Arizona Department of Administration
Benefit Services Division

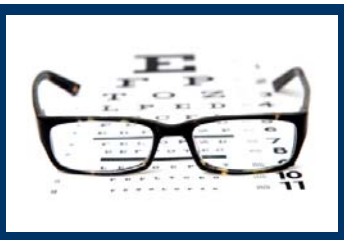
COBRA Participants

2012 Benefit Guide

In This Guide:

- Benefit Expo Dates
- Benefits Spotlight
- Benefit Eligibility
- Medical & Prescription Benefits
- Dental & Vision Benefits
- Legal Notices

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
Fax 602.542.4744
www.benefitoptions.az.gov
BenefitsIssues@azdoa.gov

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

Employee Assistance Program
602.771.9355
www.benefitoptions.az.gov/wellness/eap.asp

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
www.myameriben.com
Policy Number 1009013

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

UnitedHealthcare
1.800.896.1067
myuhc.com
Policy Number 705963

Pharmacy Plan

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

Vision Plan

Avesis, Inc.
1.888.759.9772
www.avesis.com
Advantage
Policy Number 10790-1040
Plan Number 938AZ
Discount Policy Number 10000-4
Plan Number 9000

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.TDAdental.com/adoa
Policy Number 680100

Flexible Spending Accounts

ASI Member Services
1.800.659.3035
www.asiflex.com
asi@asiflex.com

Life & Short-Term Disability Plans

The Hartford
1.866.712.3443
http://groupbenefits.thehartford.com/arizona/
Policy Number 395211

Long-Term Disability Plans

Sedgwick CMS
(ASRS participants)
1.818.591.9444
www.vpainc.com

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

For University Employees

UNUM - Short-Term Disability
1.800.799.4455
www.unum.com

Aetna Life Insurance
1.800.523.5065
www.aetna.com

University of Arizona
Benefits Office
520.621.3662, Option 3
www.hr.arizona.edu
benefits@email.arizona.edu

Arizona State University
855.278.5081
http://cfo.asu.edu/hr-benefits
OpenEnrollment@asu.edu

Northern Arizona University
Human Resources
928.523.2223
www.hr.nau.edu
hr.contact@nau.edu

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This Benefit Options guide is designed to provide an overview of the 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.

INTRODUCTION

Welcome to the 2012 COBRA Participant 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, 2012. 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.

This Benefit Options guide is designed to provide an overview of the 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.

BENEFITS SPOTLIGHT FOR PLAN YEAR 2012

Get the most out of your benefits

Did you know? That as an added feature some medical vendors are providing discounts on additional programs such as:

- Weight and Nutrition
- Gym Memberships
- Discount Vision Care
- Massage Therapy Discounts

For information on how you can access these programs through your medical vendor, please see pages 19-22 for the Medical Online Features referenced in this guide.

Diabetes Self Management Training (DSMT)

Benefit Options is one of few employer health plans who offer Diabetes Self Management Training (DSMT) as a covered benefit.

However, members are not aware of the service. DSMT is a medical service available for people with diabetes for the cost of the office visit copay. It is a 4-6 week program that provides instruction for managing diabetes.

Training is delivered by certified professionals who teach diabetes self-care skills to use on a day to day basis.

These skills and techniques help people living with diabetes control their condition and improve their health and quality of life. If you are interested, ask your physician for a referral to find a DSMT program near you.

Disease Management

Each medical vendor offers specific disease management programs for the following chronic health conditions:

- Asthma
- Diabetes
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure
- Coronary Artery Disease

Contact phone numbers for each vendor are listed below:

American Health Holding 1.866.244.8977
Aetna 1.800.333.4432
CIGNA 1.800.968.7366
UnitedHealthcare 1.800.896.1067

ELIGIBILITY

The following persons may be eligible for COBRA coverage:

1. An employee who had coverage through the State of Arizona and lost the coverage because of a reduction in hours of employment or a termination of employment for a reason other than gross misconduct.

2. An employee's legal spouse, as defined by Arizona Statute, or same-sex domestic partner who had coverage through the State of Arizona and lost the coverage for any of the following reasons:

- Death of the employee;
- Termination of the employee's employment for a reason other than gross misconduct;
- Reduction in the employee's hours of employment resulting in a loss of eligibility for coverage;
- Divorce or legal separation from the employee;
- The employee becomes eligible for Medicare.

3. An employee's dependent child who had coverage through the State of Arizona and lost the coverage for any of the following reasons:

- Death of the employee (parent);
- Termination of the parent's employment for a reason other than gross misconduct;
- A reduction in the parent's hours of employment resulting in a loss of eligibility for coverage;
- The parents' divorce or legal separation, termination of same-sex domestic partnership;
- The parent becomes eligible for Medicare or,
- The dependent ceases to be a dependent child as defined by the Benefit Options program.

The ADOA Benefit Services Division will determine final eligibility for COBRA coverage.

Eligible dependent children include:

- Natural, adopted and/or stepchild who is under 26 years old;
- A person under the age of 26 for whom the employee-member has court-ordered guardianship;
- Foster children under the age of 26
- Children placed in the employee-member home by court order pending adoption;
- Natural, adopted and/or stepchild who are disabled prior to age and a dependent under the Plan at the time of the disability.

Please note: If your dependent child is approaching age 26 and is disabled, immediately contact the ADOA Benefit Services Division regarding procedures to continue coverage for this dependent. Application for continuation of dependent status must be made within 31 days of the child's 26 birthday. You will need to provide verification that your dependent child has a qualifying permanent disability, in accordance with Social Security Administration (SSA) guidelines, that occurred prior to his or her 26 birthday.

Qualified Medical Child Support Order (QMCSO)

If a QMCSO exists, you must continue coverage for your dependent pursuant to the Order. You may not terminate coverage for a dependent covered by a QMCSO.

ELIGIBILITY Continued

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. However, a United States Federal District Court, in *Diaz v. Brewer, et al.* (2:09-cv-02402 JWS), imposed a preliminary injunction preventing the State of Arizona from implementing A.R.S. § 38-651(O) as applied to qualified same-sex domestic partners. The case is still in litigation and the State intends to defend its right to fully implement the statute and discontinue offering benefits to all domestic partners.

