Arizona Department of Administration
Benefit Services Division

New Hire
2012 Benefit Guide

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- Benefits Spotlight
- Benefit Eligibility
- Medical & Prescription Benefits
- Dental & Vision Benefits
- Life & Disability Benefits
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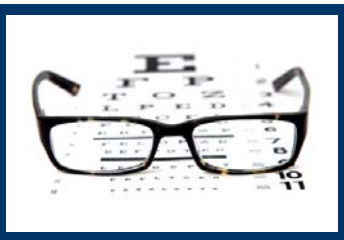
Benefit Options
Choice Value Health



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 New Hire Employees 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.

Medical Plans	Pharmacy Benefits	Dental Plans	Supplemental and Dependent Life Insurance
Disability Plans	Flexible Spending Accounts	Employee Wellness	Other Benefits
COBRA Coverage Notice	HIPAA Notice	and More	

How to Use This Guide

This guide is divided into chapters, each covering a specific benefits program or important information. These programs include:
We encourage you to review each section before making your benefit elections.

Enrolling

A.R.S. §38-671
Any employee (state or university) initially hired on or after July 20, 2011, is subject to a 90-day waiting period for Arizona Department of Administration (ADOA) Benefits.

New hires will be allowed to enroll via the website during the first 90 days of employment, with an effective date on the first day of the pay period following 90 days of employment. Employees will be offered an additional 31 days to complete a paper enrollment if he/she does not complete an electronic enrollment in the first 90 days. The effective date of benefits coverage will be the first of the pay period following receipt of a properly executed enrollment form following the 90th day of employment.

Returning employees must enroll for benefits coverage within 31 days of their re-employment if the break in service was less than two years.

If the break in service was longer than two years, the employee will be subject to the 90-day waiting period and will follow the process for new hires.

If you are nearing the end of your enrollment period and are not able to enroll using one of the websites on pages 11-12; contact your agency benefits liaison before the 31-day period has ended. 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.

ELIGIBILITY

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.

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**.

ELIGIBILITY

Eligible Employees

Active employees regularly scheduled to work 20 hours or more per week for six months or longer (except those listed below as ineligible) and their qualified dependents may participate in the Benefit Options Programs.

Ineligible Employees

A. Employees who work fewer than 20 hours per week
B. Employees in seasonal, temporary or emergency positions
C. Patients or inmates employed in State institutions
D. Non-State employee officers and enlisted personnel of the National Guard of Arizona
E. Employees in positions established for rehabilitation purposes
F. Student and work study employees

Eligible Dependents

You may add the following dependents to your plans (proper documentation may be required, see below):

A. Your legal spouse

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

a. Shares the employee's or retiree's permanent residence;
b. Has resided with the employee or retiree continuously for at least 12 consecutive months before filing an application for benefits and is expected to continue to reside with the employee or retiree indefinitely as evidenced by an affidavit filed at the time of enrollment;
c. Has not signed a declaration or affidavit of domestic partnership with any other person and has not had another domestic partner within the 12 months before filing an application for benefits;
d. Does not have any other domestic partner or spouse of the same or opposite sex;
e. Is not legally married to anyone or legally separated from anyone else;
f. Is not a blood relative any closer than would prohibit marriage in Arizona;
g. Was mentally competent to consent to the contract when the domestic partnership began;
h. Is not acting under fraud or duress in

Important Disclosure and Disclaimer:

The State of Arizona is not offering benefits to opposite-sex domestic partners. As a result of the U.S. District Court preliminary injunction (described in detail on page 5 in the "Eligibility" section of this manual), the State of Arizona is compelled at this time to continue offering benefits to qualified same-sex domestic partners. Qualified same-sex domestic partners are ADVISED and CAUTIONED that the preliminary injunction possibly could be lifted after open enrollment or during the 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 qualified 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**.

ELIGIBILITY Continued

accepting benefits;

i. Is at least 18 years of age; and

j. Is financially interdependent with the employee or retiree in at least three of the following ways:

   i. Having joint mortgage, joint property tax identification, or joint tenancy on a residential lease;

   ii. Holding one or more credit or bank accounts jointly, such as a checking account in both names;

   iii. Assuming joint liabilities;

   iv. Having joint ownership of significant property, such as real estate, a vehicle, or a boat;

   v. Naming the partner as beneficiary on the employee's life insurance, under the employee's will, or employee's retirement annuities and being named by the partner as beneficiary of the partner's life insurance, under the partner's will, or the partner's retirement annuities; and

   vi. Each agreeing in writing to assume financial responsibility for the welfare of the other, such as durable power of attorney; or

   vii. Other proof of financial interdependence as approved by the Director.

C. Your child defined as:

   a. Your or your same-sex domestic partner's natural, adopted and/or stepchild who is under 26 years old;

   b. A person under the age of 26 for whom you or your same-sex domestic partner have court-ordered guardianship;

   c. Your or your same-sex domestic partner's foster children under the age of 26;

   d. A child placed in your home by court order pending adoption;

   e. Your or your same-sex domestic partner's natural, adopted and/or stepchild;

   i. Who was disabled as defined by 42 U.S.C. 1382c before the age of 26;

   ii. Who continues to be disabled as defined by 42 U.S.C. 1382c;

   iii. Who is dependent for support and maintenance upon you or your same-sex domestic partner;

   iv. For whom you or your same-sex domestic partner had custody before the child was 26.

Dependent Documentation Requirements

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

B. If you are enrolling a dependent whose last name is different from your own, the dependent's coverage will not be processed until supporting documentation such as a marriage license for a spouse or a birth certificate or court order for a dependent, is provided to the ADOA Benefit Services Division.

Qualified Medical Child Support Order (QMCSO)

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

ELIGIBILITY Continued

If You and Your Spouse are Both 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.

Eligibility Audit

The Benefit Services Division may audit a member's documentation to determine whether an enrolled dependent is eligible according to the plan requirements. This audit may occur either randomly or in response to uncertainty concerning dependent eligibility. Should you have questions after receiving a request to provide proof of dependent eligibility, please contact the Audit Services Unit within the Benefit Services Division.

Subrogation

Subrogation is the right of an insurer to recover all amounts paid out on behalf of you, the insured. In the event you, as a Benefit Options member, suffer an injury or illness for which another party may be responsible, such as someone injuring you in an accident, and Benefit Options pays benefits as a result of that injury or illness, Benefit Options has the legal right to recover against the party responsible for your illness or injury or from any settlement or court judgment you may receive, up to the amount of benefits paid out by Benefit Options.

As a Benefit Options member, you are required to cooperate with the vendors acting on behalf of ADOA for subrogation. Failure to do so may result in legal action by the State to recover funds received by you.

End-Stage Renal Disease

If you are eligible to enroll in Medicare as an active employee or retiree because of End-Stage Renal Disease, the plan will pay for the first 30 months, whether or not you are enrolled in Medicare and have a Medicare card. At the end of the 30 months, Medicare becomes the primary payer. If a plan member who is eligible for Medicare Part B does not enroll in Medicare Part B, the plan will only pay secondary benefits after 30 months of primary coverage.

Continuing Life Insurance Options

If your employment terminates, you have the option of continuing your Life Insurance coverage with the Hartford. There are two options for continuation of coverage:

- Converting your group Life coverage to your own individual policy;
- Porting your Life coverage which continues as a term life policy. To be eligible for portability, you must terminate employment prior to Social Security Normal Retirement Age.

To apply for Conversion or Portability, you must apply within 31 days of the termination of your Life Insurance or within 15 days of the date you receive the COBRA notification not to exceed 91 days from coverage termination. For questions or to apply, call The Hartford at 1.877.320.0484.

IMPORTANT BENEFITS INFORMATION

ID Cards

ID cards for your medical, dental and vision plans will arrive separately and are sent directly from the vendor to your home address. Typically, ID cards arrive ten to fourteen business days after your benefits become effective.

- Contact the vendor directly if you do not receive your cards or if you need replacement cards.
- Most of the vendors allow members to print temporary ID cards from their websites. This may be helpful if you need services before you receive your cards.

Understanding Imputed Income

Under federal tax law, the portion of the premiums the State pays for coverage of an individual who does not qualify as an employee's tax dependent must be included in that employee's gross income. This often applies when an employee enrolls a same-sex domestic partner, or a same-sex domestic partner's child.

The following example illustrates the concept of imputed income. An employee earns a salary of $50,000 per year. He enrolls his same-sex domestic partner as a dependent under the Benefit Options program but his same-sex domestic partner does not qualify as a tax dependent. The enrollment of his same-sex domestic partner causes the state's monthly premium to rise from $484 (Emp only coverage) to $1,013 (Emp+adult coverage).

That corresponds to an additional $6,348 per year ($1,013 - $484 = $529 per month for 12 months). Because the same-sex domestic partner does not qualify as a tax dependent, the state is required to report this employee's gross income as $56,348. Therefore, the additional $6,348 he receives in benefits is subject to federal income tax withholding and employment taxes (FICA and Medicare).

