LTD
2011 ENROLLMENT FORM

FOR ALL MEMBERS

VISION PLAN SELECTION - ONLY AVAILABLE IF MEDICAL AND/OR DENTAL COVERAGE IS SELECTED

6.

VISION PLAN - MONTHLY PREMIUMS AMOUNT			
☐ DECLINE VISION COVERAGE OR			
Select A Plan (only if changing)	Retiree Only	Retiree + One	Retiree & Family
Avesis	☐ $4.83	☐ $13.52	☐ $16.86

7.

DENTAL PLANS - MONTHLY PREMIUMS AMOUNT			
☐ DECLINE DENTAL COVERAGE OR			
Select A Plan (only if changing)	Retiree Only	Retiree + One	Retiree & Family
Delta Dental PPO Plus Premier	☐ $35.94	☐ $80.7[illegible]	☐ $136.82
Total Dental Administrators	☐ $9.96	☐ $18.92	☐ $27.70

8.

MEDICAL PLANS - MONTHLY PREMIUMS AMOUNT			
FOR MEMBERS WITHOUT MEDICARE			
☐ DECLINE MEDICAL COVERAGE OR			
Select A Plan (only if changing)	Retiree Only	Retiree + One	Retiree & Family
EPO PLANS			
AETNA EPO	☐ $593.00	☐ $1387.00	☐ $1869.00
BCBS of AZ/AMERIBEN EPO	☐ $593.00	☐ $1387.00	☐ $1869.00
CIGNA EPO	☐ $593.00	☐ $1387.00	☐ $1869.00
UNITEDHEALTHCARE EPO	☐ $593.00	☐ $1387.00	☐ $1869.00
PPO PLANS			
AETNA PPO	☐ $943.00	☐ $2219.00	☐ $3074.00
BCBS of AZ/AMERIBEN PPO	☐ $943.00	☐ $2219.00	☐ $3074.00
UNITEDHEALTHCARE PPO	☐ $943.00	☐ $2219.00	☐ $3074.00
NAU Only - Available in ALL regions			
BCBS of Arizona PPO	☐ $606.42	☐$1212.84	☐ $1697.99

BENEFIT SERVICES DIVISION USE ONLY

PLAN NAME: _____ PLAN OPTION CODE: _____

FOR MEMBERS WITH MEDICARE, MAKE ENROLLMENT SELECTIONS ON THE FOLLOWING PAGE

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EXAMPLE

8. Select your medical plan. If declining medical coverage, please mark DECLINE MEDICAL COVERAGE.

9. Skip to step 12 on the next page.

WHERE TO ENROLL
ENROLLMENT FORM Continued

FOR INSTRUCTIONAL PURPOSES ONLY
PLEASE DO NOT COMPLETE THE FORM BELOW

10. Indicate whether you have Medicare Part A, Medicare Part B, or both. IMPORTANT: ATTACH A COPY OF YOUR MEDICARE CARD TO YOUR ENROLLMENT FORM. ***Medicare card required if eligible for Medicare.***

11. Select your medical plan. If declining medical coverage, please mark DECLINE MEDICAL COVERAGE.

12. Read the statement and sign and date the form. Return form to the address provided.

Benefit Options Choice. Value. Health.

STATE OF ARIZONA BENEFIT OPTIONS RETIREE/LTD
2011 ENROLLMENT FORM

FOR MEMBERS WITH MEDICARE - attach a copy of your Medicare card
(A copy of your Medicare card is required if electing a Medicare option)

10.

☐ I HAVE MEDICARE PART A	☐ I HAVE MEDICARE PART B

MEDICAL PLANS - MONTHLY PREMIUMS AMOUNT

☐ DECLINE MEDICAL COVERAGE OR ☐ KEEP MY CURRENT MEDICAL COVERAGE OR

11.

Select A Plan (only if changing)	Retiree Only with Medicare	Retiree + ONE: Both with Medicare	Retiree + ONE: One with Medicare, the other without	Retiree & Family With Medicare
EPO PLANS				
AETNA EPO	☐ $442.00	☐ $878.00	☐ $1024.00	☐ $1166.00
BCBS of AZ/AMERIBEN EPO	☐ $442.00	☐ $878.00	☐ $1024.00	☐ $1166.00
CIGNA EPO	☐ $442.00	☐ $878.00	☐ $1024.00	☐ $1166.00
UNITEDHEALTHCARE EPO	☐ $442.00	☐ $878.00	☐ $1024.00	☐ $1166.00
PPO PLANS				
AETNA PPO	☐ $789.00	☐ $1576.00	☐ $1740.00	☐ $1980.00
BCBS of AZ/AMERIBEN PPO	☐ $789.00	☐ $1576.00	☐ $1740.00	☐ $1980.00
UNITEDHEALTHCARE PPO	☐ $789.00	☐ $1576.00	☐ $1740.00	☐ $1980.00
NAU Only - Available in ALL Regions				
BCBS of Arizona PPO	☐ $548.00	☐ $1086.39	☐ $1149.76	☐ $1467.24

If you decline or cancel both medical and dental coverages you will NOT be able to re-enroll with ADOA in the future. If you choose to keep medical or dental coverage through ADOA, you may elect medical and/or dental coverages during future Open Enrollment periods.

EXAMPLE

12.

I hereby certify, under penalty of perjury, that the information provided in this application for health benefits is correct and true. I am aware that providing false information - including that which is related to my address, spouse, or dependent(s) - may subject me to denial of health benefits, disciplinary action, and prosecution pursuant to ARS 13-2310, 13-2311, 13-2407, 13-2702 and other applicable laws.

Signature: _____ Date: _____

Return form to: ADOA Benefit Services Division, 100 N. 15th Ave., Suite 103
Phoenix, AZ 85007

*** BENEFIT SERVICES DIVISION USE ONLY ***

PLAN NAME: _____ PLAN OPTION CODE: _____

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For questions about open enrollment you may contact the ADOA Benefit Services Division by calling 602.542.5008 or toll-free at 800.304.3687 from 8 a.m. to 5 p.m. Monday through Friday (Arizona Time). You can also email your questions to BenefitsIssues@azdoa.gov.

CHANGING YOUR BENEFITS

You may only change your benefit elections when you experience a Qualified Life Event (QLE). If you have not experienced a QLE, you must wait until the next open enrollment period to make benefit changes.

Qualifying Life Events

Events that may be considered include but are not limited to:

A. Changes in your marital status: marriage, divorce, legal separation, annulment, death of spouse;
B. Changes in dependent status: birth adoption, placement for adoption, death, or dependent eligibility due to age;
C. Changes in employment status or work schedule that affect benefits eligibility for you, your spouse, and/or dependent.

Submitting a Change Request

Requested benefit changes must be submitted in writing to ADOA Benefit Services Division within 31 calendar days of the event.

Effective Date of the Change

The effective date for benefit changes resulting from birth, adoption, or placement for adoption is the date of the event.

The effective date for benefit changes based on all other QLEs is the first day of the next calendar month, following the date the retiree submits the requested change, in writing, to ADOA Benefit Services Division.

Please consult with ADOA Benefit Services Division to determine whether or not the life event you are experiencing qualifies under the regulations.

Premium Changes Due to QLEs

Any change in premiums due to a QLE will be in effect the 1st of the month following the receipt of all QLE documentation.

Refer to the flow chart on the following page for help in determining the effective dates of qualified life events.

Special Notice

Retirees will be required to provide Social Security Numbers (SSN) for all dependents enrolled in the Medical Benefit Options plans. This requirement is in accordance with the Mandatory Insurer Reporting Law (Section 111 of Public Law 110-173) which was effective January 1, 2009.

Questions

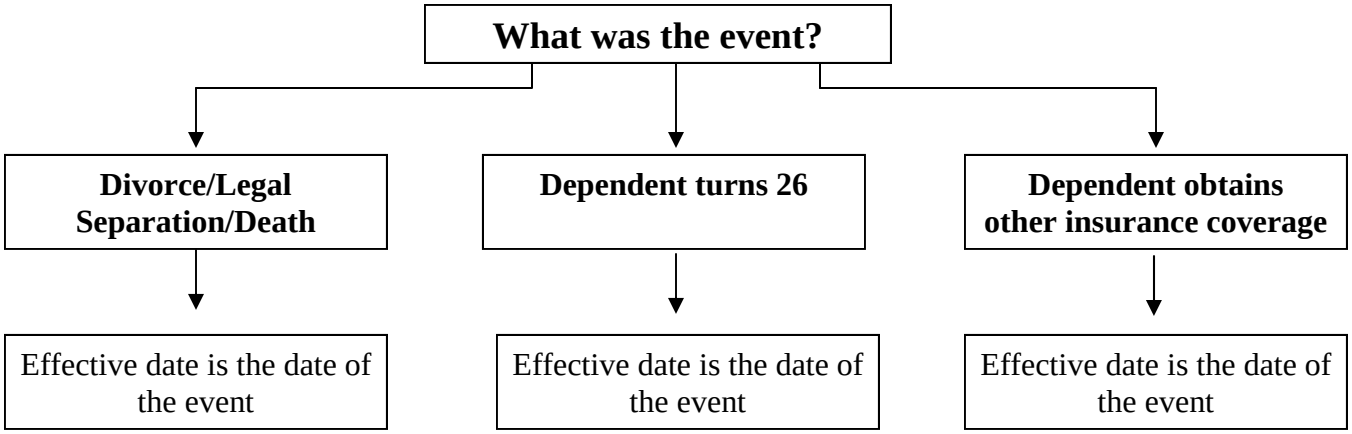
For answers about Enrollment, you may contact the ADOA Benefit Services Division by calling 602.542.5008 or toll-free 1.800.304.3687 between 8 a.m. and 5 p.m. Monday through Friday (Arizona time). You can also email your questions to BenefitsIssues@azdoa.gov.

Persons with a disability may request reasonable accommodations by contacting the ADOA Benefit Services Division. If you need this information in an alternate format, please call 602.542.5008, Option 2.

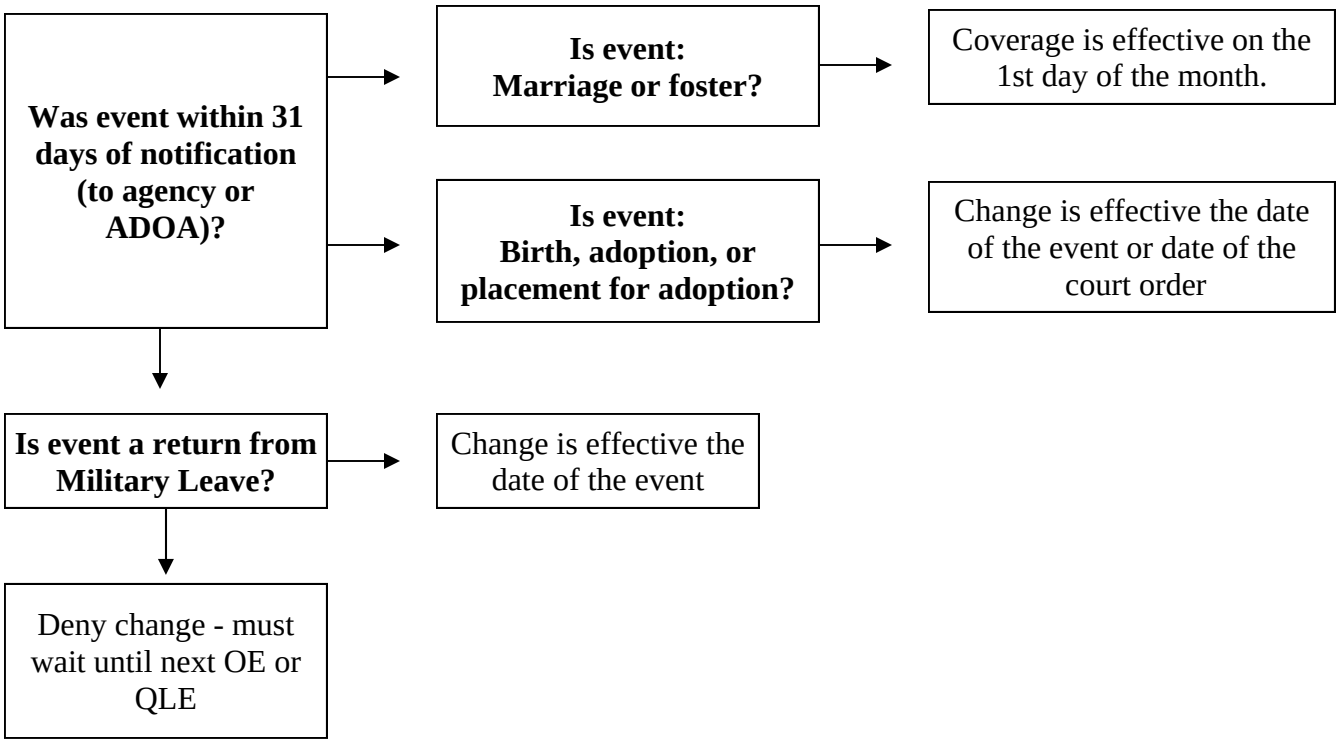
CHANGING YOUR BENEFITS FLOW CHART

The flow chart below will help you determine the effective dates for benefit changes resulting from qualifying life events.