COBRA and Medicare Entitlement

If Medicare entitlement if BEFORE COBRA begins, the is no effect on the employee, the employee can be on COBRA for 18 months.
-Spouse or dependents are eligible for 36 months.

If Medicare entitlement is AFTER COBRA begins, COBRA may terminate for the employee, depending on the individual plan description.
-Spouse or dependents treated as 2nd QLE for 36 months, or may have no effect, depending on the individual plan description.

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

As a result of the U.S. District Court preliminary injunction, 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 2012 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 2012 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**.

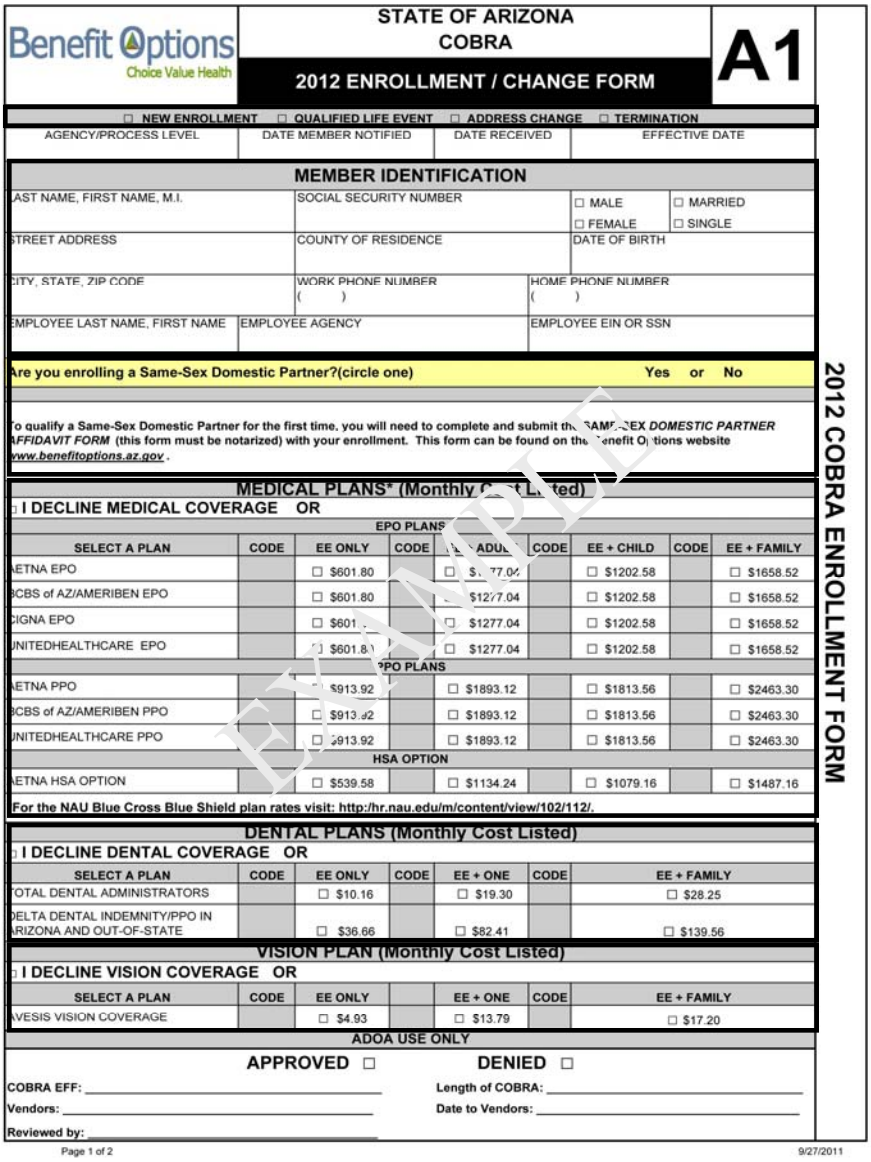
WHERE TO ENROLL

FOR INSTRUCTIONAL PURPOSES ONLY
PLEASE DO NOT COMPLETE THE FORM BELOW

1. Indicate your reason for completing the form.

- If this is your first time enrolling in COBRA, please mark NEW ENROLLMENT.
- If you are changing your enrollment options due to a qualified life event, please mark QUALIFIED LIFE EVENT.
- If you are notifying ADOA of an address change, please mark ADDRESS CHANGE
- If you are termination coverage, please mark TERMINATIONS.

2. Complete the MEMBER IDENTIFICATION section.



Benefit Options
Choice Value Health

STATE OF ARIZONA
COBRA
2012 ENROLLMENT / CHANGE FORM

A1

1. ☐ NEW ENROLLMENT ☐ QUALIFIED LIFE EVENT ☐ ADDRESS CHANGE ☐ TERMINATION

AGENCY/PROCESS LEVEL	DATE MEMBER NOTIFIED	DATE RECEIVED	EFFECTIVE DATE

MEMBER IDENTIFICATION

2.

LAST NAME, FIRST NAME, M.I.	SOCIAL SECURITY NUMBER	☐ MALE ☐ FEMALE	☐ MARRIED ☐ SINGLE
STREET ADDRESS	COUNTY OF RESIDENCE	DATE OF BIRTH	
CITY, STATE, ZIP CODE	WORK PHONE NUMBER ( )	HOME PHONE NUMBER ( )	
EMPLOYEE LAST NAME, FIRST NAME	EMPLOYEE AGENCY	EMPLOYEE EIN OR SSN	

3. 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 SAME-SEX *DOMESTIC PARTNER AFFIDAVIT FORM* (this form must be notarized) with your enrollment. This form can be found on the Benefit Options website *www.benefitoptions.az.gov* .