Understanding Pre-tax and Post-tax Deductions

An employee pays a certain portion of his/her insurance premiums through payroll deductions. Generally these deductions are taken on a pre-tax basis, which means the deductions are taken first and then, when the paycheck amount is lower, the tax is determined. Under federal tax law, however, the portion of the premiums that the employee pays for coverage of an individual who does not qualify as his/her tax dependent must be deducted on a post-tax basis. That means the tax is determined first, when the paycheck amount is higher, then the deductions are taken.

The following simplified example illustrates the concept of post-tax deductions:
An employee earns $1,000 per paycheck. She enrolls her same-sex domestic partner, who does not qualify as a tax dependent, dental coverage.

Her portion of the dental premium is $67.93 ($29.86 for Employee only coverage plus an additional $38.07 for one additional dependent). This employee's paycheck deductions would be taken in the following order:
(1) $1,000 - $29.86 (pre-tax deduction for Emp only amount of dental coverage) = $970.14
(2) Determine tax due on earnings of $970.14 (assume 10% tax rate) = $97.01 due in taxes
(3) $970.14 - $97.01 (taxes) - $38.07 (post-tax deduction for non-tax-dependent dental coverage) = $835.06 final paycheck amount
[Had the same-sex domestic partner been a tax dependent, the final paycheck amount would have been $838.86].

IMPORTANT BENEFITS INFORMATION Continued

Tax Treatment of Same-Sex Domestic Partners, and Children of Same-Sex Domestic Partners

A same-sex domestic partner, and/or same-sex domestic partner's child may qualify as an employee's tax dependent under Internal Revenue Code Section 152 (as modified by Code Section 105(b) and by IRS Notice 200479). To determine eligibility, please refer to the Benefit Options Declaration of Tax Status forms. For more information, consult a tax professional. Benefit Options staff cannot give out tax advice. Please consult with your Human Resources office to determine whether or not the life event you are experiencing qualifies under the regulations and for information regarding the effective date for the change and for the documentation required to process the change.

Pre-Tax and Post Tax Benefits

When your insurance premiums and contributions to your Flexible Spending Account(s), see page 54 for more information, are made on a pre-tax basis, your taxable income is reduced. This means you will be paying less state, federal and Social Security (FICA) tax and, as a result, you will have more take-home pay. Federal regulations restrict the circumstances under which you can make changes during the plan year when your monthly insurance premiums are paid on a pre-tax basis. The only time such changes can be made are:

• Annual Open Enrollment; and
• Qualified Life Events.

Pre-tax deductions include:

- Medical Premiums;
- Dental Premiums;
- Vision Premiums;
- Supplemental Life Insurance (first $35,000);
- Flexible Spending Accounts.

Plans paid for with Post-tax premiums do not have the same restrictions during the plan year. You can reduce or cancel post-tax plans without a Qualified Life Event. However, midyear enrollment can only occur in conjunction with an appropriate Qualified Life Event, provided the request is made within 31 days of the event. Examples of plans with after-tax premiums are:

- Short-term disability;
- That portion of your life insurance over $35,000;
- Dependent life insurance.

Changing Your Benefits

Except for plans with after-tax premiums, you may change your benefit elections during the year only when you experience a Qualified Life Event (QLE). If you have not experienced a QLE, you must wait until the next annual open enrollment period to make benefit changes.

Qualifying Life Events include but are not limited to:

- Changes in your marital/domestic partnership status: marriage, divorce, legal separation, annulment, dissolution of domestic partnership, death of spouse;
- Changes in dependent status: birth, adoption, placement for adoption, death, or loss of dependent eligibility due to age;
- Changes in employment status or work schedule that affect benefits eligibility for you or your dependents;
- Changes in residence that result in different available plan options.

Timeframe to Submit a Change Request

Requested benefit changes must be submitted in writing to your agency Benefit Liaison within 31 calendar days of the event. See chart on the next page.

IMPORTANT BENEFITS INFORMATION Continued

The following flow chart will help you to determine the effective dates of qualified life events.

Losing Eligibility

What was the event?

- Divorce
- Legal Separation
- Death
- No longer qualifies as a same-sex domestic partner*

→ Effective date is the date of the event

Dependent turns 26

→ Effective date is the date of the event

Gaining Eligibility

Was event within 31 days of earliest notification (to agency or ADOA)?

- Yes → Is event: Marriage, same-sex domestic partner,* or fosterage? → Yes → Coverage is effective on the 1st day of the first pay period following proper enrollment
- Yes → Is event: Birth, adoption, or placement for adoption? → Yes → Coverage is effective the date of the event or date of the court order
- Yes → Is event: QMCSO? → Yes → Effective date is the end of the payroll cycle following receipt of paperwork
- No → Is event a return from Military Leave?
  - Yes → Change is effective the date of the event
  - No

*Same-Sex Domestic Partners must meet qualifications. See the dependent eligibility section of this guide for more information.

IMPORTANT BENEFITS INFORMATION Continued

Changing your Benefits - Continued

Effective Date of the Change

The effective date for benefit changes resulting from birth, adoption, or placement for adoption is the date of the event. The effective date for benefit changes based on all other QLEs is the first day of the pay period following the date the employee submits the requested change, in writing, to his or her agency Benefit Liaison.

Premium Changes Due to QLEs

Any change in premiums due to a QLE will be in effect the pay period following the receipt of all QLE documentation. According to IRS regulations, no previously paid premiums will be refunded.

Leave Information

Premium Collection – Leave without pay

Premiums are collected through payroll deductions for those employees actively-atwork, or by personal payment for an employee on leave without pay.

Military Leave of Absence

Employees who must leave for military service are provided continued benefits through the Uniform Services Employment and Re-employment Rights Act (USERRA). USERRA provides extended health care coverage for up to (18) months. The employee may continue health coverage for a maximum of six months by paying the employee portion of premiums. After the six-month period, the employee must pay both the employee and State portions of monthly premiums until the employee returns to work or for a maximum of (18) months.

Family and Medical Leave Act (FMLA)

Employees on approved FMLA may continue health care coverage by paying the employee portion of monthly premiums.

Industrial Injury or Illness

Employees who are on leave without pay due to an industrial injury or illness may continue health coverage for a maximum of six (6) months from the date of injury or illness by paying the employee portion of premiums. After the six-month period, the employee must pay both the State and employee portions of monthly premiums until the employee returns to work or becomes eligible for Medicare or long-term disability, whichever comes first.

Non-Occupational Leave

Employees on leave without pay for a health related reason that is not work-related may continue health care coverage for a maximum of (30) months by paying both the employee and State portions of monthly premiums until the employee returns to work or becomes eligible for Medicare or long-term disability, whichever occurs first. You may elect to change your coverage level from family to employee+one or employee only during an unpaid leave; however, you must request this change at the beginning of the leave period. If you are placed on leave-without-pay status, please check with your benefit liaison to confirm whether you have enough leave to cover your premiums or if you will need to make personal payments. Failure to pay premiums may result in cancellation of your benefits.

IMPORTANT BENEFITS INFORMATION Continued

Medical Flexible Spending Account (FSA)- Over the Counter Drugs

The federal healthcare reform bill passed in March, 2010 states that as of January 1, 2011, over the counter (OTC) drugs and medicines will only be reimbursable through your Medical Flexible Spending Account (FSA) if you have a valid prescription.

Insulin still qualifies for reimbursement without a prescription, as well as equipment, supplies, and diagnostic devices such as bandages, hearing aid batteries, blood sugar test kits, etc.

Following is a list of examples of OTC medicine categories no longer eligible for reimbursement without a prescription after January 1, 2011:

- Acid Controllers
- Allergy & Sinus
- Anti-Diarrhea Products
- Anti-Gas Products
- Anti-Itch Insect Bite Products
- Baby Rash Ointments
- Cold Sore Remedies
- Cough, Cold & Flu Products
- Digestive Aids
- Feminine Anti-fungal/Anti-Itch
- Hemorrhoid Remedies
- Laxatives
- Motion Sickness
- Pain Relief
- Respiratory Treatments
- Sleep Aids & Sedatives
- Stomach Ailment Remedies

Prescription co-pays will remain covered for reimbursement through the Medical FSA.

WHERE TO ENROLL — STATE

Benefit elections must be made using the YES system online at *yes.az.gov*. For employees unfamiliar with the YES website function, some basic instructions are listed below.

YES Login

1. Open the YES website at *yes.az.gov*

2. Click Login located at the bottom of the YES homepage

3. In the Login window, enter your Username and Password and then click the Login tab

4. Once you are logged into YES, click the Enrollment link on the left navigational bar

5. Follow the instructions to begin your benefit elections

First Time YES Users

1. Open the YES website at *yes.az.gov*

2. Click Login located at the bottom of the YES homepage

3. a. In the Login window, Enter your Employee Identification Number (EIN) as your Username, which is the 5 or 6 digit number given to you by your Human Resource Office

   b. Enter your Password which is your 4 digit birth year plus the last four numbers of your SSN

4. Once you are logged into YES, click the Enrollment link on the left navigational bar

5. Follow the instructions to begin your benefit elections

WHERE TO ENROLL — UNIVERSITIES

ARIZONA STATE UNIVERSITY

1. Login to My ASU using your ASURITE ID and password.
2. Click on the Benefits tab in the My Employment section.
3. Click on the Enrollment link.
4. Follow screen prompts.
5. IMPORTANT: After making your elections, print the enrollment summary, and then click the Submit button.
6. After you verify your elections, click the Submit button to authorize your elections.
7. When your confirmation appears, click the OK button.