LOSING YOUR BENFITS



ADDING YOUR BENEFITS



SUMMARY OF MONTHLY INSURANCE PREMIUMS

Monthly Medical Premiums (Without Medicare)

		Premium Payment
EPO (Aetna, BCBS of AZ/AmeriBen*, CIGNA, UnitedHealthcare)	Retiree only	$593
	Retiree +1	$1,387
	Family	$1,869
PPO (Aetna, BCBS of AZ/AmeriBen*, UnitedHealthcare)	Retiree only	$943
	Retiree +1	$2,219
	Family	$3,074

Monthly Medical Premiums (With Medicare)

		Premium Payment
EPO (Aetna, BCBS of AZ/AmeriBen*, CIGNA,UnitedHealthcare)	Retiree only	$442
	Retiree +1 (Both Medicare)	$878
	Retiree +1 (One Medicare)	$1,024
	Family (Two Medicare)	$1,166
PPO (Aetna, BCBS of AZ/AmeriBen*, UnitedHealthcare)	Retiree only	$789
	Retiree +1 (Both Medicare)	$1,576
	Retiree +1 (One Medicare)	$1,740
	Family (Two Medicare)	$1,980

For the NAU Blue Cross Blue Shield plan rates visit: http:/hr.nau.edu and choose "Benefits, Health".

**Blue Cross Blue Shield of Arizona network administered by AmeriBen. Blue Cross Blue Shield, an independent licensee of the Blue Cross Blue Shield Association, provides network access only and does not provide administrative or claims payment services and does not assume any financial risk or obligation with respect to claims. AmeriBen has assumed all liability for claims payment. No network access is available from Blue Cross Blue Shield Plans outside of Arizona.*

SUMMARY OF MONTHLY INSURANCE PREMIUMS Continued

Monthly Dental Premiums

		Premium Payment
HMO (Total Dental Administrators)	Retiree only	$9.96
	Retiree +1	$18.92
	Family	$27.70
PPO (Delta Dental PPO Plus Premier)	Retiree only	$35.94
	Retiree +1	$80.79
	Family	$136.82

Monthly Vision Premiums

		Premium Payment
Insured plan (Avesis)	Retiree only	$4.83
	Retiree +1	$13.52
	Family	$16.86
Discount card (Avesis)	Retiree	$0.00

UNDERSTANDING YOUR INSURANCE COST

Calculating your monthly costs, premium benefit, and pension check can be simple. Each retiree's circumstances are different, but understanding how all the pieces work together will make it an easy process. First, premium benefit for the basic program varies depending on your years of service with the State of Arizona, the retirement system you are enrolled in, and the insurance plan in which you enroll. Second, ADOA, ASRS, and PSPRS offer retiree health insurance plans. Premiums differ depending on the plan option selected and whether you are enrolled in single or family coverage.

The worksheet below will help you determine the amount of insurance premiums that will be deducted from your monthly pension check. In the event your pension check does not cover the net premium you will be identified as a Direct Pay Member and will be required to pay ADOA and/or the insurance vendors.

NET MONTHLY HEALTH INSURANCE COST WORKSHEET

Your monthly medical plan premium from page 12			**A**
	+		
Your monthly dental plan premium from page 13			**B**
Total Premium	**(A plus B)**		**C**
Your Basic Premium Benefit Subsidy (See chart on page 16)	**-**		**D**
Your Net Premium*	**(C minus D)**	**=**	**E**

*Vision premiums are always billed directly by the insurance vendor and are in addition to this "net premium".

UNDERSTANDING INSURANCE COST Continued

What You Should Know About Premium Payments

You are responsible to pay all premiums; failure to keep your premiums current will result in cancellation of your insurance coverage. If the sum of your premium benefit subsidy and pension is greater than or equal to the total monthly premium, you will be considered a non-direct pay member. Non-direct pay members do not receive a bill.

• If you are an LTD member or Surviving Spouse not receiving a pension check from a recognized state retirement plan, you are a Direct Pay Member. You are responsible for the payment of your premium(s) by the first of each month. The monthly premium is stated on your enrollment form.

• If your monthly pension check has insufficient funds to cover your health insurance premiums, then premiums will not be deducted. You will then become a Direct Pay Member. The ADOA Benefit Services Division will mail a bill to you. It will be your responsibility to pay any outstanding premiums to the ADOA Benefit Services Division. If you do not receive a bill by the first of the month, you must contact the ADOA Benefit Services Division.

• Should the retirement system begin deducting your premium from your pension check and you have also received a bill as a Direct Pay Member, please contact the ADOA Benefit Services Division. Please see the section entitled, “Information for Direct Pay Members.”

• Depending on when the Retirement System receives your benefit elections, you may owe one or more months of health and/or dental premiums. After enrolling, check your pension check deductions. If, by your second pension check, the deduction has not occurred or the deduction is incorrect, immediately contact the ADOA Benefit Services Division at 602-542-5008.

Information for Direct Pay Members

If you are or become a Direct Pay Member, you will receive a billing notice regarding future premium payments. If you do not receive a billing notice within 60 days, please call the ADOA Benefit Services Division at 602-542-5008.

Vision Premium Payments

If you elect vision coverage, you will be billed directly from Avesis. Vision premiums are NOT deducted from any pension checks.

UNDERSTANDING INSURANCE COST Continued

Calculating Your Premium Benefit Subsidy

The Arizona State Retirement System (ASRS), the Public Safety Personnel Retirement System (PSPRS), the Elected Officials Retirement Plan (EORP) and the Corrections Officer Retirement Plan (CORP) may provide payment toward insurance premiums for eligible members and dependents who elect health coverage through the ADOA Benefit Services Division. The chart below reflects the maximum monthly premium benefit available for eligible members and their qualified dependents.

No basic premium benefit is provided to Retirees in the University Optional Retirement Plan or to PSPRS or CORP members who are LTD members.

Your retirement system will determine if you are eligible for a premium benefit and the amount to which you may be entitled. To determine your basic premium benefit, you need to know:

- Your years of credited service in your retirement system or plan if you are an ASRS or EORP member (years of service is not a criterion for CORP and PSPRS members).
- Your coverage type (i.e., single or family coverage)
- Medicare eligibility

Basic Premium Benefit Amounts

	WITHOUT MEDICARE		WITH MEDICARE A & B		COMBINATIONS	
Years of Service	Retiree Only	Retiree & Dependents	Retiree Only	Retiree & Dependents	Retiree & Dependents One with Medicare, the other(s) without	Retiree & Dependent with Medicare, other dependents without
Arizona State Retirement System (ASRS) Members						
5.0–5.9	$75.00	$130.00	$50.00	$85.00	$107.50	$107.50
6.0–6.9	$90.00	$156.00	$60.00	$102.00	$129.00	$129.00
7.0–7.9	$105.00	$182.00	$70.00	$119.00	$150.50	$150.50
8.0–8.9	$120.00	$208.00	$80.00	$136.00	$172.00	$172.00
9.0–9.9	$135.00	$234.00	$90.00	$153.00	$193.50	$193.50
10.0+	$150.00	$260.00	$100.00	$170.00	$215.00	$215.00
Elected Officials' Retirement Plan (EORP) Members						
5.0–5.9	$90.00	$156.00	$60.00	$102.00	$129.00	$129.00
6.0–6.9	$112.50	$195.00	$75.00	$127.50	$161.25	$161.25
7.0–7.9	$135.00	$234.00	$90.00	$153.00	$193.50	$193.50
8.0+	$150.00	$260.00	$100.00	$170.00	$215.00	$215.00
Corrections Officer Retirement Plan (CORP) Members						
not applicable	$150.00	$260.00	$100.00	$170.00	$215.00	$215.00
Public Safety Personnel Retirement System (PSPRS)						
not applicable	$150.00	$260.00	$100.00	$170.00	$215.00	$215.00

UNDERSTANDING INSURANCE COST Continued

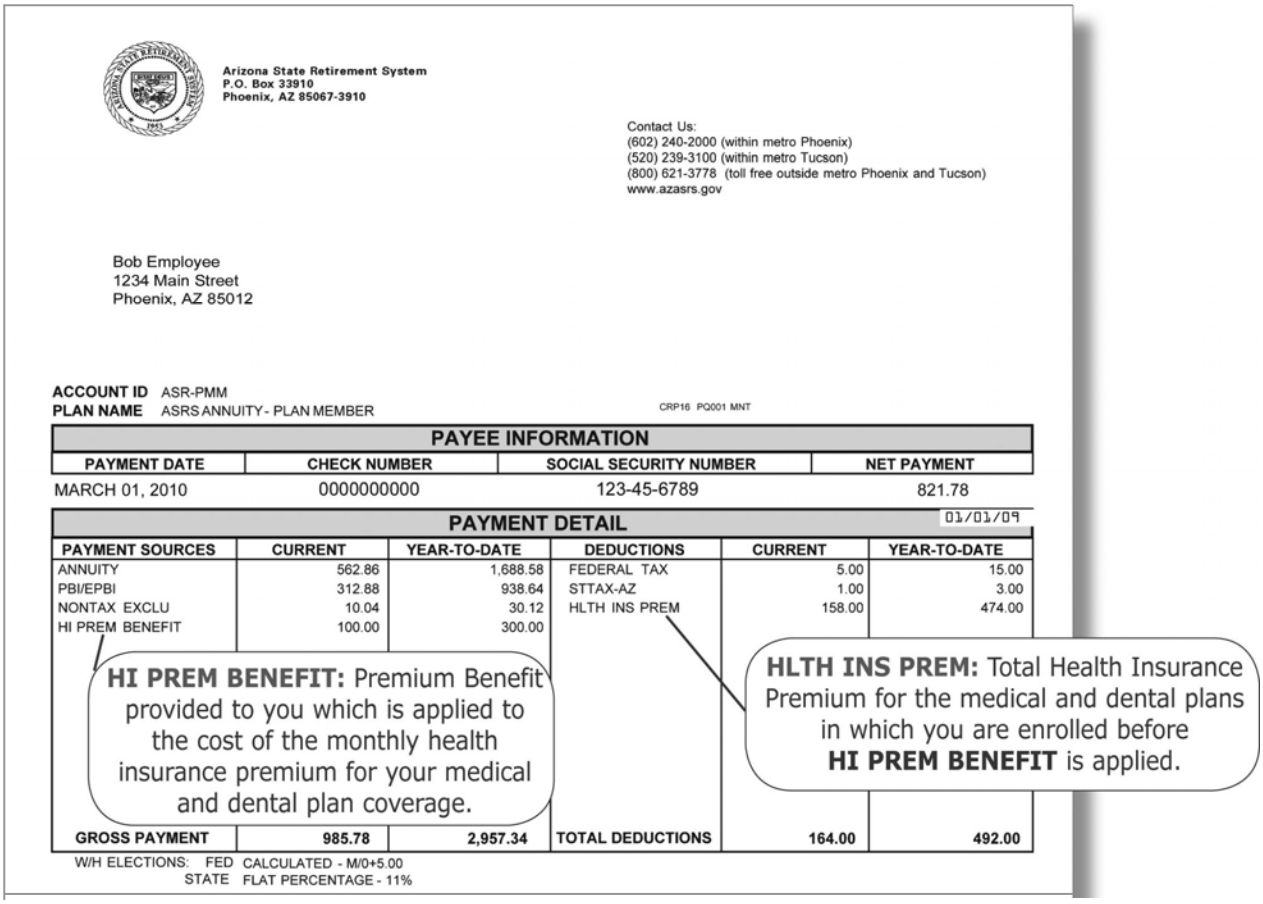
Your Pension Check

Pension checks are issued by ASRS or PSRS. Before either of the retirement systems print and mail your pension check to you, they apply your premium subsidy (refer to the worksheet on page 14). Once the premium subsidy is added into your pension check, the retirement system pays for your dental premium first. With the money left, ASRS or PSRS will pay for your medical premium.

- If your pension is large enough to cover the cost of both your dental and medical premiums, you will be mailed a check for any remaining money.
- If your pension is not enough to pay for the full cost of your dental and medical premiums you will become a Direct Pay Member.

Please refer to the "Payments" column of the pension check Payment Summary.