4. MEDICAL PLANS* (Monthly Cost Listed)

☐ I DECLINE MEDICAL COVERAGE OR

SELECT A PLAN	CODE	EE ONLY	CODE	EE + ADULT	CODE	EE + CHILD	CODE	EE + FAMILY
EPO PLANS								
AETNA EPO		☐ $601.80		☐ $1277.04		☐ $1202.58		☐ $1658.52
BCBS of AZ/AMERIBEN EPO		☐ $601.80		☐ $1277.04		☐ $1202.58		☐ $1658.52
CIGNA EPO		☐ $601.80		☐ $1277.04		☐ $1202.58		☐ $1658.52
UNITEDHEALTHCARE EPO		☐ $601.80		☐ $1277.04		☐ $1202.58		☐ $1658.52
PPO PLANS								
AETNA PPO		☐ $913.92		☐ $1893.12		☐ $1813.56		☐ $2463.30
BCBS of AZ/AMERIBEN PPO		☐ $913.92		☐ $1893.12		☐ $1813.56		☐ $2463.30
UNITEDHEALTHCARE PPO		☐ $913.92		☐ $1893.12		☐ $1813.56		☐ $2463.30
HSA OPTION								
AETNA HSA OPTION		☐ $539.58		☐ $1134.24		☐ $1079.16		☐ $1487.16

For the NAU Blue Cross Blue Shield plan rates visit: http:/hr.nau.edu/m/content/view/102/112/.

5. DENTAL PLANS (Monthly Cost Listed)

☐ I DECLINE DENTAL COVERAGE OR

SELECT A PLAN	CODE	EE ONLY	CODE	EE + ONE	CODE	EE + FAMILY
TOTAL DENTAL ADMINISTRATORS		☐ $10.16		☐ $19.30		☐ $28.25
DELTA DENTAL INDEMNITY/PPO IN ARIZONA AND OUT-OF-STATE		☐ $36.66		☐ $82.41		☐ $139.56

6. VISION PLAN (Monthly Cost Listed)

☐ I DECLINE VISION COVERAGE OR

SELECT A PLAN	CODE	EE ONLY	CODE	EE + ONE	CODE	EE + FAMILY
AVESIS VISION COVERAGE		☐ $4.93		☐ $13.79		☐ $17.20

ADOA USE ONLY

APPROVED ☐ DENIED ☐

COBRA EFF: _____ Length of COBRA: _____

Vendors: _____ Date to Vendors: _____

Reviewed by: _____

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2012 COBRA ENROLLMENT FORM

EXAMPLE

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

4. Select your medical plan. If you elect the HSA Option, you will be allowed to open and/or contribute to a health savings account. Please note, however, that the State <u>will not contribute to the account</u>. If declining medical coverage, please mark I DECLINE MEDICAL COVERAGE.

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

6. Select your vision plan. If declining vision coverage, please mark I DECLINE VISION COVERAGE.

WHERE TO ENROLL
Continued

FOR INSTRUCTIONAL PURPOSES ONLY
PLEASE DO NOT COMPLETE THE FORM BELOW

7. Read the payment and social security number information at the top of the page.

8. Complete the middle dependents section if you are enrolling dependents. Please note that social security numbers are required.

9. Read the statement, sign and date the form. Return form to the Benefit Services Division address provided.

Benefit Options
Choice Value Health

STATE OF ARIZONA
COBRA
2012 ENROLLMENT / CHANGE FORM

A2

YOUR PAYMENT TO BENEFIT OPTIONS

7. **By law, while on COBRA coverage, you will have to pay the total cost of your COBRA coverage. You are charged the full amount of the cost for similarly-situated employees or families – both the employee's and the employer's portion - plus an additional 2% administrative fee. You must make the first payment within 45 days of notifying the plan administrator of selection of COBRA coverage. The initial payment with your enrollment needs to be sent to ADOA. Thereafter, premiums are due on the first day of each month of coverage. After your first premium payment, you may have a grace period of 30 days from the usual due date to pay the premiums.**

Effective January 1, 2009, Social Security numbers (SSN) will be required for you and your enrolled dependents.

The SSN is used as the basis for the Medicare HICN. The Medicare program uses the HICN to identify Medicare beneficiaries receiving health care services, and to otherwise meet its administrative responsibilities to pay for health care and operate the Medicare program. In performance of these duties, Medicare is required to protect individual privacy and confidentiality in accordance with applicable laws, including the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act Privacy Rule. Please note that the Centers for Medicare & Medicaid Services (CMS) has a longstanding practice of requesting SSNs or HICNs for coordination of benefit purposes.

DEPENDENTS - List all eligible dependents to be enrolled or disenrolled in medical, dental, and/or vision plans

8.

LAST NAME, FIRST NAME, M.I. (USE AN ADDITIONAL FORM FOR MORE THAN 6 DEPENDENTS)	DATE OF BIRTH (MM/DD/YY)	Social Security Number	RELATIONSHIP CODE	MALE OR FEMALE	ADD OR DELETE	INDICATE PLAN TYPE MEDICAL(M) DENTAL(D) VISION(V)
LIST LAST NAME IF IT IS DIFFERENT FROM EMPLOYEE	**REQUIRED**	**REQUIRED**			**A OR D**	
Employee			S- Spouse Child D- Same-Sex Domestic Partner G- Guardian P- Placed for adoption T- Stepchild			
Spouse or Same-Sex Domestic Partner			☐ S ☐ D	☐M ☐F		☐ M ☐ D ☐ V
			☐C ☐G ☐P ☐T	☐M ☐F		☐ M ☐ D ☐ V
			☐C ☐G ☐P ☐T	☐M ☐F		☐ M ☐ D ☐ V
			☐C ☐G ☐P ☐T	☐M ☐F		☐ M ☐ D ☐ V
			☐C ☐G ☐P ☐T	☐M ☐F		☐ M ☐ D ☐ V
			☐C ☐G ☐P ☐T	☐M ☐F		☐ M ☐ D ☐ V
			☐C ☐G ☐P ☐T	☐M ☐F		☐ M ☐ D ☐ V

EXAMPLE

EMPLOYEE AUTHORIZATION AND SIGNATURE

9. **I hereby certify under penalty of perjury that the information I have provided in this application for employee benefits, including address and spouse/domestic partner and/or dependent information is accurate. I further acknowledge that I am aware that providing false information may subject me to a denial of employee benefits, disciplinary action, and potential prosecution pursuant to ARS Sections 13-2310, 13-2311, 13-2702, and other applicable provisions of the law. In addition, I have read and understand the declarations.**

SIGNATURE:_____ **DATE:**_____

Return form to: ADOA Benefit Services Division, 100 N. 15th Ave., Suite 103, Phoenix, AZ 85007 OR FAX TO:602-542-4744

2012 COBRA ENROLLMENT FORM

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.