NORTHERN ARIZONA UNIVERSITY

1. Go to https://peoplesoft.nau.edu and log into LOUIE using your employee ID and password.
2. Select "Self Service" from the left menu.
3. Under "Benefits" select Benefits Enrollment.
4. On the Benefits Enrollment page there will be an Enrollment event. To begin click "Select."
5. **IMPORTANT:** After making your elections, click Submit.
6. After you verify your elections, click the Submit button again to authorize your elections.
7. When your confirmation appears, click "OK."

If the event is not listed or the event listed is not "open", please contact the Human Resources Department at 928.523.2223 or send an email to Hr.Contact@nau.edu.

THE UNIVERSITY OF ARIZONA

1. Go to UAccess Employee at http://uaccess.arizona.edu/ and select "Employee/Manager Self Service".
2. Log in with your UA NetID and password.
3. Select "Self Service" from the left hand menu.
4. Select "Benefits"
5. Select "Benefits Enrollment"
6. On the Benefits Enrollment page, click the "Select" button for your benefits event. If you do not see an open event, contact Human Resources at 520.621.3662, option 3.

SUMMARY OF PER PAY PERIOD INSURANCE PREMIUMS — 2012

Pay Period Medical Premiums (26 pay periods)*

Plan	Tier	Employee Premium	State Premium	Total Premium	Agency HSA Contribution
EPO (Aetna, BCBS of AZ/AmeriBen**, CIGNA, UnitedHealthcare)	Emp only	$18.46	$253.85	$272.31	-
	Emp+adult	$54.92	$522.92	$577.84	-
	Emp+child	$46.62	$497.54	$544.16	-
	Family	$102.00	$648.46	$750.46	-
PPO (Aetna, BCBS of AZ/AmeriBen**, UnitedHealthcare)	Emp only	$71.54	$342.00	$413.54	-
	Emp+adult	$161.54	$695.08	$856.62	-
	Emp+child	$152.77	$667.85	$820.62	-
	Family	$224.31	$890.31	$1114.62	-
HSA (Aetna)	Emp only	$12.00	$232.15	$244.15	$27.70
	Emp+adult	$47.08	$466.15	$513.23	$55.39
	Emp+child	$37.38	$450.92	$488.30	$55.39
	Family	$89.08	$583.85	$672.93	$55.39

Pay Period Dental Premiums (26 pay periods)*

Plan	Tier	Employee Premium	State Premium	Total Premium
DHMO (Total Dental Administrators)	Emp only	$2.31	$2.29	$4.60
	Emp+1	$4.15	$4.58	$8.73
	Family	$6.46	$6.32	$12.78
PPO (Delta Dental PPO Plus Premier)	Emp only	$14.30	$2.29	$16.59
	Emp+1	$32.71	$4.58	$37.29
	Family	$56.82	$6.32	$63.14

Pay Period Vision Premiums (26 pay periods)*

Plan	Tier	Employee Premium
Insured plan (Avesis)	Emp only	$2.23
	Emp+1	$6.24
	Family	$7.78
Discount card (Avesis)	Emp	$0.00

For the NAU Blue Cross Blue Shield plan rates visit: http://hr.nau.edu/node/2102.

**UA has 24 pay period deductions, please refer to your Human Resources website for more information.*

***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 27.*

SUMMARY OF PER PAY PERIOD INSURANCE PREMIUMS — 2012

Supplemental Life and AD&D Plan - The Hartford (26 pay periods)*

Your Age	Cost per $5,000/pay period
29 AND UNDER	$0.23
30-34	$0.28
35-39	$0.32
40-44	$0.55
45-49	$0.74
50-54	$1.20
55-59	$1.71
60-64	$3.09
65-69	$3.09
70+	$4.89

Dependent Life and AD&D Plan - The Hartford (26 pay periods)*

Coverage Amount	Cost/per pay period
$2,000	$0.43
$4,000	$0.87
$6,000	$1.30
$12,000	$2.60
$15,000	$3.25
$50,000**	$11.19

Short-Term Disability Plan - The Hartford*

Employee Cost/Monthly
$0.69 per $100 of your earned monthly wages Monthly premium = (Earned monthly wages/100) x $0.69
Example: Earned monthly wages = $1,000 Monthly premium = ($1,000/100) x $0.69 = $6.90

**UA has 24 pay period deductions; ABOR, ASU, NAU and UA have other options for Life and Short-term Disability insurance. Please refer to your Human Resources website for more information.*
***Only available if employee also carries $35,000 in additional supplemental life.*

MEDICAL PLAN INFORMATION

Understanding Your Options

For the plan year beginning January 1, 2012, employees 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 15-16.

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: employee premiums, copays, and coinsurance. Refer to pages 11 and 12 for per pay period premiums and pages 19 and 20 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

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

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 18).
   - 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.

Note: Members and dependents (including spouses) enrolled in a Health Savings Account (HSA) do not qualify for a traditional Medical Flexible Spending Account; instead they qualify for a Limited Flexible Spending Account. The only qualifying expenses for this Limited Flexible Spending Account are dental and vision care expenses. Please see page 50 for more details.

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.

MEDICAL PLAN Continued

Cost for Services/Prescriptions - Continued

At the top of the table you can see that:

- In-network qualified preventative services are free, even before the deductible is satisfied
- In-network qualified preventative prescriptions 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 prescriptions are covered at 100% for the reminder of the plan year.

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. When your HSA is opened, the State will make pay period contributions to your HSA.
   - For Employee only coverage, the State will contribute $27.70 per pay period.
   - For Employee+adult, Employee+child, and Family coverage, the State will contribute $55.39 per pay period.

3. You can make additional contributions to your HSA through:
   - Payroll deductions (pre-tax);
   - Lump-sum deposits (tax deductible).

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

5. 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.

6. 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.

7. 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.

8. 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 Option)

		High Deductible Health Plan	High Deductible Health Plan
Available Plans		☑*Aetna*	☑*Aetna*
		IN-NETWORK	**OUT-OF-NETWORK**
Plan year deductible	Single employee	$1,200*	$2,400*
	Emp+adult, emp+child, family	$2,400*	$4,800*
Out-of-pocket max	Single employee	$2,000*	$5,000*
	Emp+adult, emp+child, family	$4,000*	$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 Preventive 10% coinsurance	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)

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

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

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

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

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

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

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

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

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

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

MEDICAL ONLINE FEATURES Continued

UnitedHealthcare

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

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

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

Get Information about Hospitals and Physicians
Find information on network doctors and healthcare 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 Healthcare 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.

MEDICAL MANAGEMENT

Services Available

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

The four vendors provide medical management services as follows:

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

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

Utilization Management

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

American Health Holding 1.866.244.8977
Aetna 1.800.333.4432
CIGNA 1.800.968.7366
UnitedHealthcare 1.800.896.1067

Case Management

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

Disease Management

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

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

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

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

MEDICAL MANAGEMENT Continued

Your assigned disease manager may also:

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

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

Getting Involved

The Benefit Options disease management programs offered through American Health Holding, Aetna, CIGNA, and UnitedHealthcare identify and reach out through phone calls and/or mail to members who may need help managing their health conditions.

The disease management companies work with the Benefit Options plan to provide this additional service. Participation is optional, private, and tailored to your specific needs. Also, members of the Benefit Options plan who are concerned about a health condition and would like to enroll in one of the covered programs can contact their respective disease management vendors directly to self enroll.

Please refer to the your medical management vendor's phone number on page 25 if you or your dependent is interested.

NurseLine

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

American Health Holding 1.866.244.8977

Aetna 1.800.556.1555

CIGNA 1.800.968.7366

UnitedHealthcare 1.800.401.7396

NETWORK OPTIONS OUTSIDE OF ARIZONA

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

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

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

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.

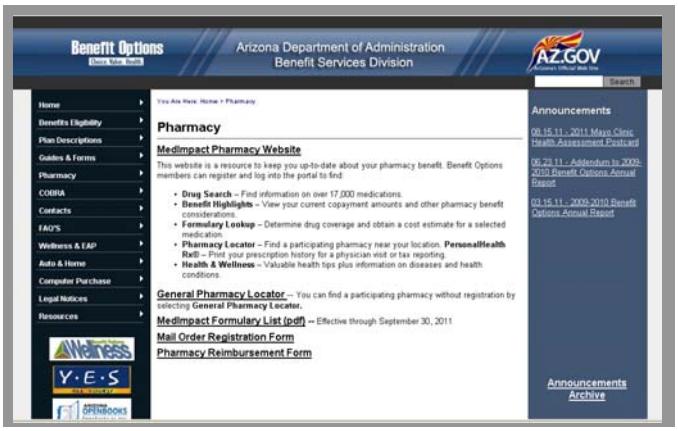
Health & Wellness
Learn valuable tips and information on diseases and health conditions.