Below is an example of an ASRS pension check. Please note, under the Payment Sources column, the inclusion of additional monies reflected in the premium benefit (HI PREM BENEFIT) this amount is the premium benefit to which you may be entitled and it reduces the full monthly medical and/or dental premiums you pay. Also note, under the deductions column, the full health insurance premium for your medical and/or dental coverage (HLTH INS PREM). Though the total premium for health insurance is shown, you are only paying the net premium after the premium benefit is applied.



Arizona State Retirement System
P.O. Box 33910
Phoenix, AZ 85067-3910

Contact Us:
(602) 240-2000 (within metro Phoenix)
(520) 239-3100 (within metro Tucson)
(800) 621-3778 (toll free outside metro Phoenix and Tucson)
www.azasrs.gov

Bob Employee
1234 Main Street
Phoenix, AZ 85012

ACCOUNT ID ASR-PMM
PLAN NAME ASRS ANNUITY - PLAN MEMBER

CRP16 PQ001 MNT

PAYEE INFORMATION

PAYMENT DATE	CHECK NUMBER	SOCIAL SECURITY NUMBER	NET PAYMENT
MARCH 01, 2010	0000000000	123-45-6789	821.78

PAYMENT DETAIL 01/01/09

PAYMENT SOURCES	CURRENT	YEAR-TO-DATE	DEDUCTIONS	CURRENT	YEAR-TO-DATE
ANNUITY	562.86	1,688.58	FEDERAL TAX	5.00	15.00
PBI/EPBI	312.88	938.64	STTAX-AZ	1.00	3.00
NONTAX EXCLU	10.04	30.12	HLTH INS PREM	158.00	474.00
HI PREM BENEFIT	100.00	300.00			
GROSS PAYMENT	985.78	2,957.34	TOTAL DEDUCTIONS	164.00	492.00

W/H ELECTIONS: FED CALCULATED - M/0+5.00
STATE FLAT PERCENTAGE - 11%

HI PREM BENEFIT: Premium Benefit provided to you which is applied to the cost of the monthly health insurance premium for your medical and dental plan coverage.

HLTH INS PREM: Total Health Insurance Premium for the medical and dental plans in which you are enrolled before **HI PREM BENEFIT** is applied.

MEDICARE PART A & B

To help you calculate, use the three step worksheet on page 14. If you feel your pension check is not accurate, you must notify your Retirement System (ASRS or PSRS) as soon as possible. If your enrollment is not processed until after the 8th of the month, it is possible the correct premiums will not be deducted from your pension check until the month following the effective date of your enrollment or change.

Eligibility

Medicare is health insurance available to people who are:

- age 65 or over
- Under age 65 with disabilities (receiving LTD from a State-sponsored LTD plan or SSI).
- diagnosed with End Stage Renal Disease.

Medicare eligibility is determined by the Social Security Administration. Many people automatically get Part A and Part B. If you get benefits from Social Security, you will get Part A and Part B starting the first day of the month you turn 65. If you are under the age of 65 and disabled, you automatically get Parts A and B after you get disability benefits from Social Security. You should get your Medicare card in the mail 3 months before your 65th birthday or your 25th month of disability.

Eligibility Notification

If you become eligible to receive Medicare due to a disability, receive your Medicare Card prior to your 65th birthday, or there is a change in your Medicare status, you must contact the ADOA Benefit Services Division with this information.

When you receive your new Medicare card, you must provide a copy of it to the Benefit Services Division. Medicare does not communicate directly with ADOA.

Parts of Medicare

The different parts of Medicare help you cover specific health services. Medicare has the following parts:

Medicare Part A (Hospital Insurance)

- Helps cover inpatient care in hospitals
- Helps cover skilled nursing facility, hospice, and home health care

Medicare Part B (Medical Insurance)

- Helps cover doctors' services and outpatient care
- Helps cover some preventative services to help maintain your health (See Chart on page 20)

Medicare Part C (Medicare Advantage Plans)

- A health coverage choice run by private companies approved by Medicare
- Includes Part A, Part B, and usually other coverage including prescription drugs

Medicare Part D (Prescription Drug Coverage)

- Helps cover the cost of prescription drugs
- May help lower your prescription drug costs and help protect against higher costs in the future

MEDICARE PART A & B Continued

Medicare Payments

- You will not typically have a monthly premium for Part A if you or your spouse paid Medicare taxes while working.
- You must pay the standard Medicare Part B premium.

You are responsible to carry Medicare Part B coverage, if you decline to enroll in Part B or disenroll from Part B you will be financially responsible for all Part B claims. The plan will not pay Part B claims if you are eligible and are not enrolled in Medicare Part B.

Medicare and ADOA

If you have Medicare A & B during open enrollment, you may elect either the EPO or PPO plan offered at the "with Medicare" premium.

Medicare Primary

If you are retired and receiving a pension check from a recognized State-sponsored Retirement Plan, OR you are receiving LTD benefits from a State-sponsored disability plan (Sedgwick, The Standard, CIGNA, or The Hartford):

- Medicare is primary coverage
- Benefit Options is secondary coverage

How it Works

Medicare A and B will only pay 80% of covered charges once you have met your deductible. Doctors often charge patients the remaining portion of the bill that Medicare has not paid. If you enroll in the Benefit Options plan the remaining portion less co-pays (20%) will be covered since Benefit Options becomes the secondary payor. The Benefit Options will pay up to the total allowable amount less copays as determined by the Plan. The Benefit Options plan also incorporates MedImpact for pharmacy coverage if you elect medical insurance. Through MedImpact pharmacy coverage there are no annual limits or caps on preferred or non-preferred medications. Copays are $10, $20, or $40. See page 38 for pharmacy benefits.

Copays

A copay is a portion paid by the member to share in the cost of medical services, supplies and prescriptions. Cost sharing helps Benefit Options with healthcare costs. Medicare also applies cost sharing. For covered services, the Benefit Options plans absorb the Medicare deductible you would otherwise pay for hospital and medical services. The Benefit Options program will pay up to the total allowable amount as determined by the Plan. Most physicians charge 20% above the amount covered by Medicare. Copays are required for all plan members regardless of medicare eligibility or disability. Your medical provider understands medical payments will be reduced by the copayment. Therefore, the copayment must be made at the time the services are rendered.

Medicare Crossover Program

Medicare Crossover is a process by which Medicare automatically forwards medical claims to your health plan after they have paid as the primary payor. All vendors have a Medicare Crossover program. Please call the number on the back of your card and let them know you would like to enroll in the Medicare Crossover program.

MEDICARE PART A & B Continued

Preventative Services Checklist

Use this checklist to consult with your doctor or other health care provider, and ask which preventative services are right for you. Visit *mymedicare.gov* to find more details about the costs, how often, and whether you meet the conditions to get these services. Write down any notes and the date you receive the services to keep track of your preventative care.

Preventative Services Checklist		
Medicare-covered Preventative Service	**Date of Service**	**Notes**
Abdominal Aortic Aneurysm Screening		
Bone Mass Measurement		
Cardiovascular Screenings		
Colorectal Cancer Screenings		
Fecal Occult Blood Test		
Flexible Sigmoidoscopy		
Colonoscopy		
Barium Enema		
Diabetes Screenings		
Diabetes Self-Management Training		
Flu Shots		
Glaucoma Tests		
Hepatits B Shots		
Mammogram (screening)		
Medical Nutrition Therapy Services		
Pap Test and Pelvic Exam (includes breast exam)		
Physical Exam (one-time "Welcome to Medicare" physical exam)		
Pneumococcal Shot		
Prostate Cancer Screenings		
Smoking Cessation (counseling to stop smoking)		

MEDICARE PART D

The Medicare Modernization Act (MMA) established on January 1, 2006 a voluntary prescription drug benefit known as Medicare Part D. This benefit is offered to all Medicare-eligible Retirees or LTD members enrolled in Medicare Part A, Medicare Part B, or both Parts A and B.

You are not required to enroll in Medicare Part D.

Low Income Assistance

If you have limited income and resources, you may qualify for extra assistance through Medicare. Most people who qualify will pay no premiums, no deductibles, and will not pay copays over $5.00 for each prescription. You may qualify if your income is below 150% of the poverty line applicable to the size of the family involved or your resources are less than $11,990 if you are single or $23,970 if you are married and living with your spouse. You automatically qualify if you:

- Have Medicare and full coverage from a state Medicaid program that currently pays for your prescriptions.
- Get help from your state Medicaid program paying your Medicare premiums (or belong to a Medicare Savings Program).
- Get Supplemental Security Income. If you would like more information or to see if you qualify for assistance, call 1.800.722.1213, log on to *socialsecurity.gov*, or visit your local Social Security Office.

The ADOA Benefit Options program provides equal to or better coverage than what is offered through Medicare Part D:

- You will not have to pay a separate monthly premium for Medicare Part D;
- You will not have to pay an annual deductible;
- You will not need to pay a percentage of your prescription costs; and
- Your medications will remain at the current $10, $20, and $40 copay levels. Learn more about our Pharmacy Plan on page 33.

For more information about Medicare Part D visit *medicare.gov* or call 1.800.633.4227

MEDICAL PLAN INFORMATION

Understanding Your Options

For the plan year beginning January 1, 2011 retirees have the option of two plans and four networks. The word, "network", describes the company contracted with the State to provide access to a group of providers (doctors, hospitals) etc. Certain providers may belong to one network but not another. Plans are loosely defined as the structure of your insurance policy: the premium, deductibles, copays, and out-of-network coverage associated with your medical benefit.

	EPO	PPO
Aetna	X	X
BCBS of AZ/AmeriBen*	X	X
CIGNA	X	
UnitedHealthcare	X	X

**Blue Cross Blue Shield of Arizona network administered by AmeriBen.*

How the Plans Work

As noted below there are two medical plans offered to retirees under Benefit Options. They are the Exclusive Provider Organization (EPO) and the Preferred Provider Organization (PPO).

The EPO Plan

If you choose the EPO plan under Benefit Options you must obtain services from a network provider. Out-of-network services are only covered in emergency situations.

Under the EPO plan, you will pay the monthly premium and any required copay at the time of service. The EPO plan is available with all four networks: Aetna, BlueCross Blue Shield of Arizona network administered by AmeriBen, CIGNA and UnitedHealthcare.

The PPO Plan

If you choose the PPO plan under Benefit Options you can see providers in-network or out-of-network, but will have higher costs for in-network and out-of-network services. Additionally, there is an in-network and out-of-network deductible that must be met. Under the PPO plan, you will pay the monthly premium and any required copay or coinsurance (percent of the cost) at the time of service. The PPO plan is available with Aetna, Blue Cross Blue Shield of Arizona network administered by AmeriBen, and UnitedHealthcare.

Choosing the Best Plan for You and Your Family

The first thing to know when making your medical benefit elections with Benefit Options is that the coverage is the same for all choices. This means that the same services are covered under the EPO and PPO, but the network of providers is different. To choose the right plan:

1. Assess the costs you expect in the coming year including: monthly premiums, copays, and out-of pocket. Refer to pages 12-13 for monthly premiums and page 28 for the plan comparisons to help determine cost.

2. Determine if your doctors and specialists are contracted with the network you are considering. Each medical network has a

website or phone number for you to determine if your doctor is contracted.

3. Once you have selected which plan best suits your needs and your budget, make your benefit elections online at *yes.az.gov* or by completing the Open Enrollment Form only if you are changing your current benefits.

Transition of Care (TOC)

If you are undergoing an active course of treatment with a provider who is not contracted with one of the new networks, you can apply for transition of care. If you are approved, you will receive in-network benefits for your current provider during a transitional period. Transition of care is typically approved if one of the following applies:

1. You have a life threatening disease or condition;
2. You have been receiving care and a continued course of treatment is medically necessary;
3. You are in the third trimester of pregnancy; or
4. You are in the second trimester of pregnancy and your doctor agrees to accept our reimbursement rate and to abide by the Plan's policies, procedures, and quality assurance requirements.

TOC forms are available on the Benefit Options website *benefitoptions.az.gov*.

Effective Dates and ID Cards

Your personal insurance cards typically arrive 7-14 business days after your benefits become effective.

If you do not make changes to your current benefits, you can continue to use your current ID card, a new card will not be sent.

Contacts

Aetna:
1.866.217.1953
aetna.com

Blue Cross Blue Shield of Arizona network administered by AmeriBen:
1.866.955.1551
https://services.ameriben.com

CIGNA:
1.800.968.7366
cigna.com/stateofaz

UnitedHealthcare:
1.800.896.1067
myuhc.com

MEDICAL ONLINE FEATURES

You can review your personal profiles, view the status of medical claims, obtain general medical information, and learn how to manage your own healthcare through the available health plan websites.

Aetna

(aetna.com)
During Open Enrollment visit:
aetnastateaz.com

DocFind
To find out if your physician or hospital is contracted with Aetna use this online directory.

