

Janice K. Brewer
Governor



Brian McNeil
Director

ARIZONA DEPARTMENT OF ADMINISTRATION

PWT 0P ÄÜÒÙWÜÒÙÁ DIVISION ÈÓÒPÒZVÀÙÒÛXÓÙ

100 NORTH FIFTEENTH AVENUE • SUITE 103
PHOENIX, ARIZONA 85007

(602) 542-5008

Dear Benefit Options Subscriber and Eligible Dependents:

This packet is to inform you that you will no longer have Active Employee Benefits with Benefit Options.

Your right to COBRA coverage

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), this qualifying event entitles you to elect continued coverage under the group health plan. You and any eligible dependents covered on your benefits on the day of the qualified life event are entitled to 18 months of COBRA coverage.

ENROLLMENT PROCEDURES ARE DESCRIBED AT THE END OF THIS LETTER

Your COBRA enrollment options

Your choices are:

- To continue family or two-party coverage, if you had family or two-party coverage on the date of the qualifying event.
- For one of more qualifying persons to individually elect single coverage.
- For all qualifying persons to decline COBRA coverage entirely.

Duration of COBRA coverage

Your COBRA coverage may end early if:

- Health coverage is no longer offered to any active employees.
- You do not make the required payments in a timely manner.
- You, your spouse, or your dependent children become covered under another group health plan that does not effectively limit coverage for any pre-existing condition.
- You, your spouse, or your dependent children become entitled to Medicare.
- Coverage was extended due to disability and the individual is determined to no longer be disabled.

Please refer to the enclosed enrollment forms for current rates and the Benefit Options website (www.benefitoptions.az.gov) for additional information.

Declining COBRA coverage

To decline COBRA coverage, return COBRA enrollment Form with the “I decline COBRA coverage” option marked. COBRA coverage will not be available to you once it is declined.

If you fail to return an enrollment form, your right to COBRA coverage will expire after 60 days from the date on this notice.

Additional information

If you have any questions related to COBRA, please contact:

Arizona Department of Administration - Benefit Services
100 N. 15th Avenue, #103
Phoenix, AZ 85007
(602) 542-5008 or (800) 304-3687

This plan is administered by:

Arizona Department of Administration - Benefit Services
100 N. 15th Avenue, #103
Phoenix, AZ 85007
(602) 542-5008

Sincerely,

Benefit Options
Member Services

****NOTICE REGARDING YOUR LIFE INSURANCE POLICY****

You may be eligible to continue life insurance coverage through portability or conversion. For more information, visit

**<http://groupbenefits.thehartford.com/arizona/> . You may also call The Hartford at
877-320-0484**

COBRA PAYMENT INFORMATION

<p>How should the first COBRA payment be made?</p>	<ul style="list-style-type: none"> ➤ You must make the first payment within 45 days of submitting a COBRA enrollment form. ➤ You may pay using a check or money order. Check/money orders should be payable to ADOA - HITF. ➤ First payment should be sent to: <div style="border: 1px solid black; padding: 5px; margin: 5px 0; text-align: center;"> ADWA Benefit Services c/o COBRA Dept 100 N. 15th Avenue, #103 Phoenix, AZ 85007 </div>
<p>When does COBRA begin</p>	<ul style="list-style-type: none"> ➤ COBRA begins the day after your active coverage ends.
<p>Will I have COBRA coverage before making payment?</p>	<ul style="list-style-type: none"> ➤ COBRA coverage is not effective until the first payment is received.
<p>I don't want to be without coverage. Is it okay to send payment with the enrollment form?</p>	<ul style="list-style-type: none"> ➤ You may send your first payment with your enrollment form.
<p>How will I know how much I owe?</p>	<ul style="list-style-type: none"> ➤ COBRA rates can be found on the enrollment forms. You may use these rates to calculate your total or you may call Member Services at (602) 542-5008 or (800) 304-3687.
<p>How are subsequent COBRA payments made?</p>	<ul style="list-style-type: none"> ➤ Payments are due on the first day of each month of coverage. ➤ You will receive a bill from ADOA- HITF monthly ➤ If you move, you must inform the Benefit Services Division so your billing address can be updated. Notifications must be in writing.
<p>How often should I pay for COBRA?</p>	<ul style="list-style-type: none"> ➤ Payments are due on the first day of each month of coverage.
<p>Will I get a bill?</p>	<ul style="list-style-type: none"> ➤ You will not receive a bill for your first payment. ➤ After that you will receive a monthly bill from ADOA- HITF. ➤ Billing statements are mailed as a courtesy. If you do not receive a bill you may call Member Services at (602) 542-5008 or (800) 304-3687 for assistance.