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

Employees 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 PLAN 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 described 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

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

Program Highlights

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

How to Use the Advantage Program

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

2. Schedule an appointment – Identify yourself as an Avesis member 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.

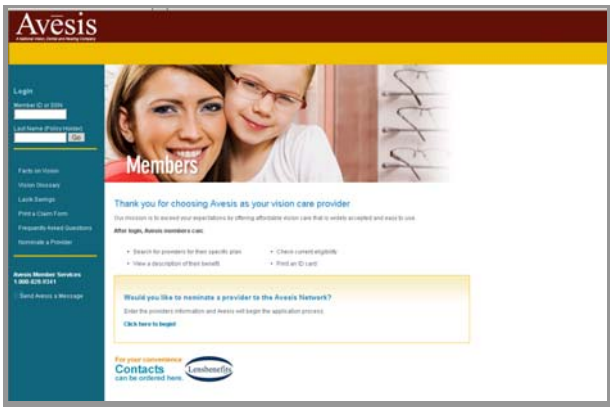
Print an ID Card
If you lose or misplace your ID card, you can print a new one.

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.*

TRAVEL ASSISTANCE

This program is offered through **The Hartford** by **Europ Assistance, USA**, and is designed for benefit eligible members and dependents. The Travel Assistance program offers:

Pre-Trip Assistance

You can contact the Europ Assistance at 1.800.243.6108 to receive important information before you leave or while you are in route such as:

- Visa.
- Passport.
- Inoculation and immunization requirements.
- International hot spots.
- Travel advisories.
- Foreign exchange rates.
- Embassy and consular referrals.

Medical Assistance

If you are outside of Arizona and/or more than 100 miles from your primary residence for a period of less than 90 days, you may receive:

- Referrals to physicians, dentist and medical facilities.
- Professional case managers will monitor your level of care.
- Transportation to the closest medical facility (Paid for if medically necessary).
- Transportation home for further medical treatment (Paid for if medically necessary).
- If you traveling companion loses travel arrangements due to your hospitalization, new arrangements will be made and funded.
- Travel arrangements for the return home of for your dependent children left unattended due to your hospitalization.
- Traveling alone and hospitalized for at least seven consecutive days or are in a critical condition, travel arrangements will be made and funded for a family member or friend to visit if that service is deemed medically necessary.
- Advances funds to cover on-site medical expenses. Guarantee of reimbursement is required.
- The proper return of remains for burial will be arranged and paid for in the event of death.
- Prescriptions or eyeglasses will be replaced if lost, stolen or used up, subject to local law, whenever possible. The cost and shipping expenses are your personal responsibility.

Emergency Personal Services:

- Sending and receiving emergency messages.
- Makes or changes airline, hotel and car rental reservations.
- Emergency cash. Guarantee of reimbursement is required.
- Assists in locating lost luggage and personal possessions.
- Assists in locating an attorney.
- Advances funds for bail, where permitted by law. Guarantee of reimbursement is required.
- Provides telephone translation.

You are personally responsible for the cost of air fare not approved as medically necessary by the attending physicians; food, hotel and car expenses; and attorney's fee.

Services Not Covered:

- Involvement in any act of war.
- Participation in any military maneuver or training exercise or piloting an aircraft.
- Mental or emotional disorders, unless hospitalized.
- Traveling for the purpose of obtaining medical services or treatment.
- Injury or illness caused by or contributed to by use of drugs or intoxicants, unless prescribed by a physician.
- Participation as a professional in athletics.
- Pregnancy and childbirth, except for complications of pregnancy.

TRAVEL ASSISTANCE
Continued

- Traveling against the advice of a physician.
- The commission of, or attempt to commit, an unlawful act.
- Suicide or attempted suicide.
- Injury or illness that can be treated locally and does not prevent continuation of the trip.
- Any assistance not shown as covered.

Learn more at *groupbenefits.thehartford.com/arizona.*

You may call 1.800.243.6108 and request a travel assistance ID Card. The Group Number for the State of Arizona is 395211.

LIFE INSURANCE*

The Hartford

The Hartford is the Benefit Options vendor for Life Insurance. The Hartford is one of the largest insurance companies and serves millions of customers worldwide with over 200 years in business.

Basic Life Insurance and AD&D

You are automatically covered for $15,000 of basic life insurance provided by The Hartford at no cost to you. Non-smokers will receive an additional $1,000. The State also pays for $15,000 of Accidental Death and Dismemberment (AD&D) insurance coverage. A $15,000 Seat Belt Benefit may also be payable if you die in an automobile accident and are wearing a seat belt. You are automatically covered in these three programs.

Supplemental Life Insurance and AD&D

Supplemental coverage is available in increments of $5,000 if you would like additional insurance beyond the $15,000 that the State already provides to you. Your cost for supplemental life and AD&D insurance is based on your age as of January 1st (the first day of the plan year). Premiums for supplemental life coverage above $35,000 are paid on an after-tax basis.

You may elect to increase or decrease your supplemental life and AD&D coverage only during Open Enrollment. This year you may increase in multiplies of $5,000 up to $20,000 not to exceed the maximum benefit of $300,000 or 3 times your annual salary. If you waived this coverage before and are electing for the first time, at this enrollment you may elect $20,000. You can also decrease your coverage in multiples of $5,000 or cancel coverage.

Your employee supplemental AD&D coverage amount is the same as the supplemental life amount that you elect.

In the event of your death, employee life and AD&D benefits are paid to your designated beneficiary. It is important to keep your beneficiary information current. If you choose more than one beneficiary, you can define the amount paid or a percent paid to each beneficiary. You may change your beneficiary online during enrollment.

Remember: adding a beneficiary does not automatically delete a previously-designated beneficiary. If you wish to change a previously designated beneficiary, you must actively do so while enrolling or as needed throughout the year.

Dependent Life Insurance

You may purchase life insurance coverage for your dependents in the amount of $2,000, $4,000, $6,000, $12,000, $15,000, or $50,000. You do not have to elect any supplemental coverage with The Hartford for yourself in order to choose this dependent plan for up to $15,000. For the $50,000 amount, you must have a combined basic and supplemental coverage of $50,000. Each person will be covered for the amount you choose for a small employee premium. In the event of a claim, you are automatically the beneficiary.

You can learn more by visiting *http://groupbenefits.thehartford.com/arizona/* or calling 1.866.712.3443.

UNIVERSITY FACULTY AND STAFF: To assist you in making an informed decision, please refer to your Human Resources website to compare both the state-sponsored and university-sponsored plans.

SHORT-TERM DISABILITY* (STD)

The Hartford

The Hartford is the Benefit Options vendor for Short-Term Disability (STD).

How STD Works

If you elect Short-Term Disability (STD) insurance and The Hartford determines you are unable to work due to illness, pregnancy, or a non-work-related injury, you may receive a weekly benefit for up to 26 weeks. The STD benefits will pay up to 66-2/3% of your pre-disability earnings during your disability. The weekly minimum benefit is $57.69; the weekly maximum benefit is $769.27. There are no pre-existing conditions or limitations. You must meet the actively-at-work provision.

Effective Dates

If you previously waived STD coverage and enroll during Open Enrollment, your insurance becomes effective on January 1.

Your benefits will start on your first day of disability due to **non-work related injury** or the 31st day of disability due to illness or pregnancy, if coverage was elected during your initial new hire/eligibility enrollment period.

If you elect coverage after your initial new hire/ eligibility enrollment period and become disabled during the first 12 months of being covered under the plan, your benefits will start on the 61st day of disability due to illness or pregnancy.

Disabled and Working Benefits

The Hartford STD program allows you to return to work and receive up to 100% of your pre-disability earnings between the STD benefit and your current weekly earnings.

To learn how your benefits are calculated for this program, see the next example:

Weekly benefit calculation under the Disabled and Working Formula = (A - B) x C / A
A = weekly pre-disability earnings (what the STD plan benefit is based on).
B = your current weekly earnings (earnings while disabled).
C = the weekly benefit payable if a claimant were totally disabled.
Assume an employee is covered by the STD plan. The employee's covered earnings (base earnings) are $1,200 a week. The employee wants to return to work part-time and is able to do so on a reduced schedule.
A = $1,200; this is what the employee was making weekly prior to being disabled.
Assume B = $300; this is what the employee is making now on a part-time basis, reduced schedule, while still being considered disabled.
C = $800; this is the weekly benefit the employee would receive if she was not working at all (1,200 x the weekly benefit percentage of 66 2/3%).
(1,200 - 300) x 800 = 720,000 / 1,200 = **$600**
This is the benefit the employee will receive under the Disabled and Working Formula.

Filing a claim is as simple as visiting *http://groupbenefits.thehartford.com/arizona/* or calling 1.866.712.3443.