Aetna members can create a user name and password and have access to:

Aetna Navigator—Review Your Plan and Benefits Information
You can verify your benefits and eligibility. You will also have access to a detailed claims status and Claim Explanation of Benefits (EOB) statements.

ID Card
Print a temporary or order a replacement ID card.

Contact and E-mail
Access contact information for Aetna Member Services as well as Aetna's 24/7/365 NurseLine. Chat live with member service representatives for quick, easy and secure assistance by using Live Help feature with in your Aetna Navigator home page.

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Estimate the Cost of Care
You can estimate the average cost of healthcare services in your area including medical procedures and medical tests

Health Information—Simple Steps to Healthier Life
This website will give access to wellness information.

Staying Healthy
Access information and resources on a variety of health and wellness topics. Learn more about programs and services available through Aetna to assist in managing your health.

Health History
Access and print historical claims information that may be useful to you and your health care professional.

MEDICAL ONLINE FEATURES Continued

Blue Cross Blue Shield of Arizona Network Administered by AmeriBen

https://services.ameriben.com

Lookup Provider
To find out if your doctor, hospital, or urgent care provider is contracted with Blue Cross Blue Shield of Arizona network administered by AmeriBen use this tool.

Blue Cross Blue Shield of Arizona network administered by AmeriBen members can create a user ID and password to have access to:

Claims Inquiry
View and read the detailed status of all medical claims submitted for payment. You can also obtain your Explanation of Benefits (EOB).

Optional Electronic Paperless EOB
Reduce mail, eliminate filing and help the planet by going green.

Coverage Inquiry
Verify eligibility for you and your dependents.

Wellness Tools
You can have access to wellness information.

Online Forms
You can submit and complete important health forms online, including filing an appeal.

Help
You can instant message Blue Cross Blue Shield of Arizona network administered by AmeriBen with questions about your benefits, claims or general information about your health plan.

MEDICAL ONLINE FEATURES
Continued

CIGNA

Non-member: *cigna.com/stateofaz*
Existing member: *mycigna.com*

For employees not enrolled on the CIGNA plan visit *cigna.com/stateofaz* for a provider listing, program and resource information.

For employees already enrolled on the CIGNA plan please visit *mycigna.com*, and have access to:

Personal Profile
You can verify your coverage, copays, deductibles, and view the status of claims.

ID Card
Order a new ID card or print a temporary one.

Evaluate Costs
You can find estimated costs for common medical conditions and services.

Rank Hospitals
Learn how hospitals rank by cost, number of procedures performed, average length of stay, and more.

Assess Treatments
You can get facts to make informed decisions about condition-specific procedures and treatments.

Conduct Research
With an interactive library, you can gather information on health conditions, first aid, medical exams, wellness, and more.

Health Coaching
Take a quick health assessment, get personalized recommendations and connect to immediate online coaching resources.

Monitor Health Records
Keep track of medical conditions, allergies, surgeries, immunizations, and emergency contacts.

MEDICAL ONLINE FEATURES
Continued

UnitedHealthcare

Non-member: *welcometouhc.com/stateofaz*
Existing member: *myuhc.com*

Provider Search
Find the physicians and hospitals that are convenient and right for you.

Once you become a member, you can register and connect to:

Get Information about Hospitals and Physicians
Find information on network doctors and health care professionals. Find out what physicians are recognized in the United Health Premium designation program, a free informational tool that evaluates physicians and facilities using national quality and cost efficiency standards in their specialty.

Improve Health Habits
Participate in Health Coaching Programs that can help you to achieve health objectives.

Learn about health conditions and treatment options
Look up a variety of health conditions, procedures, and topics.

Ask Health Care Professionals
Chat online with registered nurses 7 days a week when you have a question or during times when you cannot reach your doctor.

Organize and Store all Health Data in one Convenient, Confidential Place
Record your and your family's health history, allergies and immunizations, as well as personal contacts. Print historical claims summary and more.

Learn more about Coverage
Check current eligibility, deductibles, and out-of-pocket costs; confirm what is covered and what is not covered.

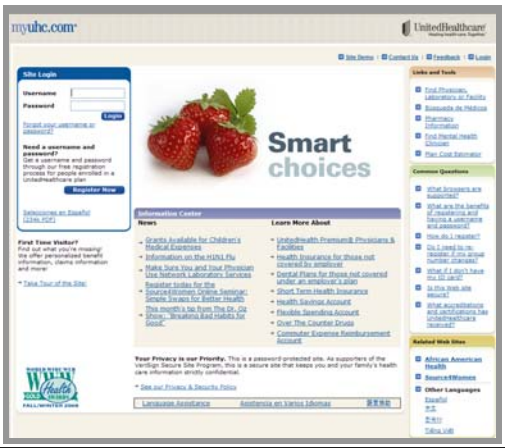
Request a medical ID Card
Print a temporary ID card or request a replacement card.

Organize Medical Claims Online
View processed claims, remaining balances for deductibles and out-of-pocket expenses via health statements. Download claims to a spreadsheet, set-up automatic payments, direct deposit and more.

Go Green. Electronic Paperless Statements (optional)
You can set your mailing preferences to "online only," to view your documents online instead of receiving paper mailings.

Compare Hospitals
Compare hospitals based on quality of care, procedures, and patient safety measures.

Compare treatment cost
Find out and compare what different treatments will cost using the Treatment cost Estimator tool.



MEDICAL PLANS COMPARISON CHART

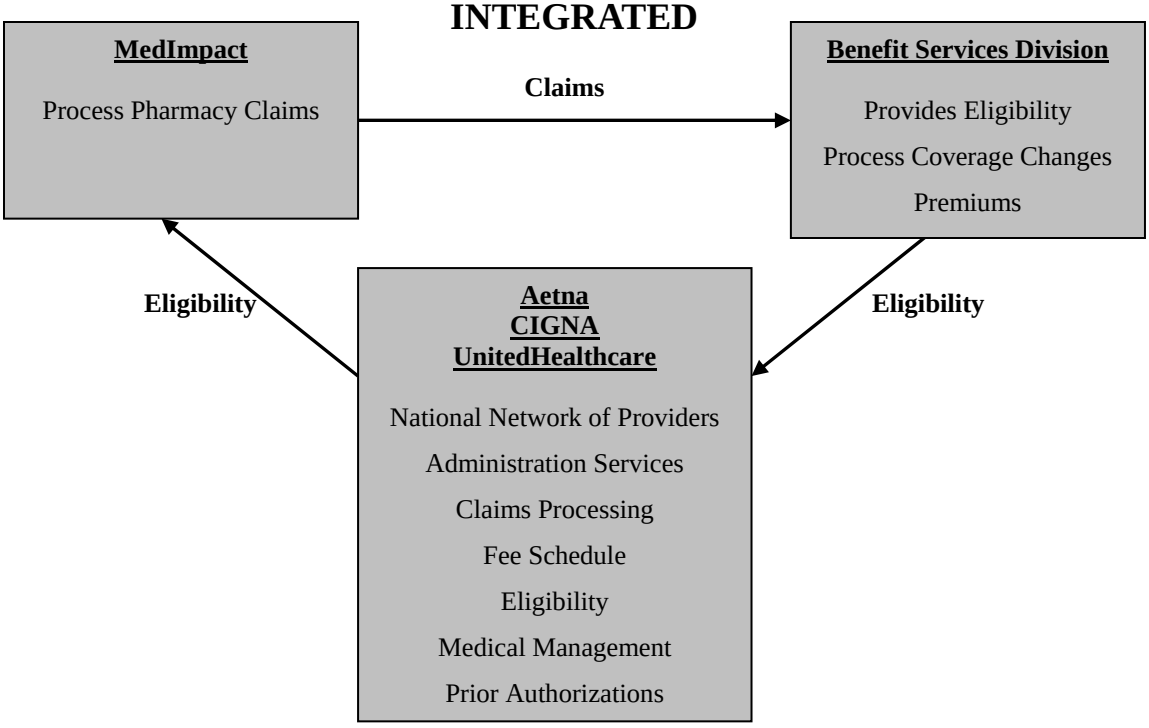
	EPO	PPO	PPO
Available Plans	☑*Aetna* ☑*BCBS of AZ/ AmeriBen** ☑*CIGNA* ☑*UnitedHealthcare*	☑*Aetna* ☑*BCBS of AZ/ AmeriBen** ☑*UnitedHealthcare*	☑*Aetna* ☑*BCBS of AZ/ AmeriBen** ☑*UnitedHealthcare*
	IN-NETWORK	**IN-NETWORK**	**OUT-OF-NETWORK**
Plan year deductible Single employee	none	$500**	$1,000**
Emp+adult, emp+child, family	none	$1,000** +	$2,000**
Out-of-pocket max Single employee	none	$1,000** +	$4,000**
Emp+adult, emp+child, family	none	$2,000**	$8,000**
Lifetime max	none	none	No maximum
	EMPLOYEE COST FOR CARE		
Behavioral health Inpatient	$150	$150	50% after deductible
Outpatient	$15	$15	50% after deductible
Chiropractic	$15	$15	50% after deductible
Durable medical equipment	$0	$0	50% after deductible
Emergency Ambulance	$0	$0	Amount above in-network rate
ER copay waived if admitted ER	$125	$125	$125
Urgent care	$40	$40	50% after deductible
Home health services Maximum visits per year	42	42	
Hospital admission (Room and Board)	$150	$150	50% after deductible
Mammography	$0	$0	50% after deductible
Office visits PCP	$15	$15	50% after deductible
Max of 1 copay/day/provider Specialist	$30	$30	50% after deductible
Preventative	$15	$15	50% after deductible
OB/GYN	$10	$10	50% after deductible
Outpatient services Freestanding ambulatory facility or hospital outpatient surgical center	$50	$50	50% after deductible
Radiology	$0	$0	50% after deductible

**Blue Cross Blue Shield of Arizona network administered by AmeriBen.*
***Copayments apply to out-of-pocket maximum after deductible is met for PPO plans. The plan pays 100% after out-of-pocket maximum is met.*
+ PPO in-network deductible must be met before co-payment applies.

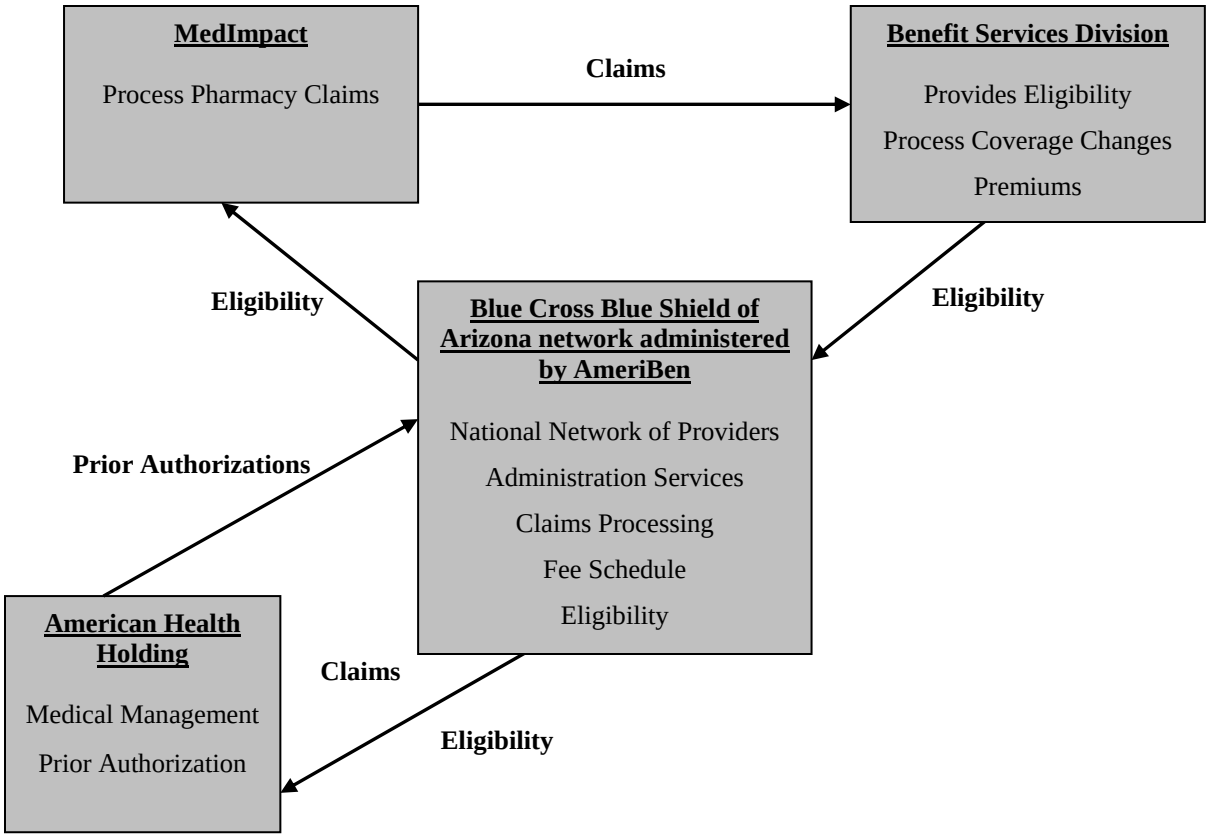
For the NAU only BCBS PPO plan details, go to http://hr.nau.edu/m and choose Benefits, Health, BCBS Plan Book.