UNDERSTANDING YOUR COBRA COVERAGE

How Long COBRA Coverage Lasts

If you lose coverage through the State of Arizona plan because of a termination of employment or a reduction in hours, you and your eligible family members may maintain COBRA coverage for a maximum period of 18 months from the date of the event.

If an employee's covered dependents lose their coverage because:

- of the employee's death or entitlement to Medicare;
- of the employee's legal separation or divorce the employee's child is no longer a dependent under the Plan.

The eligible family members may maintain COBRA coverage for a maximum period of 36 months from the date of the event.

By law, these coverage periods may be reduced for any of the following reasons:

- the State of Arizona no longer provides group health coverage to any of its employees;
- you do not pay the amount due for your COBRA coverage on time;
- you or one of your covered family members become covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition; or
- you or one of your covered family members become entitled to Medicare.

Extended COBRA Coverage

In addition, if during or before an 18 month period of COBRA coverage, you or any of your qualified dependents are determined by the Social Security Administration to be disabled, the maximum period of COBRA coverage may be extended for up to 11 months. This extension is available if: The Social Security Administration determines that the individual's disability began no later than 60 days after the employee's employment was terminated or his/her hours were reduced; and you or another member of your family notifies the ADOA Benefit Services Division of the disability determination by the Social Security Administration before the end of the 18 month COBRA coverage period.

Electing Your COBRA Benefits

Upon termination from State Service, employees and eligible dependents will be notified in writing of their COBRA rights and the deadline for returning their enrollment form(s).

To have the opportunity to continue coverage after a loss of coverage due to a qualified life event, the employee and/or affected family member(s) must inform the ADOA Benefit Services Division in writing no later than 60 days after the event.

If notice is not received by the end of that 60-day period, the affected spouse or dependent will not be entitled to choose COBRA coverage. When notified that one of these events has happened, the ADOA Benefit Services Division will provide the covered dependents with the information and forms needed to elect COBRA coverage.

Under the law, the covered dependents have 60 days from the date they would lose coverage because of one of the events described above, to inform the ADOA Benefit Services Division that they want to elect COBRA coverage.

COBRA coverage may be elected for some members of the family but not others (including one or more dependents, even if the employee does not elect it), as long as those for whom it is chosen were covered by the Plan on the date of the event (e.g., termination of employment, death, divorce) that led to the loss of regular coverage.

UNDERSTANDING YOUR COBRA COVERAGE Continued

A parent may elect or reject COBRA coverage on behalf of dependent children living with him or her.

If one of the dependents elects COBRA coverage for him/herself only, the enrollment form must be signed by that dependent unless the dependent is a minor. When the dependent is a minor, the employee-parent must sign the form.

Changing Your COBRA Benefits

If, while you are enrolled for COBRA coverage, you marry, have a child or have a child placed for adoption, you may enroll that spouse or child for coverage for the balance of the period of your COBRA coverage, provided you do so within 30 days after the marriage, birth or placement. Adding a spouse or child may increase the amount you must pay for COBRA coverage.

A Second Qualified Life Event

If you have a second Qualified Life Event while under COBRA coverage and you were eligible for COBRA coverage as the result of an employee's termination (for other than gross misconduct) or the reduction in hours of an employee, you may be granted an extension of coverage for up to 36 months from the date of termination or reduction in hours.

The extension applies only to qualified beneficiaries, including children of the employee who were born or adopted while the employee was on COBRA coverage. (Qualified beneficiaries include an employee's spouse who was covered by the Plan and an employee's dependent children who were covered by the Plan).

If You and Your Spouse are State Employees

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 employee contributions.

COBRA Coverage for Dependent Children over 26

If your child is age 26 years old and is no longer eligible to be continued on your coverage, s/he may be eligible for continuation coverage for up to 36 months pursuant to the Consolidated Omnibus Budget Reconciliation Act (COBRA).

The member must notify the Benefit Services Division when a dependent is no longer eligible or fails to meet the criteria for coverage of a dependent and complete an Enrollment/Change form to cancel the dependent from their benefit plan.

A COBRA enrollment form with coverage information and rates will be mailed to the employee's home address on file by the Benefit Services Division.

Your Contributions

By law, while on COBRA coverage, you must pay the total cost of your COBRA coverage. You are charged the full amount of the cost for similarly-situated employees or families – both the employee's and the employer's portion - plus an additional 2% administrative fee.

When to Pay

You must make the first payment within 45 days of notifying the plan administrator of selection of COBRA coverage. Thereafter, premiums are due on the first day of each month of coverage.

After your first premium payment, you may have a grace period of 30 days from the usual due date to pay the premiums.

UNDERSTANDING YOUR COBRA COVERAGE Continued

MAXIMUM PERIOD OF CONTINUATION OF COVERAGE

Qualifying Event	Qualified Beneficiaries	Maximum Period of Continuation Coverage
Termination (for reasons other than gross misconduct) or reduction in hours of employment	Employee Spouse Dependent Child	18 months*
Employee enrollment in Medicare	Spouse Dependent Child	36 months
Divorce or legal separation	Spouse Dependent Child	36 months
Death of employee	Spouse Dependent Child	36 months
Loss of "dependent child" status under the plan	Dependent Child	36 months

**If during or before the 18th month period of COBRA coverage a dependent is determined to be disabled by the Social Security Administration, COBRA coverage will be extended for up to an additional 11 month period if deemed disabled within 60 days after COBRA begins.*

If a second qualified life event occurs while under COBRA coverage, qualified beneficiaries might be granted an extension of coverage for up to 36 months.