****UNIVERSITY FACULTY AND STAFF: To assist you in making an informed decision, please refer to your Human Resources website to compare both the state-sponsored and university-sponsored plans.***

LONG-TERM DISABILITY (LTD)

As a benefits-eligible employee, you are automatically enrolled in one of the State's two Long-Term Disability (LTD) programs, starting the day after you complete your initial hire/ eligibility waiting period (participation is mandatory). The retirement system to which you contribute determines the LTD program available to you. Refer to the list below for the name of your LTD program:

Arizona State Retirement System (ASRS Participants)

Sedgwick, CMS (formerly VPA, Inc.) is administered through ASRS. Your LTD benefit will pay up to 66-2/3% of your income earnings during your disability as determined by Sedgwick, CMS and based on supporting medical documentation. Your benefits may be subject to an offset based on Social Security payments, retirement benefits and other disability benefits. LTD benefits can be paid until age 65 or until you are able to return to work after your disability as determined by Sedgwick, CMS.

Medical documentation of your disability is required to continue your payment of benefits. You may learn more about the LTD plan offered by ASRS by visiting: *azasrs.gov* or calling 602.240.2000 or 1.800.621.3778 if outside of Phoenix. For hearing impaired, please call TTY 602.240.5333.

Public Safety Personnel Retirement System (PSPRS), Corrections Officer Retirement Plan (CORP), Elected Officials' Retirement Plan (EORP), Optional Retirement Plans of the Universities (TIAA-CREF, and Fidelity Investments) -Non-ASRS Participants:

The Hartford is the vendor for Long-Term Disability administered through Benefit Options to non-ASRS participants. Your LTD benefit may pay up to 66-2/3% of your monthly pre-disability earnings with a maximum benefit of $10,000 per month during your disability as determined by The Hartford and based on supporting medical documentation.

Your benefits may be subject to an offset based on Social Security payments, retirement benefits and other income benefits. LTD benefits can be paid until age 65 or until you are able to return to work after your disability as determined by The Hartford. Medical documentation of your disability is required to continue your payment of benefits. You can learn more about the LTD plan offered by The Hartford by visiting *http://groupbenefits.thehartford.com/arizona/* or calling 1.866.712.3443.

If you are facing a possible long-term disability, you should contact The Hartford within 90 days from the date of your illness or injury. You will be provided the information you need to apply for LTD benefits. This could include a waiver of insurance premiums or you may be eligible for life insurance conversion (converting your supplemental policy from a group policy to an individual one). Although your life and/or disability insurance premiums may be waived, your medical, dental and vision insurance premiums are not waived. You are still responsible for payment of these premiums.

Changing Retirement Systems

Changing jobs between state agencies or within a single agency may result in a change to your retirement system. Please be aware that this change could impact your LTD coverage.

LIFE, STD, LTD ONLINE FEATURES*

You can access important information about your Life and AD&D, Short-Term and Long-Term Disability insurances by visiting *http://groupbenefits.thehartford.com/arizona/*.

It's My Choice Calculator
This calculator will help you estimate your life insurance needs.

Premium Calculator
Estimate the cost of coverage of your Life and AD&D Insurance. You can also estimate the cost of your dependent coverage.

Benefit Highlight Sheets
Learn important information such as: eligibility, coverage, effective dates and other information.

File a Claim Online
File a short-term disability claim by calling The Hartford or online by accessing the link to *thehartfordatwork.com*.

Your Booklets
Find booklets with your important information about Life, Short-Term Disability and Long-Term Disability information.

Claims
Learn how to file a claim.

Check Your Claim Status
View the status of all your claims submitted at *thehartfordatwork.com.*

Life Planning & Services
You can learn about different programs offered by The Hartford, such as Life Conversations, Ability Assist, Beneficiary Assist and others.

To learn more about these programs and other features visit *http://groupbenefits.thehartford.com/arizona/*.

****UNIVERSITY FACULTY AND STAFF: Please refer to your Human Resources website for additional online features.***

WELLNESS - BEWELL BENEFIT

Benefit Options Wellness is committed to helping employees and their dependents be well today and stay well for life. The BeWell Benefit is designed to enhance the overall health and quality of life for State of Arizona employees and is one of the most important long-term benefits available to our health plan members.

Wellness provides free or low-cost educational programming, health screenings, immunizations, interactive web tools, and health improvement services to help both employees and the State of Arizona save money on escalating healthcare costs.

BeWell Programs and Services

Mini-Health Preventative Screening

The work site mini-health screen focuses on prevention and early detection of heart disease and diabetes. Tests included in this screening are the full lipid panel, blood pressure, body composition, and blood glucose. Our vendors also offer optional screens such as osteoporosis, facial skin analysis or a PSA.

Mobile Onsite Mammography

To fight cancer through early detection, mammograms are offered at work sites across Arizona. For convenience, employees' results are sent directly to their physician and appointments only last 15 minutes.

Prostate Cancer Screening

Early detection is the best defense against prostate cancer. Wellness contracts with Prostate Onsite Projects to provide free, convenient prostate screenings at the worksite with a mobile medical unit. The doctor on board performs: a PSA blood test, digital rectal exam (DRE), testicular exam and a doctor consultation. Men can get tough, get checked, and get going.

Flu Vaccine Program (October 1, 2011 through December 31, 2011)

Wellness provides free flu shots at many State work sites and public clinic locations for employees. More information can be found on the Wellness website at *benefitoptions.az.gov/wellness.*

Health Management Education Series

Wellness provide worksite health management educational courses 5-12 weeks in length. These classes are lead by professional health educators and designed to help employees make health improvements by adopting positive lifestyle habits. Class topics include: Weight Management, Cholesterol, Hypertension, Stress and more. Wellness subsidizes the class fees to make it affordable for employees. For more information on the health management classes go to the website: *benefitoptions.az.gov/wellness*.

Employee Assistance Program (EAP)

EAP is a confidential Wellness benefit that provides short-term counseling to employees, their spouses, and their dependents. Employees can access 6 free counseling sessions to help with personal issues, coping with a loss, stress/anxiety, or financial concerns. ADOA offers an EAP contract which serves most State agencies. The ADOA EAP website and phone number are available 24/7 for local resources, informational articles, and counseling: *guidanceresources.com* or 1-877-327-2362. The ADOA company code is HN8876C. Other EAP contracts that serve State agencies can be found at *benefitoptions.az.gov/wellness.*

WELLNESS - BEWELL BENEFIT Continued

Fees for Wellness Services

Service	Employee Cost
Mini Health	**$0**
- Bone Density	**$0 for women 40+**
- PSA	**$5 for men 40+**
Mammography	**$0**
Flu Shot	**$0**
Prostate Screening	**$0**

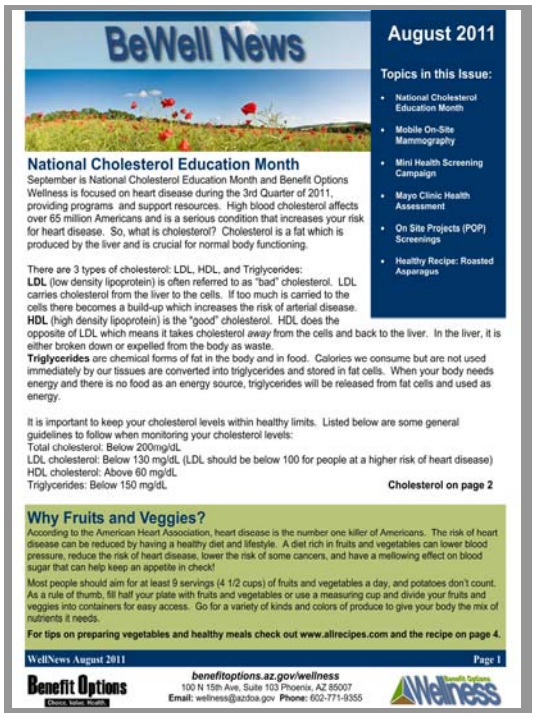
Other Wellness Resources

Website

The Wellness website provides up-to-date information on Wellness programs, services, and campaigns. A schedule of upcoming programs can be found on the "Events Schedule" online. An event request form (to host a screening or class) is also available (see right).

Monthly Newsletter (BeWell News)

This electronic newsletter is sent via email to designated agency contacts and should be distributed to all employees. The newsletter is also posted bimonthly on the Wellness website homepage *benefitoptions.az.gov/wellness*.


BeWell News

August 2011

Topics in this Issue:

- National Cholesterol Education Month
- Mobile On-Site Mammography
- Mini Health Screening Campaign
- Mayo Clinic Health Assessment
- On Site Projects (POP) Screenings
- Healthy Recipe: Roasted Asparagus

National Cholesterol Education Month

September is National Cholesterol Education Month and Benefit Options Wellness is focused on heart disease during the 3rd Quarter of 2011, providing programs and support resources. High blood cholesterol affects over 65 million Americans and is a serious condition that increases your risk for heart disease. So, what is cholesterol? Cholesterol is a fat which is produced by the liver and is crucial for normal body functioning.