INTEGRATED & NON-INTEGRATED

INTEGRATED



NON-INTEGRATED



MEDICAL MANAGEMENT

Services Available

When you choose Benefit Options medical insurance you get more than basic healthcare coverage. You get personalized medical management programs at no additional cost. Under the Benefit Options health plan there are four medical management vendors: American Health Holding (AHH), Aetna, CIGNA, and UnitedHealthcare. Each vendor serves their specific members based on which medical network you select during enrollment.

The four vendors provide medical management services as follows:

- American Health Holding (AHH) serves Blue Cross Blue Shield of Arizona administered by AmeriBen members only
- Aetna serves only Aetna members
- CIGNA serves only members enrolled with the CIGNA network
- UnitedHealthcare serves only UnitedHealthcare members

Professional, experienced staff work on your behalf to make sure you are getting the best care possible and that you are properly educated on all aspects of your treatment.

Utilization Management

AHH, Aetna, CIGNA, and UnitedHealthcare provide prior authorization and utilization review for the ADOA Benefit Options plan when members require non-primary care services. Prior to any elective hospitalization and/or certain outpatient procedures, you or your doctor must contact your designated medical management vendor for Authorization. Please refer to your Plan Document posted at *benefitoptions.az.gov* for the specific list of services that require prior authorization. Each vendor has a dedicated line to accept calls and inquiries:

American Health Holding 1.866.244.8977

Aetna 1.800.333.4432

CIGNA 1.800.968.7366

UnitedHealthcare 1.800.896.1067

Case Management

Case management is a collaborative process whereby a case manager from your designated medical management vendor works with you to assess, plan, implement, coordinate, monitor, and evaluate the services you may need. Often case management is used with complex treatments for severe health conditions. The case worker uses available resources to achieve cost effective health outcomes for both the member and the Benefit Options plan.

Disease Management

The purpose of disease management programs is to educate you and/or your dependents about complex or chronic health conditions. The programs are typically designed to improve self-management skills and help make lifestyle changes that promote healthy living.

The following disease management programs are available to all Benefit Options members regardless of their selected networks:

- Asthma
- Diabetes

- Chronic Obstructive Pulmonary Disease
- Congestive Heart Failure
- Pregnancy/Maternity
- Coronary Artery Disease

If you are eligible or become eligible for one of the programs listed, a disease manager from your designated medical management vendor will assess your needs and work with your physicians to develop a personalized plan. Your personalized plan will establish goals and steps to help you to positively change your specific lifestyle habits and improve your health.

Your assigned disease manager may also:

- Provide tips on how to keep your diet and exercise program on track
- Help you to maintain your necessary medical tests and annual exams
- Offer tips on how to manage stress and help control the symptoms of stress
- Assist with understanding your doctor's treatment plan
- Review and discuss medications, how they work and how to use them.

Generally a disease manager will work with you as quickly or as slowly as you like, allowing you to complete the program at your own pace. Over the course of the program participants learn to incorporate healthy habits and improve their overall health.

Getting Involved

The Benefit Options disease management programs offered through American Health Holding, Aetna, CIGNA, and UnitedHealthcare identify and reach out to members who may need help managing their health conditions. The disease management companies work with the Benefit Options plan to provide this additional service.

Participation is optional, private, and tailored to your specific needs. Also, members of the Benefit Options plan who are concerned about a health condition and would like to enroll in one of the covered programs can contact their respective disease management vendors directly to self enroll. Please refer to the your medical management vendor's phone number below if you or your dependent is interested.

Nurse Line

A dedicated team of physicians, nurses, and dietitians are available 24/7 for member consultations. Members needing medical advice or who have treatment questions can call the toll-free nurse line:

American Health Holding
1.866.244.8977

CIGNA 1.800.968.7366

Aetna 1.800.556.1555

UnitedHealthcare 1.800.401.7396

NETWORK OPTIONS OUTSIDE OF ARIZONA

The charts below indicate the coverage options and networks for members who live out-of-state. All four medical networks offer statewide and nationwide coverage and are not restricted to regional areas. All plans are available in all domestic locations. However, not all plans have equal provider availability, so it is important to check with your current provider to determine if he/she is contracted with your selected health plan network .

EPO PLAN	LOCATION	NETWORK
Aetna	Nationwide	Aetna Select Open Access
BCBS of AZ/ AmeriBen* +	BCBS of Arizona network for In-State Services	PHCS / MultiPlan for Nationwide Services
CIGNA	Nationwide	CIGNA Open Access Plus
UHC	Nationwide	UHC Choice

PPO PLAN	LOCATION	NETWORK
Aetna	Nationwide	Aetna Choice POS II Open Access
BCBS of AZ/ AmeriBen* +	BCBS of Arizona network for In-State Services	PHCS / MultiPlan for Nationwide Services
UHC	Nationwide	UHC Options PPO

**Blue Cross Blue Shield of Arizona network administered by AmeriBen.*
+ The Blue Cross Blue Shield of Arizona network administered by AmeriBen is only available in Arizona. AmeriBen has made the PHCS / MultiPlan network available to those members living out of state.

PHARMACY PLAN INFORMATION

MedImpact

If you elect any Benefit Options medical plan, MedImpact will be the network you use for pharmacy benefits. Enrollment is automatic when you enroll in a medical plan and there is no separate cost.

MedImpact currently services 32 million members nationwide, providing leading prescription drug clinical services, benefit design, and claims processing since 1989 through a comprehensive network of pharmacies.

How it works

All prescriptions must be filled at a network pharmacy by presenting your medical card. You can also fill your prescription through the mail order service. **The cost of prescriptions filled out-of-network will not be reimbursed.**

No international pharmacy services are covered. Be sure to order your prescriptions prior to your trip and take them with you.

The MedImpact plan has a three-tier formulary described in the chart on page 38. The copays listed in the chart are for a 30-day supply of medication bought at a retail pharmacy.

Generic and brand name medications

If a name brand medication is prescribed by a physician as "substitution permissible" and a generic version of the medication is available, members who elect to purchase the brand name medication will pay the copay and the difference between the cost of the brand-name medication and the cost of the generic version.

For example: The cost of a brand name medication is $100 and the cost of the generic version is $30 with a $10 copay. When prescribing the medicine, if the physician indicates that either the brand name or the generic equivalent is acceptable, then the cost for the brand name will be $80 ($100 brand name - $30 generic +$10 copay) if the member elects the brand name, or $10 for the generic version. If the physician specifically prescribes the brand name to the member and does not allow for any substitution of a generic version, the member will have to **pay the generic copay and the difference between the cost of the brand name and the generic.**

Generic drugs help you save money without compromising quality. The United States Food and Drug Administration (FDA) require generics to be as safe and effective as their brand name counterparts. Nearly 50% of all prescriptions in the U.S. are now filled with generic medications. Your doctor may choose to prescribe a generic for you, or, if he or she recommends a brand name, you can ask if a generic is available. Pharmacists will usually substitute a generic for a brand name, unless otherwise directed by your doctor or prohibited by law. You will pay the lowest copay for generic drugs. Generic drug prices on average are 20 to 50 percent lower than their brand-name counterparts, so your choice of generics can help keep the Plan's costs down and benefits high.

PHARMACY PLAN INFORMATION Continued

Formulary

A formulary is a list of medications chosen by a committee of doctors and pharmacists to help you maximize the value of your prescription benefit. These generic and brand name medications are available at a lower cost. The use of non-preferred medications will result in a higher copay. Changes to the formulary can occur during the plan year. Medications that no longer offer the best therapeutic value for the plan are deleted from the formulary. Ask your pharmacist to verify the current copay amount at the time your prescription is filled. To see what medications are on the formulary, go to *benefitoptions.az.gov* or contact the MedImpact Customer Care Center and ask to have a copy sent to you. Sharing this information with your doctor helps ensure you are getting the best value for the medications you need, which saves money for you and your Plan.

Finding a Pharmacy

To find a pharmacy refer to *benefitoptions.az.gov*. See online features for more information.

The Customer Care Center is available 24 hours a day, 7 days a week. The toll-free telephone number is 1.888.648.6769.

Medication Prior Authorization

Prescriptions for certain medications may require clinical approval before they can be filled, even with a valid prescription. These prescriptions may be limited to quantity, frequency, dosage or may have age restrictions.

The authorization process may be initiated by you, your local pharmacy, or your physician by calling MedImpact at 1.888.648.6769.

For a complete list of drugs under this program please refer to the formulary at *benefitoptions.az.gov*.

Medications for the following conditions through the Specialty Pharmacy Program include, but are not limited to:

- Cystic Fibrosis
- Multiple Sclerosis
- Rheumatoid Arthritis
- Prostate Cancer
- Endometriosis
- Enzyme Replacement
- Precocious Puberty
- Osteoarthritis
- Viral Hepatitis
- Asthma

Step Therapy Program

Step therapy is a program which promotes the use of safe, cost-effective and clinically appropriate medication.

This program requires that members try a generic alternative medication that is safe and equally effective before a brand name medication is covered.

For a complete list of drugs under this program please refer to the formulary at *benefitoptions.az.gov*.

PHARMACY PLAN INFORMATION Continued

Specialty Pharmacy Program

Certain medications used for treating chronic or complex health conditions are handled through the Walgreens Specialty Pharmacy Program. This program assists you with monitoring your medication needs and also provides patient education.

The Walgreens Specialty Pharmacy Program includes monitoring of specific injection drugs and other therapies requiring complex administration methods and special storage, handling, and delivery. Specialty medications are limited to a 30-day supply and may be obtained only at a Walgreens retail pharmacy or by calling 1.888.782.8443.

A Specialty Care Representative may contact you to facilitate your enrollment in the Specialty Pharmacy Program. You may also enroll directly into the program by calling 1.888.782.8443.

Pharmacy Mail Order Service

A convenient and less expensive mail order service is available for retirees who require medications for on-going health conditions or who will be in an area with no participating retail pharmacies for an extended period of time.

Here are a few guidelines for using the mail order service:

- Submit a 90-day written prescription from your physician.
- Request up to a 90-day supply of medication for **two copays**
- Payments can be made by check or credit card: Visa, MasterCard, American Express, or Discover.
- Register your e-mail address to receive information on your orders.
- Order refills online at *WalgreensMail.com/easy* or via phone at 1.866.304.2846.

Have your insurance card ready when you call!

Choice90

With this program, employees who require medications for an on-going health condition can obtain a 90-day supply of medication at a local retail pharmacy for **two and a half copays.**

For more information contact MedImpact Customer Care Center at 1.888.648.6769.

Limited Prescription Drug Coverage

Prescription drug coverage will generally be limited to medications that do not have an equally effective over-the-counter substitute.

Non-Covered Drugs

Certain medications are not covered as part of the Benefit Options plan. If you find such a drug has been prescribed for you, discuss an alternative treatment with your doctor.

PHARMACY PLAN INFORMATION Continued

Contacts

	Phone
MedImpact	
Customer Care Center and Prior Authorization	1.888.648.6769
Walgreens	
Mail Order	1.866.304.2846
Specialty Pharmacy	1.888.782.8443

NAU Retiree BCBS Member only

There is no need to elect or enroll in this plan; it is part of your Medical Plan coverage. Prescription drug benefits are available at four cost-sharing levels. The amount you pay depends on the specific drug dispensed by the pharmacy. The pharmacy will charge you a generic, preferred brand, non-preferred brand A, or non-preferred brand B copayment.

The BCBSAZ Prescription Medication Guide can be used to determine your copayment and this guide can be found on the BCBS website at *http://www.bcbsaz.com/Medications/Tiered-Copay-Plans.aspx*. Go to 4 level prescription drug benefits.

Up to a 90-day supply of maintenance drugs (the same drug and drug strength) may be obtained through the Walgreens Prescription Drug Mail-Order Program. Maintenance drugs are drugs you take consistently. The copayment for the 90-day supply is equivalent to one month's copayment.

PHARMACY PLAN ONLINE FEATURES

Members can view pharmacy information by registering at *benefitoptions.az.gov*. Click pharmacy.

General Pharmacy Locator
You can locate a pharmacy near you selecting the General Pharmacy Locator link.