SUMMARY OF MONTHLY INSURANCE PREMIUMS — 2012

Monthly Medical Premiums

Plan	Tier	COBRA Participant Premium
EPO (Aetna, BCBS of AZ/AmeriBen*, CIGNA, UnitedHealthcare)	Emp only	$601.80
	Emp+adult	$1,277.04
	Emp+child	$1,202.58
	Family	$1,658.82
PPO (Aetna, BCBS of AZ/AmeriBen*, UnitedHealthcare)	Emp only	$913.92
	Emp+adult	$1,893.12
	Emp+child	$1,813.56
	Family	$2,463.30
HSA (Aetna)	Emp only	$539.58
	Emp+adult	$1134.24
	Emp+child	$1079.19
	Family	$1487.16

Monthly Dental Premiums

Plan	Tier	COBRA Participant Premium
DHMO (Total Dental Administrators)	Emp only	$10.16
	Emp+1	$19.30
	Family	$28.25
PPO (Delta Dental PPO Plus Premier)	Emp only	$36.66
	Emp+1	$82.41
	Family	$139.56

Monthly Vision Premiums

Plan	Tier	COBRA Participant Premium
Insured plan (Avesis)	Emp only	$4.93
	Emp+1	$13.79
	Family	$17.20
Discount card (Avesis)	Emp	$0.00

**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, see page 23.*

MEDICAL PLAN INFORMATION

Understanding Your Options

For the plan year beginning January 1, 2012, COBRA participants have the option of three plans, four networks, and four coverage tiers. 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.

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

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

Finally, choose the tier that meets your needs. A tier describes the number of persons covered by the medical plan.

How the Plans Work

As noted above there are three medical plans offered to active COBRA participants under Benefit Options. They are the Exclusive Provider Organization (EPO), the Preferred Provider Organization (PPO), and the Health Savings Account Option (HSA).

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, Blue Cross 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.

The High Deductible Health Plan (HSA Option)

If you choose to enroll in the High Deductible Health Plan (HSA Option), you will be eligible to open a Health Savings Account (HSA), which is a special type of account that allows tax-free contributions, earnings, and healthcare-related withdrawals.

If you choose the HSA Option you can use in-network and out-of-network providers. Members pay the copay and/or coinsurance after the deductible is met.

The premiums for the HSA Option are lower, qualified preventative services are free, and members pay coinsurance and/or copays. More detailed information on the HSA Option is available on pages 13-14.

MEDICAL PLAN Continued

Choosing the Best Plan for You and Your Family

To choose the right plan for you:

1. Assess the costs you expect in the coming year including: COBRA participants premiums, copays, and coinsurance. Refer to page 10 for monthly premiums and pages 17 and 18 for plan comparisons to help determine costs.

2. Determine if your doctors are contracted with the network you are considering. Each medical network has a website or phone number (listed to the right) to help you 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.

Transition of Care (TOC)

If you are undergoing an active course of treatment with a doctor who is not contracted with one of the networks, you can apply for transition of care.

If you are approved, you will receive in-network benefits for your current doctor during a transitional period after January 1, 2012. 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

Changes made during Open Enrollment 2012 will become effective January 1, 2012. 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
MyAmeriBen.com

CIGNA: 1.800.968.7366
cigna.com/stateofaz

UnitedHealthcare: 1.800.896.1067
welcometouhc.com/stateofaz

MEDICAL PLAN Continued

Understanding the High Deductible Health Plan (HSA Option)

Things You Should Know:

1. The High Deductible Health Plan (HSA Option) works in conjunction with a Health Savings Account (HSA):
   - Enrolling in the HSA Option automatically enrolls you in a Health Savings Account (HSA) upon completion of the customer identification process (see page 16).
   - HSA is a special type of savings account that allows tax-free contributions, earnings, and healthcare-related withdrawals.
2. The HSA Option offers financial advantages in that:
   - An HSA Option member pays lower employee premiums (paycheck deductions).
   - In the HSA Option, qualified preventative services are free.
   - An HSA Option member may have lower out-of-pocket costs.
   - An HSA Option member is eligible to open and contribute to a Health Savings Account (HSA).
3. The HSA Option presents financial disadvantages in that:
   - HSA Option members pay copays and/or coinsurance after the deductible is met (qualified preventative services are free).
4. The HSA Option might be right for you if:
   - You want to open a tax-advantaged HSA and save for future healthcare costs.
   - You are willing to accept some degree of financial risk.
   - You can afford to pay a high deductible if necessary.
5. The HSA Option may be wrong for you if:
   - You like copays because they are simple and predictable.
   - You are not willing to accept some degree of financial risk.
   - You cannot afford to pay a high deductible.

Cost for Services/Prescriptions

The cost for services/prescriptions depends on three things:

Whether the service/prescription is:
- Qualified Preventative
- Non-Preventative
- Emergency

Whether the provider is:
- In-Network
- Out-of-Network

How much you have paid so far during the plan year:
- Less than the deductible
- More than the deductible, but less than the out-of-pocket maximum
- Out-of-pocket maximum

These three areas are shaded in the table on the next page.

At the top of the table you can see that:
- In-network qualified preventative <u>services</u> are free, even before the deductible is satisfied
- In-network qualified preventative <u>prescriptions</u> will cost the regular copay amounts ($10/$20/$40) up to the out-of-pocket maximum.
- Once the out-of-pocket maximum is satisfied, in-network qualified preventative <u>prescriptions</u> are covered at 100% for the reminder of the plan year.

MEDICAL PLAN Continued

Cost for Services/Prescriptions - Continued

In the middle of the table you can see that:

- In-network emergency services will not be covered until after the deductible is satisfied.
- Once the deductible is satisfied, in-network emergency services will be 90% covered. The remaining 10% must be paid by the member.
- Once the out-of-pocket maximum is satisfied, in-network emergency services will be 100% covered (no member cost).

Before enrolling in the HSA Option, make sure you fully understand the table below.

Qualified Preventative care

Preventative care is defined as:

- Periodic health evaluations, including tests and diagnostic procedures ordered in connection with routine examinations (i.e., annual physicals)
- Routine prenatal and well-child care
- Child and adult immunizations
- Tobacco cessation programs
- Certain screening services
- Prescriptions that are preventative in nature.

Individual/emp+adult/emp+child/family total out-of-pocket cost at time of expense →			**Less than deductible**	**More than deductible, less than out-of-pocket maximum**	**Out-of-pocket maximum**
IN-NETWORK	Qualified Preventative	Services	$0	$0	$0
		Prescriptions	$10/$20/$40 copays	$10/$20/$40 copays	
	Non-Preventative	Services	100% of contracted rate	10% of contracted rate	
		Prescriptions	100% of contracted rate	$10/$20/$40 copays	
	Emergency	Services	100% of contracted rate	10% of contracted rate	
OUT-OF-NETWORK	Qualified Preventative	Services	50% of total cost	50% of total cost	
	Non-Preventative	Services	100% of total cost	50% of total cost	$0
	Emergency	Services	100% of total cost	10% of total cost	

MEDICAL PLAN Continued

Understanding Health Savings Accounts (HSAs)

The HSA is only offered if you enroll in the High Deductible Health Plan Option (HSA Option).