There are 3 types of cholesterol: LDL, HDL, and Triglycerides:
LDL (low density lipoprotein) is often referred to as "bad" cholesterol. LDL carries cholesterol from the liver to the cells. If too much is carried to the cells there becomes a build-up which increases the risk of arterial disease.
HDL (high density lipoprotein) is the "good" cholesterol. HDL does the opposite of LDL which means it takes cholesterol *away* from the cells and back to the liver. In the liver, it is either broken down or expelled from the body as waste.
Triglycerides are chemical forms of fat in the body and in food. Calories we consume but are not used immediately by our tissues are converted into triglycerides and stored in fat cells. When your body needs energy and there is no food as an energy source, triglycerides will be released from fat cells and used as energy.

It is important to keep your cholesterol levels within healthy limits. Listed below are some general guidelines to follow when monitoring your cholesterol levels:
Total cholesterol: Below 200mg/dL
LDL cholesterol: Below 130 mg/dL (LDL should be below 100 for people at a higher risk of heart disease)
HDL cholesterol: Above 60 mg/dL
Triglycerides: Below 150 mg/dL

Cholesterol on page 2

Why Fruits and Veggies?

According to the American Heart Association, heart disease is the number one killer of Americans. The risk of heart disease can be reduced by having a healthy diet and lifestyle. A diet rich in fruits and vegetables can lower blood pressure, reduce the risk of heart disease, lower the risk of some cancers, and have a mellowing effect on blood sugar that can help keep an appetite in check!

Most people should aim for at least 9 servings (4 1/2 cups) of fruits and vegetables a day, and potatoes don't count. As a rule of thumb, fill half your plate with fruits and vegetables or use a measuring cup and divide your fruits and veggies into containers for easy access. Go for a variety of kinds and colors of produce to give your body the mix of nutrients it needs.

For tips on preparing vegetables and healthy meals check out www.allrecipes.com and the recipe on page 4.

WellNews August 2011 Page 1

Benefit Options

benefitoptions.az.gov/wellness
100 N 15th Ave, Suite 103 Phoenix, AZ 85007
Email: wellness@azdoa.gov Phone: 602-771-9355

Wellness

How to Request a Wellness Event

1. Go to the Wellness Website at *benefitoptions.az.gov/wellness* and click on the "Events Request" button in the left margin.
2. Click on the online request form and complete all of the required fields: desired event, date, time, location, number of employees, etc.
3. Ensure your agency has a space available to host the requested event on your desired date and time.
4. Print, scan and e-mail to: wellness@azdoa.gov.

These steps will send an email request to the Benefit Options Wellness program coordinator and your event will be scheduled. You will receive marketing materials and any registration information to distribute to the employees in your agency. Events should be requested 4-6 weeks in advance to ensure vendor availability. The minimum participation requirements are posted on the Wellness website for reference.

Contact Information
Phone: 602.771.9355
Toll free: 800.304.3687
wellness@azdoa.gov

FLEXIBLE SPENDING ACCOUNTS*

Again this year, you have the option to open Medical and/or Dependent Care (child care) Flexible Spending Accounts (FSAs) administered by **ASI**.

The FSAs allow you to pay eligible out-of-pocket medical and dependent care expenses with pretax dollars, reducing your taxable wages and, therefore, decreasing your taxes.

It is important to set aside only as much money in your Flexible Spending Accounts as you intend to use each plan year. Any monies not claimed by the employee within the specified period will be forfeited in accordance with the Internal Revenue Service Regulations.

You specify the annual dollar amount of your earnings to be deposited to each account. This amount is deducted in 26 equal payments, one each pay period**.**

At your request, your FSA reimbursement may be deposited into your checking or savings account by enrolling in direct deposit. To obtain an application, visit the ASI website at *asiflex.com*. A description of each type of account is provided below.

Medical FSA

This account allows you to set aside pretax dollars to pay for copays, coinsurance, deductibles, some prescriptions and over-the-counter supplies and other expenses.

Please note that you are required to submit a prescription for over-the-counter medications in order for these expenses to be eligible for reimbursement through your Medical FSA.

Dependent Care FSA

A dependent care FSA can be used to pay for out-of-pocket child care expenses for children under the age of 13. Also, you can use the account to pay for care for older dependents that live with you at least 8 hours each day and require assistance with day living.

Note: Dependent medical and/or other expenses should be submitted through the medical FSA not the dependent care FSA.

There are additional IRS rules that apply to your dependent care FSA contributions. You may be eligible to claim the dependent care tax credit on your federal income tax return. Consult a tax advisor to determine if participating in this program or taking the dependent care tax credit gives you the greater advantage.

Before you incur an expense, determine if it is eligible for reimbursement on the ASI website, *asiflex.com.*

UNIVERSITY FACULTY AND STAFF: Please refer to your Human Resources website for the Flexible Spending Account options available to you.

FLEXIBLE SPENDING ACCOUNTS Continued

File a Claim

You will need to fill out your claim form and attach copies of invoices for services you received.

Submitting a Claim Form

You can:

- Fax your claim and documentation, toll-free to ASI at 1.877.879.9038
- Mail the claim form and documentation to the location indicated on the claim form, or
- Submit your claims online at *https://my.asiflex.com*. You need your ASI-assigned PIN, along with your State of Arizona employee identification number (EIN). All documentation must be scanned into PDF format.

Reimbursement

Your reimbursement can be by direct deposit or check. An email notification of your reimbursement will be sent to you if you choose to elect direct deposit.

Claims are processed within two business days of receipt. However, processing time will depend upon the volume of the claims received.

If you wish to start direct deposit after the Open Enrollment period, you will need to do so through ASI. The direct deposit request form is Available at *asiflex.com*.

You may file claims as soon as you incur charges and services have been provided.

You have from January 1, 2012 through December 31, 2012 to use account funds. All the claims for medical and dependent care expenditures must be filed with ASI prior to March 31, 2013 for reimbursement.

End of Employment

Your coverage ends at the end of the pay period of your last deduction when you leave employment.

If your employment ends prior to the end of the plan year, any expenses must be incurred prior to your termination date in order for you to receive reimbursement.

Note: Members and dependents (including spouses) enrolled in a Health Savings Account (HSA) do not qualify for a traditional Medical FSA; instead they qualify for a Limited Flexible Spending Account. The only qualifying expenses for a Limited Flexible Spending Account are dental and vision care expenses. Please see page 50 for more details.

FLEXIBLE SPENDING ACCOUNTS COMPARISON CHART

	MEDICAL CARE	DEPENDENT CARE
Maximum Contributions	$5,000 annually	$5,000 annually ($2,500 if married and filing separately)
Minimum Contributions	$130 annually	$260 annually
Use of the Account	*To pay (with pretax money) for health-related expenses that are not covered or only partially covered, including expenses for your spouse or children not enrolled in your medical, dental, or vision plans	*To pay expenses for care of dependent provided by a non-dependent *To pay care provided for your children under the age of 13 for whom you have custody, for a physically or mentally handicapped spouse or other dependents who spend at least eight hours a day in your home *To pay dependent care provided so that you can work
Samples of Eligible Expenses	*Copays *Deductibles *Charges above reasonable and customary limits *Dental fees *Eyeglasses, exam fees, contact lenses and solution, LASIK surgery *Orthodontia	*Services provided by a day care facility. Must be licensed if the facility cares for six or more children *Babysitting services while you work *Practical nursing care *Preschool
What's Not Covered	*Premiums for medical or dental plans *Items not eligible for the healthcare tax exemptions by IRS *Long-term care expenses	*Private school tuition including kindergarten *Overnight camp expense *Babysitting when you are not working *Transportation and other separately billed charges *Residential nursing home care
Restrictions/ Other Information	*See IRS Publication 502 (expenses in this plan qualify based on when the services are provided regardless of when you pay for the expense) or go to ASI's website at *asiflex.com* for specific details on what expenses are allowed *You cannot transfer money from one account to the other *Your election amount may be increased (but not decreased) if you have a qualified life event	*See IRS Publication 503 (expenses in this plan qualify based on when the services are provided regardless of when you pay for the expense) or go to ASI's website at *asiflex.com* for specific details on what expenses are allowed *You may not use the account to pay your spouse, your child who is under 19 or a person whom you could claim as a dependent for tax purposes *You cannot change your election unless you have a qualified life event

FLEXIBLE SPENDING ACCOUNTS Continued

Deciding How Much to Deposit Into Your Flexible Spending Accounts

Estimate the amount you expect to pay during the plan year for eligible, uninsured out-of-pocket medical and/or dependent care expenses. This estimated amount cannot exceed the established limits (Medical limit =$5,000; Dependent Care limit = $5,000).

Be conservative in your estimates, since any money remaining in your accounts will be forfeited.

TAX-FREE MEDICAL EXPENSE WORKSHEET

Estimate your eligible, uninsured out-of-pocket medical expenses for the plan year, which is January 1, 2012 through December 31, 2012.

YOUR OUT-OF-POCKET MEDICAL, DENTAL AND VISION EXPENSES

$ _____
$ _____
$ _____
$ _____
$ _____
$ _____

SUBTOTAL
Your total contribution during the year cannot exceed $5,000.

$ _____

DIVIDE
By the number of paychecks (26) you will receive during the plan year.

This is your pay period contribution -

$ _____

TAX-FREE DEPENDENT CARE WORKSHEET

Estimate your eligible dependent care expenses for the plan year, which is January 1, 2012 through December 31, 2012.