Members can create a user name and password to have access to:

Benefit Highlights
View your current copayment amounts and other pharmacy benefit considerations.

Formulary Lookup
You can research medications to learn whether they are generic, preferred or nonpreferred drugs. This classification will determine what copay is required. Search by drug name or general therapeutic category.

Prescription History
You can view your prescription history, including all of the medications received by each member, under PersonalHealth Rx.

Drug Search
You can research information on prescribed drugs like how to use the drug, side effects, precautions, drug interactions, etc.

Health & Wellness
You can learn valuable tips and information on diseases and health conditions.

Mail Order
A link will direct you to the Walgreens website where you may register for mail order service by downloading the registration form and following the instructions.

Locate a Nearby Pharmacy
You can locate a pharmacy near your home address, out-of-town vacation address, or your dependent's address.

Generic Resource Center
Learn more about generic drugs and savings opportunities.

Choice90
Learn more about the Choice90 option. With this program, you can obtain a 90-day supply of medication for a reduced copay.

NAU Retirees only Blue Cross/Blue Shield Members

Refer to more information by accessing Blue Net, BlueCross/ BlueShield of Arizona's online member website at *www.bcbsaz.com*. Information on the pharmacy plan and copayment levels for prescriptions can be found at *http://www.bcbsaz.com/Medications/Tiered-Copay-Plans.aspx* go to 4-level prescription drug benefit.

PHARMACY BENEFITS SUMMARY

	ADOA Benefit Options (Aetna, Blue Cross Blue Shield of Arizona network administered by AmeriBen, CIGNA, UnitedHealthcare)	BC/BS NAU Only www.bcbsaz.com
Pharmacy Benefits Administered By	MedImpact	Blue Cross / Blue Shield
Retail Requirements	In-Network pharmacies only: one copay per prescription	In-network only: one copay per prescription
Mail Order	Two copays for 90-day supply	One copay for 90-day supply
Choice90	Two & 1/2 copays for 90-day supply	None
Generic	$10 copay	$10 copay
Preferred Brand*	$20 copay	$25 "brand"
Non-Preferred Brand*	$40 copay	$45 for non-preferred brand "A" $85 for non-preferred brand "B"
Annual Maximum	None	None

**Member may have to pay more if a brand is chosen over a generic.*

DENTAL PLAN INFORMATION

Dental Plan Options

Employees may choose between two plan types. They are the Prepaid/DHMO and the Indemnity/Preferred Provider Organization (PPO) plan. Each plan's notable features are bulleted below.

Prepaid/DHMO Plan – Total Dental Administrators Health Plan, Inc. (TDAHP)

- You MUST use a Participating Dental Provider (PDP) to provide and coordinate all of your dental care
- The dentist you select must participate in the DHMO plan
- No annual deductible or maximums
- No claim forms
- No waiting periods
- Pre-existing conditions are covered
- Specific copayments for services
- Specific lab fees for prosthodontic materials

Each family member may choose a different general dentist. You can select or change your dentist by contacting TDAHP by telephone or using the "change my dentist" function on the website *tdadental.com/adoa*. Members may self-refer to dental specialists within the network.

Specialty care copayments are listed in the plan booklet. Specialty services not listed are provided at a discounted rate. This discount includes services at a Pedodontist, Prosthodontist, and TMJ care.

Indemnity/PPO Plan – Delta Dental PPO Plus Premier

- You may see licensed dentist anywhere in the world
- Deductible and/or out-of-pocket payments apply
- You have a maximum benefit of $2,000 per person per plan year for dental services
- There is a maximum lifetime benefit of $1,500 per person for orthodontia
- Benefits may be based on reasonable and customary charges

Over 85% of Arizona's licensed dentists participate in the Delta Dental PPO Plus Premier plan and agree to accept Delta's allowable fee as payment in full after any deductibles and/or copayments are met. Amounts billed by network providers in excess of the allowable fee will not be billed to the patient. If you choose to see a nonparticipating dentist, Delta will still provide benefits, although typically at reduced levels. You may need to submit a claim form for eligible expenses to be paid. To find participating providers visit *deltadentalaz.com.*

How to Choose the Best Dental Plan for You

When choosing between a prepaid/DHMO plan and an indemnity/PPO plan, you should consider: dental history, level of dental care required, costs/budget and provider in the network. If you have a dentist, make sure he/she participates on the plan (prepaid/DHMO plan -TDAHP or indemnity/PPO - Delta Dental PPO Plus Premier) you are considering.

DENTAL PLAN INFORMATION Continued & ONLINE FEATURES

For a complete listing of covered services for each plan, please refer to the plan description located on *benefitoptions.az.gov*.

New enrollees should receive a card within 10-14 business days after the benefits become effective.

Total Dental Administrators Health Plan (TDAHP), Inc

If you are enrolling with TDAHP go to *tdadental.com/adoa* to access:

Participating Providers
You can search for a specific dentist contracted under this plan under pre-paid, not PPO.

Select or Change Participating Provider
You can select or change your specific participating provider.

Nominate a Dentist
If you have a preferred dentist that is not a participating provider you can nominate your dentist to be included in the plan.

Plan A500S
Learn about the plan by clicking on this option.

Delta Dental PPO Plus Premier

If you choose to enroll in **Delta Dental** visit *deltadentalaz.com*, set up an ID and password to have access to:

Download Claim Forms
Download claim forms by clicking on the State of Arizona Employee Dental Benefits tab, then selecting Document Download.

Dentist Search
Search for a specific provider contracted under the Delta Dental PPO Plus Premier plan or locate a dentist in your area.

Oral Health and Wellness
Information on dental and oral health.

Benefits and Eligibility
You can review and print your benefits and eligibility.

Claims Information
With this secure online system you can check your claims information by dates and view/ print copies of the Explanation of Benefits (EOB) statements.

DENTAL PLANS COMPARISON CHART

	TDAHP Total Dental Administrators	Delta Dental PPO Plus Premier
PLAN TYPE	Prepaid/DHMO	Indemnity/PPO
PLAN NAME	A500S	Premier with preferred access
DEDUCTIBLES	None	$50/$150
PREVENTATIVE CARE	**CO-PAY**	**CO-INSURANCE**
Office Visit	$0	$0 - Deductible Waived*
Oral Exam	$0	$0 - Deductible Waived*
Prophylaxis/Cleaning	$0	$0 - Deductible Waived*
Fluoride Treatment	$0 (to age 15)	$0 - Deductible Waived* (to age 18)
X-Rays	$0	$0 - Deductible Waived*
BASIC RESTORATIVE	**CO-PAY**	**CO-INSURANCE**
Office Visit	$0	
Sealants	$10 per tooth (to age 17)	20% (to age 19)
Fillings	Amalgam: $10-$37 Resin: $26-$76	20%
Extractions	Simple: $30 Surgical $60	20%
Periodontal Gingivectomy	$225	20%
Oral Surgery	$30 - $145	20%
MAJOR RESTORATIVE	**CO-PAY**	**CO-INSURANCE**
Office Visit	$0	
Crowns	$270 + $185 Lab Fee ($455)	50%
Dentures	$300 + $275 Lab Fee ($575)	50%
Fixed Bridgework Crown/Bridge Repair	$270 + $185 Lab Fee ($455) per unit $75	50% 50%
Inlays	$250 - $327	Alternate benefit
ORTHODONTIA		
Child Adult	$2800 - $3400 $3200 - $3700	50% See maximum lifetime benefit
TMJ SERVICES		
Exam, services, etc.	20% Discount	
MAXIMUM BENEFITS		
Annual Combined Preventive, Basic and Major Services	No Dollar Limit	$2000 per person
Orthodontia Lifetime	No Dollar Limit	$1500 per person

**Routine visits and exams are covered only two times per year at 100%. This is a summary only: please see plan descriptions for detailed provisions.*

VISION PLAN INFORMATION

Coverage for vision is available through Avesis. This year Benefit Options is offering two vision care programs: Avesis Advantage Program and Avesis Discount Program.

Avesis Advantage Program

Employees are responsible for the full Premium of this voluntary plan.

Program Highlights

- Yearly coverage for a vision exam, glasses or contact lenses
- Extensive provider access throughout the state
- $300 allowance for LASIK surgery
- Unlimited discounts on additional optical purchases
- Increased in-network contact lens allowance.

How to use the Advantage Program

1. Find a provider – You can find a provider using the Avesis website *avesis.com* or by calling customer service at 1.888.759.9772. Although you can receive out-of-network care as well, visiting an in-network provider will allow you to maximize your vision care benefit.
2. Schedule an appointment – Identify yourself as an Avesis member under the State of Arizona when scheduling your appointment.

Out-of-Network Benefits

If services are received from a nonparticipating provider, you will pay the provider in full at the time of service and submit a claim to Avesis for reimbursement. The claim form and itemized receipt should be sent to Avesis within three months of the date of service to be eligible for reimbursement. The Avesis claim form can be obtained at the website *avesis.com*. Reimbursement will be made directly to the member.

Avesis Discount Program

If you do not enroll in the fully-insured plan, you will automatically receive an Avesis discount card at no cost. This program will provide each member with substantial discounts on vision exams and corrective materials. **No enrollment is necessary.**

How to use the Discount Program

1. Find a provider – Go to *avesis.com* or call customer service at 1.888.759.9772.

2. Schedule an appointment – Identify yourself as an Avesis discount card holder under the State of Arizona.

In-Network Benefits Only

Avesis providers who participate in the Avesis Discount Vision Care Program have agreed to negotiated fees for products and services. This allows members to receive substantial discounts on the services and materials they need to maintain healthy eyesight.

Providers not participating in the program will not honor any of the discounted fees. The member will be responsible for full retail payment.

VISION PLAN Continued & ONLINE FEATURES

For a complete listing of covered services please refer to the plan descriptions at *benefitoptions.az.gov*.

Online Features

Members can view **Avesis** information by visiting *avesis.com/members.html*.

Login with your EIN Number and your last name to have access to:

Search for Providers
Search for contracted network providers near your location.

Benefit Summary
Learn about what is covered under your vision plan and how to use your vision care benefits.

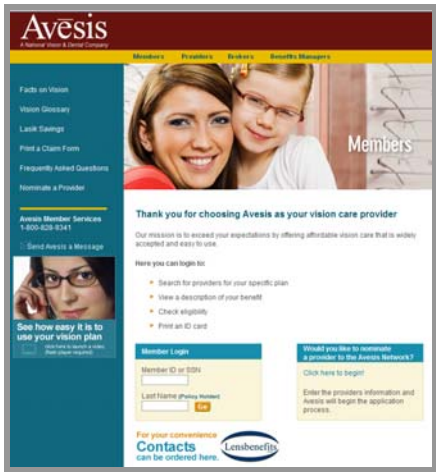
Print an ID Card
If you lose or misplace your ID card, you can print a new one.

Verifying Eligibility
You can check your eligibility status before you schedule an exam or order new materials.

Glossary
You can learn about vision terminology.

Facts on Vision
Learn about different vision facts.

Claim Form
You can obtain an out-of-network claim form.