HSA Overview

1. You open your HSA.
   - The State cannot restrict what you spend it on.
   - You maintain ownership even after ending State employment.
   - You can invest the money like you would invest money in an IRA.
   - Your funds will earn interest.

2. You can make additional contributions to your HSA through:
   - Lump-sum deposits (tax deductible).

3. The Internal Revenue Service sets annual contribution limits. Visit *www.irs.gov* for additional information.

4. You can spend HSA funds tax-free on qualified healthcare-related expenditures (defined by the Internal Revenue Service)
   - You can use a debit card or ATM.
   - Non-qualified withdrawals are allowed, however, effective January 1, 2012 they are subject to tax and a 20% penalty.

5. HSAs should not be confused with FSAs:
   - FSA stands for Flexible Spending Account. It is a special type of savings account that allows tax-free contributions and healthcare-related withdrawals.
   - FSAs have "use-it-or-lose-it" rules. Unused funds do not rollover from year to year.

6. HSAs have no "use-it-or-lose-it" rules. Unused funds will rollover from year to year. This allows you to create a healthcare nest egg.

7. If the member does not require services (other than the free qualified preventative services), the money stays in the HSA and grows tax free. It can be used to pay for qualified healthcare costs anytime in the future.

About the HSA

The HSA offers the following features:

- No set-up fees
- No monthly administration fee
- No withdrawal forms
- Debit card and/or checkbook
- HSA tracking through JP Morgan Chase direct website: www.*chasehsa.com*
- Cost Estimator Tool—Cost of Care

There are some fees associated with the HSA, visit *benefitoptions.az.gov*, click on:

-Plan Descriptions,
-Medical Insurance Coverage,
-Under HSA Plan link click where it indicates for more information.

MEDICAL PLAN Continued

How To Open Your HSA

Your HSA will automatically be established in your name when you enroll in the High Deductible Health Plan Option and pass the Customer Identification Process (see below for additional information). You will receive a welcome kit by mail 3-4 weeks after the account is opened. The State will start contributing to your account on the first pay cycle following the plan year effective date. State contributions will only be made if you receive a paycheck.

Using Your HSA

- Use the Aetna HSA Visa® debit card to pay for qualified out-of-pocket expenses.
- Invest your HSA funds in a variety of investment options (JPMorgan mutual funds) once the funds reach $2,000.
- You can contribute to the HSA as long as you are enrolled in a qualified health plan (such as the HSA Option). You may use the HSA funds anytime.

Customer Identification Process

Aetna is required to confirm some of your personal information prior to establishing your HSA. This includes your correct name, address, date of birth, and Social Security Number. Doing so is required by Section 326 of the USA Patriot Act. It is a process known as the "Customer Identification Process."

Here are some common reasons that may cause a delay:

- Addresses that do not match;
- Not legally changing your name after a marriage or divorce;
- Use of a nickname;
- Inconsistent use of your middle initial;
- Americanized version of your name;
- Different spelling of your name.

Please provide any information Aetna requests for the purpose of establishing your HSA.

MEDICAL PLANS
COMPARISON CHARTS (EPO/PPO)

	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.*
***Copays and Coinsurance apply to out-of-pocket maximum after deductible is met. The plan pays 100% after out-of-pocket maximum is met.*
+PPO in-network deductible must be met before copay applies.

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

MEDICAL PLANS COMPARISON CHART (HSA)

		High Deductible Health Plan	High Deductible Health Plan
Available Plans		☑*Aetna*	☑*Aetna*
		IN-NETWORK	**OUT-OF-NETWORK**
Plan year deductible	Single employee Emp+adult, emp+child, family	$1,200* $2,400*	$2,400* $4,800*
Out-of-pocket max	Single employee Emp+adult, emp+child, family	$2,000* $4,000*	$5,000* $10,000*
Lifetime max		No maximum	No maximum
		EMPLOYEE COST FOR CARE	
Behavioral health	Inpatient	10% coinsurance after deductible	50% coinsurance after deductible
	Outpatient	10% coinsurance after deductible	50% coinsurance after deductible
Chiropractic		10% coinsurance after deductible	50% coinsurance after deductible
Durable medical equipment		10% coinsurance after deductible	50% coinsurance after deductible
Emergency	Ambulance	10% coinsurance after deductible	10% coinsurance after deductible
ER copay waived if admitted	ER	10% coinsurance after deductible	10% coinsurance after deductible
	Urgent care	10% coinsurance after deductible	50% coinsurance after deductible
Home health services Maximum visits per year		42	
Hospital admission (Room and Board)		10% coinsurance after deductible	50% coinsurance after deductible
Mammography		Preventative at no cost Non-Preventative 10% coinsurance after deductible	50% coinsurance after deductible
Office visits	PCP	Preventative at no cost Non-Preventative 10% coinsurance after deductible	50% coinsurance after deductible
Max of 1 copay/day/provider	Specialist	Preventative at no cost Non- Preventative 10% after deductible	50% coinsurance after deductible
	Preventative	Preventative at no cost	50% coinsurance after deductible
	OB/GYN	Preventative at no cost Non- Preventative 10% after deductible	50% coinsurance after deductible
Outpatient services Freestanding ambulatory facility or hospital outpatient surgical center		10% after deductible	50% coinsurance after deductible
Radiology		10% after deductible	50% coinsurance after deductible

**Copays and Coinsurance apply to out-of-pocket maximum after deductible is met. The plan pays 100% after out-of-pocket maximum is met.*

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.

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.

Smart Source
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.

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

Aetna Mobile
Simply type aetna.com in your smart phone to access doctors, Aetna Navigator, and much more. There's even an I-Phone application available for downloading.

HSA Savings Calculator Tool
Use the HSA Savings Calculation Tool to help you discover the savings opportunity and tax advantages associated with a Health Savings Account (HSA).