NUMBER OF WEEKS
You will have dependent (child, adult or elder) care expenses for the plan year. Remember *to subtract holidays, vacations, and other times you may not be paying for eligible dependent care.*

Weeks _____

MULTIPLY
by the amount of money you expect to spend each week

$_____

SUBTOTAL
Total contribution cannot exceed IRS limits for the calender year and your employer's plan year.

$_____

DIVIDE
By the number of paychecks (26) you will receive during the plan year.

This is your pay period contribution -

$ _____

LIMITED FLEXIBLE SPENDING ACCOUNT*

The Limited Flexible Spending Account (FSA) is a money-saving option available only to members who are enrolled in a Health Savings Account (HSA). You have the option to open a Limited Medical Flexible Spending Account administered by **ASI**.

Members including dependents enrolled in an HSA are not allowed to enroll in a traditional Medical Flexible Spending Account.

Limited FSA Highlights

- Allows you to set aside pretax dollars, reducing your taxable wages and, therefore, decreasing your taxes.
- You can specify the annual dollar amount of earnings to be deposited. This amount is deducted in 26 equal payments, one each pay period.
- At your request, your FSA reimbursement may be deposited into your checking or savings account by enrolling in Direct Deposit. To obtain an application, visit the ASI website at *asiflex.com.*

- Monies not claimed within the plan year will be forfeited in accordance with the Internal Revenue Service regulations.

Limited Medical FSA

The limited medical FSA works the same way as our traditional FSA with the difference that it limits what expenses are eligible for reimbursement. **Dental and Vision** care costs are the only reimbursable expenses covered under the limited medical FSA.

Before you incur an expense under your medical FSA, determine if it is eligible for reimbursement on the ASI website, *asiflex.com*.

UNIVERSITY FACULTY AND STAFF: Please refer to your Human Resources website for the Flexible Spending Account options available to you.

LIMITED FLEXIBLE SPENDING ACCOUNTS

File a Claim

You will need to fill out your claim form and attach copies of invoices for services you received.

Submitting a Claim Form

You can:

- Fax your claim and documentation, toll-free to ASI at 1.877.879.9038;
- Mail the claim form and documentation to the location indicated on the claim form, or
- Submit your claims online at *https://my.asiflex.com*. You need your ASI-assigned PIN, along with your state of Arizona employee identification number (EIN). All documentation must be scanned into PDF format.

Reimbursement

Your reimbursement can be by direct deposit or check. An email notification of your reimbursement will be sent to you, if you choose to elect direct deposit.

Claims are processed within two business days of receipt. However, processing time is dependent upon the volume of the claims received.

If you wish to start direct deposit after the Open Enrollment period, you will need to do so through ASI. The direct deposit request form is available at *asiflex.com*.

You may file claims as soon as you incur charges and services have been provided.

You have from January 1, 2012 through December 31, 2012 to use account funds. All the claims for medical expenditures must be filed with ASI prior to March 31, 2013 for reimbursement.

End of Employment

Your coverage ends at the end of the pay period of your last deduction when you leave employment.

If your employment ends prior to the end of the plan year, any expenses must be incurred prior to your termination date in order for you to receive reimbursement.

OTHER BENEFIT PROGRAMS

The State of Arizona offers many benefits to its employees, learn more about your benefits with the information below.

Note: Arizona Department of Public Safety employees shall refer to the Law Enforcement Merit System Council (LEMSC) rules for leave policies and rules.

Work-Life Programs

Information on all of the supportive programs the State offers is available on the Work-Life website *hr.state.az.us/worklife*. Work-Life staff answers questions about state programs and also research additional options to help us lead more successful and effective lives.

Employee Suggestion Program

The Employee Suggestion Program offers both monetary and non-monetary recognition for original ideas on ways government services can be provided more efficiently or at the lowest possible cost.

Recognition Programs

Many agencies also have their own recognition programs, which are an important part of total rewards.

Employee Assistance Program (EAP)

The Employee Assistance Program (EAP) is one of your many benefits as an employee of the State of Arizona. Please use this benefit as needed. EAP is available to assist you in achieving and maintaining your highest level of job performance. EAP provides you with the opportunity to resolve a wide range of personal and job-related issues. If you need assistance in addition to your usual coping skills to deal with personal or job related issues, EAP may be the answer. Visit the EAP website at *benefitoptions.az.gov/wellness/eap.asp*.

Arizona Learning Center

Arizona Learning Center offers a wide range of courses that permits state employees to develop the knowledge and skills to perform their jobs and improve productivity. Employees can also participate in the Supervisor Academy, that provides research-based information, best practices, and skill exercises. Log onto *yes.az.gov*, under Employee Training to see what the Arizona Learning Center has to offer.

Career Center

The Career Center assist employees with career development, career coaching, career assessment, educational advisement, goal setting, resume development, interviewing and networking. To learn more visit *careercenter.az.gov*.

State of Arizona Retirement Programs*

The State matches employee contributions to the following programs:

Arizona State Retirement System (ASRS)

Most State employees who are hired to work at least twenty weeks in a fiscal year, for twenty or more hours per week, must enroll in the Arizona State Retirement System (ASRS). Enrollment is automatic when hired. For more information visit *asrs.state.az.us*.

Public Safety Personnel Retirement System (PSPRS)

Employees serving in law enforcement occupations are required to join this program. Enrollment when hired. PSPRS also administers the **Corrections Officers Retirement Plan (CORP)** and **Elected Officials Retirement Plan (EORP).** For more information visit *psprs.com.*

****UNIVERSITY FACULTY AND STAFF: Please refer to your Human Resources website for more information on University-sponsored*** retirement plans.

OTHER BENEFIT PROGRAMS Continued

State of Arizona Retiree Accumulated Sick Leave (RASL) Program

The Arizona Retiree Accumulated Sick Leave (RASL) Program offers an officer or employee of the State the opportunity for cash payment of accumulated (unused) sick leave at retirement. Refer to the following web site for further information: http://www.gao.az.gov/rasl/default.asp.

Deferred Compensation Plan

Nationwide Retirement Solutions (NRS) provides public employees their deferred compensation plans. The plans allows state employees to invest pre-tax dollars into a supplemental retirement account. The state oversees the administration of the plan while NRS provides enrollment, plan administration and retirement education.

You may contact a local representative at 602.266.2733 (or toll free at 1.800.796.9753) to schedule a consultation or for a list of scheduled educational seminars. You may also visit the local office at 4747 N. 7th Street, Suite 418, Phoenix, Arizona (office hours: 8 a.m. to 5 p.m.).

You can visit *arizonadc.com* for more information.

Paid Time Off

As part of your compensation as a State employee, you receive paid time off. For detailed information regarding paid time off, review the State of Arizona Personnel Rules, Article 4. Also, be sure to familiarize yourself with your agency's policies and procedures for requesting the various types of leave.

State Service Holidays (10 days)

- January 1, New Year's Day
- 3rd Monday in January, Martin Luther King, Jr./Civil Rights Day
- 3rd Monday in February, Lincoln/ Washington/Presidents' Day
- Last Monday in May, Memorial Day
- July 4, Independence Day
- 1st Monday in September, Labor Day
- 2nd Monday in October, Columbus Day
- November 11, Veterans' Day
- 4th Thursday in November, Thanksgiving Day
- December 25, Christmas Day

If the holiday falls on Saturday, then it is observed on the preceding Friday. If the holiday falls on Sunday, then it is observed on the following Monday.

Annual Leave

Eligible employees accrue annual leave in accordance with the following schedule:

Credited Service	Hours Accrued Bi-Weekly
Less than 3 years	3.7
3 years but less than 7 years	4.62
7 years but less than 15 years	5.54
15 or more years	6.47

Eligible part-time employees accrue a proportional amount of annual leave.

Accumulation during a calendar year is unlimited; however, annual leave accumulated in excess of 240 hours at the end of a calendar year is subject to forfeiture, unless the ADOA Director authorizes an exception in an individual case.

OTHER BENEFIT PROGRAMS

Sick Leave

Eligible employees accrue sick leave at the rate of eight hours per month. Eligible part-time employees accrue a proportional amount of sick leave. Accumulation is unlimited.

Employees who retire with 500 or more unused sick leave hours may file for accumulated sick leave benefits through their personnel office.

Miscellaneous Paid Leave

- Civic Duty Leave
- Military Leave
- Educational Leave
- Bereavement Leave

Be sure to follow the personnel rules and your agency's guidelines if the need should arise for these leave categories.

Parental Leave

Parental leave is any combination of annual leave, sick leave, compensatory leave, or leave without pay (LWOP) taken by an employee due to pregnancy, childbirth, miscarriage, abortion or adoption of children.

Leave Without Pay (LWOP)

LWOP is defined as a leave which has been approved in advance, in writing, for a period of time, when there will be no paycheck from the employer.

The State's Personnel Rules explain the procedures and conditions for LWOP including authorization, use, documentation, return to work, and benefits.