VISION PLANS COMPARISON CHART

IN-NETWORK BENEFITS		
	Advantage Vision Care Program	**Discount Vision Care Program***
Examination Frequency	Once every 12 months	Once per 12 months
Lenses Frequency	Once every 12 months	Once per 12 months
Frame Frequency	Once every 12 months	Once per 12 months
Examination Copay	$10 copay	No more than $45
Optical Materials Copay (Lenses & Frame Combined)	$0 copay	Refer to schedule below Once per 12 months
Standard Spectacle Lenses		
Single Vision Lenses	Covered-in-full	No more than $35
Bifocal Lenses	Covered-in-full	No more than $50
Trifocal Lenses	Covered-in-full	No more than $65
Lenticular Lenses	Covered-in-full	No more than $80
Standard Progressive Lenses	Uniform discounted fee schedule less the allowance for Standard Lenses	No more than the Uniform discounted fee schedule
Selected Lens Tints & Coatings	Uniform discounted fee schedule	No more than the Uniform discounted fee schedule
Frame		
Frame	Covered up to $100-$150 retail value ($50 wholesale cost allowance)	20-50% Discount
Contact Lenses (in lieu of frame/spectacle lenses)		
Elective	10-20% discount & $150 allowance	10-20% Discount
Medically Necessary	Covered-in-full	20% Discount
LASIK/PRK		
LASIK/PRK	Up to 20% savings & $300 allowance in lieu of all other services for the plan year	20% Discount

**Members that choose not to enroll in the Advantage Vision Care Program will automatically receive an Avesis discount card at no cost.*

VISION PLANS COMPARISON CHART

OUT-OF-NETWORK BENEFITS		
	Advantage Vision Care Program	**Discount Vision Care Program***
Examination Frequency	Once every 12 months	No benefit
Lenses Frequency	Once every 12 months	No benefit
Frame Frequency	Once every 12 months	No benefit
Examination	Up to $50 reimbursement	No benefit
Standard Spectacle Lenses		
Single Vision Lenses	Up to $33 reimbursement	No benefit
Bifocal Lenses	Up to $50 reimbursement	No benefit
Trifocal Lenses	Up to $60 reimbursement	No benefit
Lenticular Lenses	Up to $110 reimbursement	No benefit
Progressive Lenses	Up to $60 reimbursement	No benefit
Lens Tints & Coatings	No benefit	No benefit
Frame		
Frame	Up to $50 reimbursement	No benefit
Contact Lenses (in lieu of frame/spectacle lenses)		
Elective	Up to $150 reimbursement	No benefit
Medically Necessary	Up to $300 reimbursement	No benefit
LASIK/PRK		
LASIK/PRK	Up to $300 reimbursement in lieu of all other services for the plan year	No benefit

**Members that choose not to enroll in the Advantage Vision Care Program will automatically receive an Avesis discount card at no cost.*

INTERNATIONAL COVERAGE

	International Coverage
MEDICAL CARE	
EPO Plans	
Aetna	Emergency & Urgent Only
BCBS of AZ/AmeriBen*	Emergency & Urgent Only
CIGNA	Emergency & Urgent Only
UnitedHealthcare	Emergency & Urgent Only
PPO Plans	
Aetna	Emergency & Urgent Only at In-Network Benefit Level**
BCBS of AZ/AmeriBen*	Emergency & Urgent Only at In-Network Benefit Level**
UnitedHealthcare	Emergency & Urgent Only at In-Network Benefit Level**
NAU Only	
Blue Cross Blue Shield PPO	For assistance with locating a provider and submitting claims call 1.800.810.2583 or 1.804.673.1177. For an international claim form, go to *www.bcbs.com/blue cardworldwide/index*
PHARMACY	
MedImpact	Not covered
DENTAL CARE	
Prepaid/DHMO Plan	
Total Dental Administrators Health Plan, Inc.	Emergency Only
PPO Plan	
Delta Dental PPO Plus Premier	Coverage is available under non-participating provider benefits
VISION CARE	
Avesis	Covered as out-of-network and will be reimbursed based on the Avesis reimbursement schedule

*Blue Cross Blue Shield of Arizona network administered by AmeriBen.
**All other services covered at out-of-network benefit level.

LONG-TERM DISABILITY MEMBERS

When receiving Long-Term Disability (LTD) benefits, for purposes of health, dental, and vision benefits, LTD members are considered "Retirees" and will fall under all premiums, processes and guidelines as retired members.

No Longer Eligible for LTD Benefits and Not Able to Retire

Your eligibility in the Benefit Options plan terminates the end of the month in which you lose eligibility. You may wish to contact your retirement system to determine if you are eligible to enroll in their health plan. It is your responsibility to notify us when your LTD entitlement ends.

Returning to Work

Your return to work will be considered a Qualified Life Event. You must make your new benefit elections within 31 days of your return to work. Please contact your agency Human Resources personnel for further instructions immediately after you lose your LTD eligibility status.

Waiver of Premiums

A Waiver of Premium only applies to life insurance and does not apply to your health, dental and vision benefits. Even if your life insurance premiums are waived, you are still responsible for payment of your medical, dental, and vision monthly premiums. Your Waiver of Premium eligibility is determined by the LTD carrier.

Please contact your LTD carrier with any questions and to learn if you are eligible for a Waiver.

Disability Benefits from Social Security and Eligibility for Medicare

If you have been receiving disability benefits from Social Security or the Railroad Retirement Board for 24 months, you will be automatically entitled to Medicare Part A and Part B beginning the 25th month of the disability benefit entitlement. You will not need to do anything to enroll in Medicare.

Your Medicare card will be mailed to you about 3 months before your Medicare entitlement date. You must mail a copy of your Medicare card to the ADOA Benefit Services Division within 31 days of receiving the card.

If you are under age 65 and have a disease such as Lou Gehrig's Disease (ALS), you will be entitled to Medicare the first month you receive disability benefits from Social Security or the Railroad Retirement Board. For more information, call the Social Security Administration at 1.800.772.1213.

Receiving Social Security Disability

The Benefit Options health plans require all Medicare-eligible members to enroll in both Part A (hospital insurance) and Part B (medical insurance). For more information, contact the Social Security Administration or the ADOA Benefit Services Division.

COBRA COVERAGE NOTICE

COBRA coverage is available when a "qualifying event" occurs that would result in a loss of coverage under the health plan, such as marriage, divorce, legal separation, annulment, and death.

Federal law requires that most group health plans give qualified beneficiaries the opportunity to continue their group health coverage when there is a qualifying event. Depending on the type of qualifying event, "qualified beneficiaries" can include a retiree covered under the group health plan and his/her enrolled dependents. Certain newborns, newly adopted children, and children of parents under Qualified Medical Child Support Orders (QMCSOs) may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below. COBRA coverage is the same coverage that the State of Arizona offers to participants.

Each qualified beneficiary who elects COBRA coverage will have the same rights under the Plan as other participants, including open enrollment and HIPAA special enrollment rights. The description of COBRA coverage contained in this notice applies only to group health coverage offered by the State of Arizona (medical, dental and vision). The Plan provides no greater COBRA rights than what COBRA requires – nothing in this notice is intended to expand your rights beyond COBRA's requirements.

Electing COBRA Coverage

To elect COBRA coverage, you must complete the election form according to the directions on the election form and mail or deliver by the date specified on the election form to the ADOA Benefit Services Division. Each qualified beneficiary has a separate right to elect COBRA coverage.

For example, the retiree's spouse may elect COBRA coverage even if the retiree does not and can elect coverage on behalf of all the qualified beneficiaries. COBRA coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries.

You may elect COBRA under the group health coverage (medical, dental, and vision) in which you were covered under the Plan on the day before the qualifying event. Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected.

However, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under another group health plan (but only after any applicable pre-existing condition exclusions of that other plan have been exhausted or satisfied).

Special Considerations in Deciding Whether to Elect COBRA

In considering whether to elect COBRA coverage, you should take into account that a failure to elect COBRA will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage.

Election of COBRA coverage may eliminate this gap. Second, you may lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get COBRA coverage for the maximum time available to you. Finally, you should take into account that you may have special enrollment rights under federal law. You may have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group coverage ends because of the qualifying event. You will also have the same special enrollment right at the end of COBRA coverage if you get COBRA coverage for the maximum time available to you.

How Long Will COBRA Coverage Last

COBRA coverage will generally be continued only for up to a total of 18 months. If the retiree became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the retiree) who lose coverage under the Plan as a result of the qualifying event can last up to 36 months from the date of Medicare entitlement. In the case of an loss of coverage due to a retiree's death, divorce or legal separation, or a dependent child ceasing to be a dependent under the terms of the Plan, COBRA coverage may be continued for up to a total of 36 months.

This notice shows the maximum period of COBRA coverage available to qualified beneficiaries. COBRA coverage will automatically terminate before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing COBRA coverage, under another group health plan (but only after any applicable pre-existing condition exclusions of that other plan have been exhausted or satisfied),
- the State ceases to provide any group health plan for its employees; or
- during a disability extension period (explained on page 50), the disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled.

COBRA COVERAGE NOTICE Continued

COBRA coverage may also be terminated for any reason that traditional enrollment would be terminated (for example, the Plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage in the case of fraud). You must notify the COBRA administrator(s) in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare (Part A, Part B or both) or becomes covered under another group health plan (but only after any pre-existing condition exclusions of that other plan have been exhausted).

COBRA coverage will terminate (retroactively if applicable) as of the date of Medicare entitlement or as of the beginning date of the other group health coverage (after satisfaction of any applicable pre-existing condition exclusions). The plan will require repayment of all benefits paid after the termination date, regardless of whether or when you provide notice of Medicare entitlement or other group health plan coverage.

Extending the Length of COBRA Coverage

If you elect COBRA coverage, an extension of the period of coverage may be available if a qualified beneficiary is or becomes disabled or a second qualifying event occurs. You must notify the COBRA administrators in writing of a disability or a second qualifying event in order to extend the period of COBRA coverage. Failure to provide notice of a disability or second qualifying event will affect the right to extend the period of COBRA coverage.

Disability

If any of the qualified beneficiaries is determined by the Social Security Administration to be disabled, the maximum COBRA coverage period (generally 18 months as described above) may be extended up to a total of 29 months.

The disability must have started at some time before the 61st day of COBRA coverage and must last until the end of the 18-month period of COBRA coverage.

Each qualified beneficiary who has elected COBRA coverage will be entitled to the disability extension if one of them qualifies. The disability extension is available only if you notify the COBRA administrator(s) in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- the date of the Social Security Administration's disability determination;
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan.

You must also provide this notice within the original 18 months of COBRA coverage obtained due to the loss of coverage in order to be entitled to a disability extension.

COBRA COVERAGE NOTICE
Continued

The notice must be provided in writing and must include the following information:
• the name(s) and address(es) of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event;

- the name and address of the disabled qualified beneficiary;
- the date that the qualified beneficiary became disabled;
- the date that the Social Security Administration made its determination of disability;
- a statement as to whether or not the Social Security Administration has subsequently determined that the qualified beneficiary is no longer disabled; and
- the signature, name and contact information of the individual sending the notice beneficiary is no longer disabled; and
- the signature, name and contact information of the individual sending the notice.

Your notice must include a copy of the Social Security Administration's determination of disability. You must mail this notice within the required time periods to the ADOA Benefit Services Division.

If the above procedures are not followed or if the notice is not provided within the 60-day notice period, there will be no COBRA coverage disability extension. If the qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the COBRA administrator(s) of that fact within 30 days after the Social Security Administration's determination.

The notice must be provided in the same manner as, and include the same information required for, a notice of disability as described.

Second Qualifying Event

An extension of coverage will be available to spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the first 18 months (or, in the case of a disability extension, the first 29 months) of COBRA coverage following the retiree's loss of coverage. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months from the date COBRA coverage began. Such second qualifying events include the death of a covered retiree, divorce or legal separation from the covered retiree, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan.

This extension due to a second qualifying event is available only if you notify the COBRA administrator(s) in writing of the second qualifying event within 60 days after the date of the second qualifying event. The notice must include the following information:

- the name(s) and address(es) of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event;
- a description of the second qualifying event;
- the date of the second qualifying event;
- the signature, name and contact information of the individual sending the notice.

COBRA COVERAGE NOTICE Continued

In addition, you must provide documentation supporting the occurrence of the second qualifying event if the ADOA Benefit Services Division requests it. Acceptable documentation includes a copy of the divorce decree, death certificate, or dependent child's birth certificate, driver's license, marriage license or letter from a university or institution indicating a change in student status. You must mail this notice within the required time periods to the ADOA Benefit Services Division.

If the above procedures are not followed or if the notice is not provided within the 60-day notice period, there will be no extension of COBRA coverage due to a second qualifying event.

COBRA Coverage Cost

Generally each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary is required to pay may not exceed 102 percent (or, in the case of an extension of COBRA coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant who is not receiving COBRA coverage. The required monthly payment for each group health benefit provided under the Plan under which you are entitled to elect COBRA is noted on the Enrollment/Change form.

Making Your COBRA Coverage Payment

If you elect COBRA coverage, you do not have to send any payment with the election form. However, you must make your first payment for COBRA coverage no later than 45 days after the date of your election (this is the date the election form is postmarked, if mailed, or the date your election form is received by the individual at the address specified for delivery on the election form, if hand delivered).

If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election, you will lose all COBRA rights under the Plan. Your first Payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the current month.

You are responsible for making sure that the amount of your first payment is correct. Please contact the ADOA Benefit Services Division for information about your COBRA payment including how much you owe.

Monthly Payments for COBRA Coverage

After you make your first payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each coverage period for each qualified beneficiary will be shown in the notice you receive. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage.

If you make a monthly payment on or before the first day of the month to which it applies, your COBRA coverage under the Plan will continue for that month without any break. You will be billed for your COBRA coverage. It is your responsibility to pay your COBRA premiums on time. Grace Periods for Monthly Payments although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days after the first day of the month to make each payment for that month. Your COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for the month. However, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that your coverage will be suspended.

If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan. If mailed, your payment is considered to have been made on the date that it is postmarked. If hand delivered, your payment is considered to have been made when it is received.

Payments received or postmarked after the due date will not be accepted. You will not be considered to have made any payment if your check is returned due to insufficient funds or otherwise.