HSA Video
The HSA Online Videos teach enrolled HSA account holders and those considering enrolling in an HSA plan, the basics of managing the HSA. It also helps employees and members understand how to make the right health care choices and how to manage the savings account in a simple, conversational style.

MEDICAL ONLINE FEATURES Continued

Blue Cross Blue Shield of Arizona Network Administered by AmeriBen

Non-member: *www.myameriben.com/arizona2.htm*
Existing member: *MyAmeriBen.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 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 COBRA participants 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 of UnitedHealthcare, 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 for trusted information and peace of mind, 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 in your own Personal Health Record. 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 with the "Hospital Comparison" tool.

Compare Treatment Cost
Find out and compare what different treatments will cost using the Treatment Cost Estimator, before you need to make a decision.

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

HSA PLAN	LOCATION	NETWORK
Aetna	Nationwide	Aetna Choice POS II Open Access

**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 the medical plan.

MedImpact currently services 33 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 your prescriptions with you.

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

Formulary

The formulary is the 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, 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.

Pharmacy Mail Order Service

A convenient and less expensive mail order service is available for employees 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** (offer available to HSA Option members only when copays apply).
- 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 *WalgreensHealth.com* or via phone at 1.866.304.2846. Have your insurance card ready when you call!

PHARMACY PLAN INFORMATION Continued

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.

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.

Step Therapy Program

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

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.

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.

Extended Vacation or Working Abroad

Whether you go to a retail pharmacy or use mail order for your prescriptions, you will need to notify MedImpact in writing of why you are requesting an additional supply of medication, the date when you are leaving, and how long you plan to be gone. MedImpact will be able to authorize a VACATION OVERRIDE allowing you to have the extra medication you will need *providing you have the appropriate number of refills remaining.*

Order refills at least two weeks in advance of your departure. If there is a problem, such as, *not enough refills*, you will have enough time to phone your physician. If you're using Mail Order, contact MedImpact at least three weeks in advance.

Copays will be the same as you would normally pay times the number of refills you need.

PHARMACY PLAN INFORMATION Continued

If you are already out of town and need a prescription call MedImpact. Tell the representative you are out of town and need to find a participating pharmacy in the area where you are. You will need the zip code where you are visiting. In most cases you will have several choices.

If your medication is lost, stolen, or damaged, replacement medication is not covered.

Contacts

MedImpact
Customer Care Center
and Prior Authorization 1.888.648.6769

Walgreens
Mail Order 1.866.304.2846
Specialty Pharmacy 1.888.782.8443

	ADOA Benefit Options (Aetna, Blue Cross Blue Shield of Arizona network administered by AmeriBen, CIGNA, UnitedHealthcare)
Pharmacy Benefits Administered By	MedImpact
Retail Requirements	In-Network pharmacies only: one copay per prescription
Mail Order*	Two copays for 90-day supply
Choice90	Two & 1/2 copays for 90-day supply
Generic	$10 copay
Preferred Brand**	$20 copay
Non-Preferred Brand**	$40 copay
Annual Maximum	None

**Offer available to HSA Option members only when copays apply.*
***Member may have to pay more if a brand is chosen over a generic.*

PHARMACY ONLINE FEATURES

Members can view pharmacy information located at *benefitoptions.az.gov*. Click pharmacy. Click on the pharmacy link and then click "MedImpact Pharmacy Website".

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

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

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

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

Drug Search
Research information on prescribed drugs like how to use the drug, side effects, precautions, drug interactions, and what to do if there is an overdose.

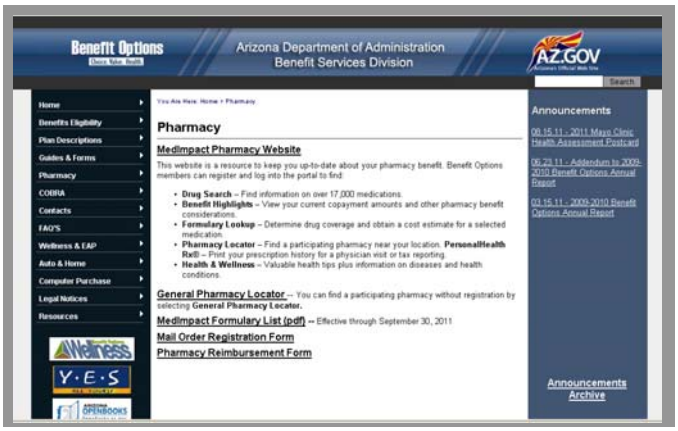
Health & Wellness
Learn valuable tips and information on diseases and health conditions.

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 step-by-step instructions.

Locate a Nearby Pharmacy
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.



DENTAL PLAN INFORMATION

Dental Plan Options

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

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

- You MUST use a DHMO/Prepaid Participating Dental Provider (PDP) to provide and coordinate all of your dental care.
- No annual deductible or maximums.
- No claim forms.
- No waiting periods.
- Pre-existing conditions are covered.
- Specific copays 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 copays 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 a 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 Dental's allowable fee as payment in full after any deductibles and/or copays 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 non-participating dentist, Delta Dental 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 the following: 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.

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

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

DENTAL PLANS COMPARISON CHART

	TDAHP Total Dental Administrators	Delta Dental PPO Plus Premier
PLAN TYPE	Prepaid/DHMO	Indemnity/PPO
PLAN NAME	A500S	Delta Dental PPO plus Premier
DEDUCTIBLES	None	$50/$150
PREVENTATIVE CARE	**COPAY**	**COINSURANCE**
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	**COPAY**	**COINSURANCE**
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	**COPAY**	**COINSURANCE**
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% $1,500 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 plan year at 100%. This is a summary only: please see plan descriptions for detailed provisions.*

DENTAL ONLINE FEATURES

Total Dental Administrators Health Plan (TDAHP), Inc.

If you are enrolling with TDAHP go to *TDAdental.com/adoa* to access the online features describe below:

Participating Providers

You can search for a specific dentist contracted under this plan (DHMO/Prepaid) by visiting *TDAdental.com/adoa*.

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 Delta Dental's secured online features described below:

Download Claim Forms

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

Dentist Search

With this secure online system, you can 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, for you or your dependents.

Contact Information

Get the most updated contact information.