If in the future you are on LWOP, be sure you and your benefits liaison fully discuss your benefit options, costs, and the effect your decisions will have on your benefits upon your return to work. When your LWOP begins, you can make changes to your coverage, such as switching from family to single coverage, lowering the amount of supplemental life or declining some or all coverage.

Generally, an employee who is on LWOP must pay both the employee and employer portion to maintain medical and dental health care coverage and basic life insurance. Vision, supplemental life insurance and disability coverage have only employee-paid premiums. The only exceptions are LWOP due to industrial disability or leave covered by the Family and Medical Leave Act (FMLA).

Employees on industrial or FMLA leave may continue benefits by paying just the employee portion for periods of time established by applicable laws and rules.

If the employee is on leave beyond these limits, the employee must pay both the employer and employee portions of premiums to continue coverage.

If the employee on LWOP allows premium payment to become delinquent, coverage terminates. If the employee's coverage was cancelled for non-payment, the employee cannot re-enroll until the first open enrollment after the employee returns to work.

If the employee's coverage was not cancelled for non-payment of premium, the employee can restore the coverage changed at the start of the leave upon his or her return to active employment.

An employee who chooses to go on LWOP has many decisions to make and should fully discuss them with his or her benefits liaison.

OTHER BENEFIT PROGRAMS
Continued

Employees returning from LWOP should check their payroll deductions for any discrepancies with the coverage choices made.

Nursing Mothers Program

Agencies may provide a private room and other resources to nursing mothers who want to continue nursing after returning to work.

Agency-Specific Benefits

Your agency may provide other benefits, such as an agency newsletter, employee assistance programs, award programs and/or recognition leave. For information ask your agency's Human Resources/Personnel office.

When You Leave State Service

Termination

If you should terminate employment with the State of Arizona, most likely you will have insurance continuation rights, for certain coverage, under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985. The former employee who elects this continuation of coverage pays 102% of the full monthly premium (employee cost + employer cost + 2% administrative fee).

Retirement

When you retire from State service, you have the option of continuing medical, dental and/or vision coverage through the ADOA Benefit Options Program or electing coverage through the program sponsored by your retirement system. Retirees pay the entire monthly premium; however, if you qualify, your retirement system may subsidize your monthly medical and/or dental premium in an amount relative to your length of service. Retirees may also elect COBRA coverage.

Retires who choose COBRA coverage or retirement system coverage may not later return to the plan sponsored by ADOA. However, those retirees who elect COBRA coverage may elect coverage through their retirement system when their COBRA coverage terminates.

OTHER BENEFIT PROGRAMS Continued

Computers via Payroll Deduction

Purchasing Power offers State of Arizona employees a convenient and disciplined way to purchase new, brand name computers through the ease of payroll deductions.

Determine If Purchasing Power Is Your Best Option

Purchasing Power is not a discount program, but is an alternative to financing. If you have cash, going direct to the manufacturer or retailer may be your best option. However, many people need to finance their purchase and pay for it over some period of time. If you choose to finance your purchase or simply prefer the convenience of payroll deductions, Purchasing Power is a great solution. Regardless of personal credit, you will be able to make a purchase and finish paying your balance in 12 months.

The Convenience of Payments Made Directly from Your Paycheck

For everything you buy from Purchasing Power, your payments are consolidated into one amount that is deducted from your paycheck. No extra check to write, no additional bill to keep up with.

Fair Prices with No Surprises

When paying cash you may find lower prices, but the interest rates on credit cards and in-store financing plans can make your actual cost much higher than the cash price. We show you exactly what you will pay over a 12-month period.

When you do not want to use cash or credit, Purchasing Power is the best way to buy. Make manageable payments over just 12 months. Easy payroll deductions ensure you will not miss a payment A credit check is not necessary Brand-name merchandise will be delivered right to your home.

Easy Qualification

- You must be at least 18 years of age.
- You must be an employee of the State of Arizona for at least 6 months.
- You must earn at least $16,000 a year.
- You must have a bank account or credit card (to be used in case of non-payment via payroll deductions).

For more information or to order, call 1.866.638.3954 or visit *Arizona.PurchasingPower.com*

Notice: Members may enroll in any of the Other Benefit Programs shown herein at any time during the year. As the companies associated with these programs are subject to periodic changes, members are encouraged to check the Benefit Options website at *benefitoptions.az.gov* for the most current programs available. The Other Benefit Programs listed above are current as of the publication of this guide.

UNIVERSITY FACULTY AND STAFF: This benefit is not offered to University faculty and staff.

OTHER BENEFIT PROGRAMS*
Continued

Auto and Home Insurance Program

Did you know?

You do not have to wait until your current auto and home insurance policies are due to expire to request quotes and apply to enroll in the Auto and Home Insurance Program. You can apply year-round.

Did You Know?

You could also get an extra discount for choosing to pay your premiums through automatic payroll deduction.

The Auto and Home Insurance Program gives you access to comparison shop three of the nation's leading insurance providers. Advantages of the program include special group discounts for your auto and home insurance and the convenience of automatic payroll deduction to easily budget your premiums.

The providers of the Employee Auto and Home Insurance Program include:

Travelers
MetLife Auto & Home®
Liberty Mutual

Benefits-At-A-Glance

- Ability to apply year-round
- Special group discounts
- Convenient payroll
- Wide-array of coverages
- Money-saving discounts
- 24/7 claim reporting
- Portable policies*
- Free, no-obligation quotes from licensed insurance professionals coverages and rates

Additional Protection

- Condominium
- Renters
- High-value home
- Valuable items
- Personal Excess liability (umbrella)
- Identity theft**
- Boat & yacht
- Flood***

How to Request Quotes and Apply

Each provider offers customer representatives to answer your questions, help you explore any lower cost options, and issue your protection right over the phone, should you decide to participate. Contact each provider to compare coverages and rates.

Travelers:	1.888.695.4640
MetLife Auto & Home:	1.800.GET.MET.8 (1.800.438.6388)
Liberty Mutual:	1.800.786.1855

**Coverage is subject to applicable law, underwriting guidelines, and state availability.*
***Certain carriers offer identity protection services at no additional cost to policyholders in most states and with most policy forms.*
****Flood insurance is not offered with any group discount and is provided as part of the National Flood Insurance Program (NFIP), which is administered by the federal government.*

Legal Disclosures

The carriers listed operate independently and are not responsible for each others' financial obligations. Insurance is underwritten by The Travelers Indemnity Company or one of its property casualty affiliates, One Tower Square, Hartford, CT 06183. In FL: Auto insurance policies are underwritten by First Floridian Auto and Home Insurance Company, The Travelers Home and Marine Insurance Company, or by The Travelers Commercial Insurance Company. In MA: Auto policies are underwritten by The Premier Insurance Company of Massachusetts, an independent, single-state subsidiary of The Travelers Indemnity Company. In NJ: Auto insurance policies are underwritten by Travelers Auto Insurance Co. of New Jersey, a single state, independent subsidiary of The Travelers Indemnity Company. In TX: Auto insurance is offered by Travelers MGA, Inc. and underwritten by Consumers County Mutual Insurance Company.

OTHER BENEFIT PROGRAMS*
Continued

Legal Disclosures Continued

Coverages, discounts, repair options and billing options are subject to state requirements and availability, individual qualifications and/or the insuring company's underwriting guidelines. ©2010 The Travelers Indemnity Company. All rights reserved.

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Notice: Members may enroll in any of the Other Benefit Programs shown herein at any time during the year. As the companies associated with these programs are subject to periodic changes, Members are encouraged to check the Benefit Options website at *benefitoptions.az.gov* for the most current programs available. The Other Benefit Programs listed above are current as of the publication of this guide.

****UNIVERSITY FACULTY AND STAFF: Please refer to your Human Resources website for more information on University-sponsored Auto and Home Insurance Programs.***

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 healthcare 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 healthcare 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 healthcare 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 healthcare 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 healthcare FSA will be covered together for healthcare 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 healthcare 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, healthcare 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

- 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 healthcare 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 Benefit Services Division.

If the above procedures are not followed or if the notice is not provided within the 60-day notice period, there will be no COBRA coverage disability extension. If the qualified beneficiary is determined by the Social Security administration to no longer be disabled, you must notify the COBRA administrator(s) of that fact within 30 days after the Social Security Administration's determination. The notice must be provided in the same manner as, and include the same information required for, a notice of disability as described 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 health plan is available from the:
Centers for Medicare & Medicaid Services (CMS)
Private Health Insurance Group
7500 Security Boulevard
Mail Stop S3-16-16
Baltimore, 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 healthcare 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 Healthcare 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.

Healthcare operations include activities such as:

- Quality assessment and improvement activities;
- Activities designed to improve health or reduce healthcare costs;
- Clinical guideline and protocol development, case management and care coordination;
- Contacting healthcare providers and participants with information about treatment alternatives and other related functions;
- Healthcare 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 the 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 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 do not 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 contact the ADOA Benefit Services Division at 1.800.304.3687 or visit our website at www.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 the 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 19 and 20).

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.

Domestic Partner
Refer to pages 5-7 for eligibility requirements.

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.

HDHP
(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.

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

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

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

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