More Information About Individuals Who May Be Qualified Beneficiaries

A child born to, adopted by, or placed for adoption with a covered member during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered member is a qualified beneficiary, the covered member has elected COBRA coverage for himself or herself and enrolls the child within 30 days of the birth, adoption or placement for adoption. To be enrolled in the Plan, the child must satisfy the otherwise applicable eligibility requirements (for example, age).

COBRA COVERAGE NOTICE Continued

Alternative Recipients Under QMCSOs

A child of the covered retiree who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the State during the covered retiree's dates of coverage with the State is entitled to the same rights to elect COBRA as any other eligible dependent child of the covered retirees.

This notice does not fully describe COBRA coverage or other rights under the Plan. More information about COBRA coverage and your rights under the Plan is available from the ADOA Benefit Services Division. If you have any questions concerning the information in this notice or your rights, please contact us:

ADOA Benefit Services Division
100 N. 15th Ave., Suite 103
Phoenix, AZ 85007
602.542.5008 or 800.304.3687
BenefitsIssues@azdoa.gov

Information about COBRA provisions for a governmental health plan is available from the:

Centers for Medicare & Medicaid Services (CMS)
Private Health Insurance Group
7500 Security Boulevard
Mail Stop S3-16-16
Baltimore, Maryland 21244-1850

Or you may call 1.410.786.1565 for assistance. This is not a toll-free number. The CMS website is *cms.hhs.gov*.

HIPAA NOTICE

This notice describes how medical information about you may be used and disclosed, how you may gain access to this information, and the measures taken to safeguard your information. Benefit Options knows that the privacy of your personal information is important to you.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires health plans to notify plan participants and beneficiaries about its policies and practices to protect the confidentiality of their health information. For purposes of this Notice, health information refers to any information that is considered Protected Health Information (PHI) as defined in the Privacy Rule of the Administrative Simplification provision of HIPAA.

Throughout this Notice, all references to Benefit Options refer to the administrators of the Program. Please review it carefully.

Use and Disclosure of Health Information

Benefit Options may use your health information for purposes of making or obtaining payment for your care, and for conducting health care operations. We have established a policy to guard against unnecessary disclosure of your health information.

How the Plan May Use and Disclose Health Information

To Make or Obtain Payment

Benefit Options may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, Benefit Options may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

To Conduct Health Care Operations

Benefit Options may use or disclose health information for its own operations to facilitate and, as necessary, to provide coverage and services to all Benefit Options' participants. Health care operations include activities such as:

- Quality assessment and improvement activities;
- Activities designed to improve health or reduce health care costs;
- Clinical guideline and protocol development, case management and care coordination;
- Contacting health care providers and participants with information about treatment alternatives and other related functions;
- Health care professional competence or qualifications review and performance evaluation;
- Accreditation, certification, licensing or credentialing activities;
- Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits;
- Reviews and auditing, including compliance reviews, medical reviews, legal services and compliance programs;

HIPAA NOTICE Continued

- Business planning and development including cost management and planning analyses and formulary development. In addition, summary health information may be provided to third parties in connection with the solicitation of health plans or the modification or amendment of the existing plan;
- Business management and general administrative activities of Arizona Benefit Options, including customer service and resolution of internal grievances.

As an example, Benefit Options may use your health information to conduct case management, quality improvement and utilization review, and provider credentialing activities or to engage in customer service and grievance resolution activities.

For Treatment Alternatives
Benefit Options may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

For Distribution of Health-Related Benefits and Services
Benefit Options may use or disclose your health information to provide you with information on health-related benefits and services that may be of interest to you.

When Legally Required
Benefit Options will disclose your health information when it is required to do so by any federal, state or local law.

To Conduct Health Oversight Activities
Benefit Options may disclose your health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. However, we may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

In Connection With Judicial and Administrative Proceedings
As permitted or required by state law, Benefit Options may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when Benefit Options makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

For Law Enforcement Purposes
As permitted or required by state law, Benefit Options may disclose your health information to a law enforcement official for certain law enforcement purposes, including but not limited to if Benefit Options has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

In the Event of a Serious Threat to Health or Safety
Benefit Options may, consistent with applicable law and ethical standards of

conduct, disclose your health information if Benefit Options, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

For Specified Government Functions
In certain circumstances, federal regulations require Benefit Options to use or disclose your health information to facilitate specific government functions related to the military and veterans, to national security and intelligence activities, to protective services for the president and others, and to correctional institutions and inmates.

For Workers Compensation
Benefit Options may release your health information to the extent necessary to comply with laws related to workers compensation or similar programs.

Authorization to Use or Disclose Health Information

Other than as previously stated , Benefit Options will not disclose your health information without your written authorization. If you authorize Benefit Options to use or disclose your health information, you may revoke that authorization in writing at any time.

Your Rights with Respect to Your Health Information

You have the following rights regarding your health information that Benefit Options maintains:

Right to Request Restrictions
You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on Benefit Options' disclosure of your health information to someone involved in the payment of your care. However, Benefit Options is not required to agree to your request.

Right to Receive Confidential Communications
To safeguard the confidentiality of your health information, you may request that Benefit Options communicate in a specified manner or at a specified location. Alternatively, for example, you may request that all health information be mailed to your work location rather than your home. If you wish to receive confidential communications, please make your request in writing. Benefit Options will accommodate reasonable requests, when possible.

Right to Inspect and Copy Your Health Information
You have the right to inspect and copy your health information. If you request a copy of your health information, Benefit Options may charge a reasonable fee for copying, assembling costs and, if applicable, postage associated with your request.

Right to Amend Your Health Information
If you believe that your health information records are inaccurate or incomplete, you may request that Benefit Options amend the records. That request may be made as long as the information is maintained by Benefit Options.

HIPAA NOTICE Continued

Benefit Options may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created by Benefit Options, if the health information you are requesting to amend is not part of Benefit Options' records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if Arizona Benefit Options determines the records containing your health information are accurate and complete.

Right to an Accounting

You have the right to request a list of disclosures of your health information made by Benefit Options for any reason other than for treatment, payment or health operations. The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time going back more than six (6) years. Benefit Options will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. Benefit Options will inform you in advance of the fee, if applicable.

Right to a Paper Copy of this Notice

You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically.

Benefit Options Duties

Benefit Options is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice of its duties and privacy practices.

Changes to this notice

Benefit Options reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If Benefit Options changes its policies and procedures, Benefit Options will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change.

Complaints

You have the right to express complaints to Benefit Options and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Benefit Options encourages you to express any concerns you may have regarding the privacy of your information. **Note:** You will not be penalized or retaliated against in any way for filing a complaint.

HIPAA NOTICE
Continued

Contact Information

For more information or for further explanation of this notice, you may contact us:

ADOA Benefit Services Division
100 N. 15th Ave., Suite 103
Phoenix, AZ 85007
602.542.5008 or 800.304.3687
Email: BenefitsIssues@azdoa.gov

You may also obtain a copy of this Notice at our web site at *www.benefitoptions.az.gov*.

The ADOA Privacy Officer may be contacted at:
100 N. 15th Avenue, Suite 401
Phoenix, AZ, 85007
602.542.1500
Fax at 602.542.2199

Notice Effective Date
April 14, 2003.

PATIENT PROTECTION & AFFORDABLE CARE ACT (PPACA) NOTICES

Grandfather Status Notice

The Arizona Department of Administration believes the Benefit Options plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (PPACA). As permitted by the PPACA, a grandfathered health plan can preserve certain health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means the your plan may not include certain requirements of the PPACA that apply to other plans; for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other requirements in the PPACA; for example, the elimination of lifetime limits on benefits.

Questions regarding which requirements do and do not apply to a grandfathered health plan and what might cause a plan to change from a grandfathered health plan status can be directed to ADOA Benefits at 602-542-5008 or benefitsissues@azdoa.gov.

Notice of Rescission

Under the PPACA, Benefit Options cannot retroactively cancel or terminate an individual's coverage, except in cases of fraud and similar situations. In the event that the Benefit Options plan rescinds coverage under the allowed grounds, affected individuals must be provided at least 30 days advanced notice.

Form W-2 Notice

Pursuant to the PPACA for tax years starting on and after January 1, 2011, in addition to the annual wage and tax statement employers must report the value of each employee's health coverage on form W-2, although the amount of health coverage will remain tax-free. The W-2s due in early 2012 will be the first to report coverage costs for the prior calendar year.

GLOSSARY

Accidental Death and Dismemberment (AD&D)
A type of insurance through which your beneficiary will receive money if you die or if you are accidentally injured in a specific way.

Appeal
A request to a plan provider for review of a decision made by the plan provider.

Balance Billing
A process in which a member is billed for the amount of a provider's fee that remains unpaid by the insurance plan. You should never be balance billed for an in-network service; out-of-network services and Non-covered services are subject to balance billing.

Beneficiary
The person you designate to receive your life insurance (or other benefit) in the event of your death.

Brand-Name Drug
A drug sold under a specific trade name as opposed to being sold under its generic name. For example, Motrin is the brand name for ibuprofen.

Case Management
A process used to identify members who are at risk for certain conditions and to assist and coordinate care for those members.

Claim
A request to be paid for services covered under the insurance plan. Usually the provider files the claim but sometimes the member must file a claim for reimbursement.

COBRA (Consolidated Omnibus Budget Reconciliation Act)
A federal law that requires larger group health plans to continue offering coverage to individuals who would otherwise lose coverage. The member must pay the full premium amount plus an additional administrative fee.

Coinsurance
A percentage of the total cost for a service/ prescription that a member must pay after the deductible is satisfied.

Coordination of Benefits (COB)
An insurance industry practice that allocates the cost of services to each insurance plan for those members with multiple coverage.

Copay
A flat fee that a member pays for a service/ prescription.

Deductible
Fixed dollar amount a member pays before the health plan begins paying for covered medical services. Copayments and/or coinsurance amounts may or may not apply see comparison charts on page 28.

GLOSSARY Continued

Dependent
An individual other than a health plan subscriber who is eligible to receive healthcare services under the subscriber's contract. Generally, dependents are limited to the subscriber's spouse and minor children.

Disease Management
A program through which members with certain chronic conditions may receive educational materials and additional monitoring/support.

Domestic Partner
Refer to pages 3-5 for eligibility requirements.

Emergency
A medical or behavioral condition of sudden onset that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a person who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the insured person in serious jeopardy, serious impairment to bodily functions, serious disfigurement of the insured person, serious impairment of any bodily organ or part of the insured person, or in the case of a behavioral condition, placing the health of the insured person or other persons in serious jeopardy.

EPO
(Exclusive Provider Organization)
A type of health plan that requires members to use in-network providers.

Exclusion
A condition, service, or supply not covered by the health plan.

Explanation of Benefits (EOB)
A statement sent by a health plan to a covered person who files a claim. The explanation of benefits (EOB) lists the services provided, the amount billed, and the payment made. The EOB statement must also explain why a claim was or was not paid, and provide information about the individual's rights of appeal.

Formulary
The list that designates which prescriptions are covered and at what copay level.

Generic Drug
A drug which is chemically equivalent to a brand name drug whose patent has expired and which is approved by the Federal Food and Drug Administration (FDA).

Grievance
A written expression of dissatisfaction about any benefits matter other than a decision by a plan provider.

HSA
(Health Savings Account)
An account that allows individuals to pay for current health expenses and save for future health expenses on a tax-free basis. Only certain plans are HSA-eligible.

ID Card
The card provided to you as a member of a health plan. It contains important information such as your member identification number.

GLOSSARY

Long-Term Disability
A type of insurance through which you will receive a percentage of your income if you are unable to work for an extended period of time because of a non-work-related illness or injury.

Mail-Order Pharmacy
A service through which members may receive prescription drugs by mail.

Member
A person who is enrolled in the health plan.

Medically Necessary
Services or supplies that are, according to medical standards, appropriate for the diagnosis.

Member Services
A group of employees whose function is to help members resolve insurance-related problems.

Network
The collection of contracted healthcare providers who provide care at a negotiated rate.

Out-of-Pocket Maximum
The annual amount the member will pay before the health plan pays 100% of the covered expenses. Out-of-pocket amounts do not carry over year to year.

Over-the-Counter (OTC) Drug
A drug that can be purchased without a prescription

PPO
(Preferred Provider Organization)
A type of health plan that allows members to use out-of-network providers but gives financial incentives if members use in-network providers.

Pre-Authorization
The process of becoming approved for a healthcare service prior to receiving the service.

Preventative Care
The combination of services that contribute to good health or allow for early detection of disease.

Short-Term Disability
A type of insurance through which you will receive a percentage of your income if you are unable to work for a limited period of time because of a non-work related illness or injury.

Supplemental Life
Life insurance in an amount above what the state provides.

Usual and Customary (UNC) Charges
The standard fee for a specific procedure in a specific regional area.

Wellness
A Benefit Options program focused on preventing disease, illness, and disability