VISION PLAN INFORMATION

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

Avesis Advantage Program

COBRA participants 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 employed by the State of Arizona when scheduling your appointment.

Out-of-Network Benefits

If services are received from a non-participating 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 employed by 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.

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

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
Continued

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.*

VISION 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.

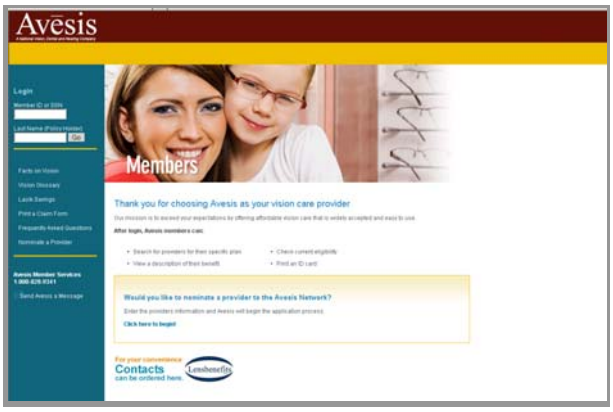
Print an ID Card
If you lose or misplace your ID card, you can print a new one.

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.



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 1.804.673.1686. 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.*

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 end of employment, reduction of the employee's hours, employee becoming entitled to Medicare, marriage, divorce, legal separation, annulment, or 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 an employee 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, vision and healthcare Flexible Spending Account [FSA]). 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 employee's spouse may elect COBRA coverage even if the employee 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, vision and health care FSA) 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).

Electing COBRA Under the Healthcare FSA

COBRA coverage under the health care FSA will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected under the health care FSA by the covered employee reduced by reimbursements of expenses incurred up to the time of the qualifying event, is equal to or more than the amount of premiums for healthcare FSA COBRA coverage that will be charged for the remainder of the plan year COBRA coverage will consist of the health care FSA coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event).

COBRA COVERAGE NOTICE Continued

The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year. FSA COBRA coverage will terminate at the end of the plan year. All qualified beneficiaries who were covered under the health care FSA will be covered together for health care FSA COBRA. However, each qualified beneficiary has separate election rights, and each could alternatively elect separate COBRA coverage to cover that qualified beneficiary only, with a separate health care FSA annual coverage limit and a separate COBRA premium. Contact the ADOA Benefit Services Division for more information.

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. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) 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.

This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months before the termination of employment or reduction of hours. In the case of a loss of coverage due to a employee'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. Regardless of the qualifying event, health care FSA COBRA coverage may only be continued to the end of the plan year in which the qualifying event occurred and cannot be extended for any reason. 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

COBRA COVERAGE NOTICE Continued

- during a disability extension period (the disability extension is explained below), the disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled.

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 a 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 preexisting 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 preexisting 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 (the period of COBRA health care FSA cannot be extended end of the current plan year under any circumstances).

Disability

If any of the qualified beneficiaries is determined by the Social Security Administration to be disabled, the maximum COBRA coverage period that results from the covered employee's termination of employment or reduction of hours (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 obtained due to the covered employee's termination of employment or reduction of hours with the State 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 as a result of the covered employee's termination of employment or reduction of hours; and
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination or reduction of hours. You must also provide this notice within the original 18 months of COBRA coverage obtained due to the covered employee's 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.

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 Benefits Office.

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 above.

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 covered employee'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 employee, divorce or legal separation from the covered employee, 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.

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 NOTICE Continued

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 month before the month in which you make your first payment. 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 that payment.

However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, 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.

COBRA COVERAGE NOTICE Continued

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).

Alternative Recipients Under QMCSOs

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

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 Avenue, Suite 103
Phoenix, AZ 85007
602.542.5008 or 800.304.3687
BenefitsIssues@azdoa.gov

Information about COBRA provisions for a governmental healthplan is available from the:
Centers for Medicare & Medicaid Services (CMS)
Private Health Insurance Group
7500 Security Boulevard
Mail Stop S3-16-16
Baltimore, MD 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;
- 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.

HIPAA NOTICE
Continued

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 healthcare 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.

HIPAA NOTICE Continued

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. 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.

HIPAA NOTICE Continued

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.

Contact Information
For more information or for further explanation of this notice, you may contact us:
ADOA, Benefit Services Division
100 N. 15th Avenue, Suite 103
Phoenix, AZ 85007
602.542.5008 or 800.304.3687
Fax 602.542.4744
BenefitsIssues@azdoa.gov

You may also obtain a copy of this Notice at our web site at *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. Grandfathered health plans 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, 2012, 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 2013 will be the first to report coverage costs for the prior calendar year.

MEDICARE NOTICE OF CREDITABLE COVERAGE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage through the Benefit Options program and about your options under Medicare's prescription drug coverage. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

2. ADOA has determined that the prescription drug coverage offered by Benefits Options Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare Drug Plan.

When Can You Join A Medicare Drug Plan?

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

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

If you decide to join a Medicare drug plan, your current Benefit Options coverage will be affected. If you enroll in a Medicare Part D Plan, you will not be eligible for Benefit Options medical coverage.

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

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

You should also know that if you drop or lose your current coverage with Benefit.

Options and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium.

MEDICARE NOTICE OF CREDITABLE COVERAGE Continued

You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

For further information ADOA Benefit Services Division at 1.800.304.3687 or visit our website at *benefitoptions.az.gov*. Questions can also be sent to the Benefit Services Division via email at BenefitsIssues@azdoa.gov.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Benefit Options changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

- Visit *www.medicare.gov*,
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help,
- Call 1.800.MEDICARE (1.800.633.4227). TTY users should call 1.877.486.2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at *www.socialsecurity.gov*, or call them at 1.800.772.1213 (TTY 1.800.325.0778).

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

A copy of this notice is posted at *benefitoptions.az.gov*, click on the Legal Notices link.

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. Copays and/or coinsurance amounts may or may not apply, see comparison charts on pages 17 and 18.

Dependent
An individual other than a health plan subscriber who is eligible to receive healthcare services under the subscriber's contract.

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

GLOSSARY Continued

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.

High Deductible Health Plan
A type of health plan that provides members the opportunity to open a health savings account.

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.

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.

GLOSSARY
Continued

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.

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