COBRA ENROLLMENT INSTRUCTIONS

	You must act within...	Follow these steps...
COBRA enrollment	60 days	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Review the enclosed COBRA information and the information on the website: www.benefitoptions.az.gov <input checked="" type="checkbox"/> Choose your COBRA enrollment options. <input checked="" type="checkbox"/> Complete the enclosed enrollment. <input checked="" type="checkbox"/> Return the enrollment form to the Benefit Services Division at the address below.

Return all COBRA forms to:	Benefit Services 100 N. 15 th Avenue, #103 Phoenix, AZ 85007
For information, please visit:	www.benefitoptions.az.gov www.cms.hhs.gov/COBRAContinuationofCov/
If you have additional questions, please call:	Member Services (602) 542-5008 or (800) 304-3687

2013 ENROLLMENT / CHANGE FORM

NEW ENROLLMENT
 QUALIFIED LIFE EVENT
 ADDRESS CHANGE
 TERMINATION

MEMBER IDENTIFICATION

LAST NAME, FIRST NAME, M.I.		SOCIAL SECURITY NUMBER		<input type="checkbox"/> MALE	<input type="checkbox"/> MARRIED
				<input type="checkbox"/> FEMALE	<input type="checkbox"/> SINGLE
STREET ADDRESS		COUNTY OF RESIDENCE		DATE OF BIRTH	
CITY, STATE, ZIP CODE		WORK PHONE NUMBER ()		HOME PHONE NUMBER ()	
EMPLOYEE LAST NAME, FIRST NAME	EMPLOYEE AGENCY		EMPLOYEE EIN OR SSN		

Are you enrolling a Same-Sex Domestic Partner? (circle one) Yes or No

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

MEDICAL PLANS* (Monthly Cost Listed)

I DECLINE MEDICAL COVERAGE

EPO PLANS

SELECT A PLAN	CODE	EE ONLY	CODE	EE + ADULT	CODE	EE + CHILD	CODE	EE + FAMILY
AETNA EPO		<input type="checkbox"/> \$601.80		<input type="checkbox"/> \$1277.04		<input type="checkbox"/> \$1202.58		<input type="checkbox"/> \$1658.52
BCBS of AZ/AMERIBEN EPO		<input type="checkbox"/> \$601.80		<input type="checkbox"/> \$1277.04		<input type="checkbox"/> \$1202.58		<input type="checkbox"/> \$1658.52
CIGNA EPO		<input type="checkbox"/> \$601.80		<input type="checkbox"/> \$1277.04		<input type="checkbox"/> \$1202.58		<input type="checkbox"/> \$1658.52
UNITEDHEALTHCARE EPO		<input type="checkbox"/> \$601.80		<input type="checkbox"/> \$1277.04		<input type="checkbox"/> \$1202.58		<input type="checkbox"/> \$1658.52

PPO PLANS

AETNA PPO		<input type="checkbox"/> \$913.92		<input type="checkbox"/> \$1893.12		<input type="checkbox"/> \$1813.56		<input type="checkbox"/> \$2463.30
BCBS of AZ/AMERIBEN PPO		<input type="checkbox"/> \$913.92		<input type="checkbox"/> \$1893.12		<input type="checkbox"/> \$1813.56		<input type="checkbox"/> \$2463.30
UNITEDHEALTHCARE PPO		<input type="checkbox"/> \$913.92		<input type="checkbox"/> \$1893.12		<input type="checkbox"/> \$1813.56		<input type="checkbox"/> \$2463.30

HSA OPTION

AETNA HSA OPTION		<input type="checkbox"/> \$539.58		<input type="checkbox"/> \$1134.24		<input type="checkbox"/> \$1079.16		<input type="checkbox"/> \$1487.16
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*For the NAU Blue Cross Blue Shield plan rates visit: <http://hr.nau.edu/m/content/view/102/112/>.

DENTAL PLANS (Monthly Cost Listed)

I DECLINE DENTAL COVERAGE

SELECT A PLAN	CODE	EE ONLY	CODE	EE + ADULT	CODE	EE + CHILD	CODE	EE + FAMILY
TOTAL DENTAL ADMINISTRATORS		<input type="checkbox"/> \$9.17		<input type="checkbox"/> \$18.34		<input type="checkbox"/> \$17.86		<input type="checkbox"/> \$27.51
DELTA DENTAL INDEMNITY/PPO IN ARIZONA AND OUT-OF-STATE		<input type="checkbox"/> \$36.66		<input type="checkbox"/> \$77.14		<input type="checkbox"/> \$61.69		<input type="checkbox"/> \$120.63

VISION PLAN (Monthly Cost Listed)

I DECLINE VISION COVERAGE

SELECT A PLAN	CODE	EE ONLY	EE + ONE	EE + FAMILY
AVESIS VISION COVERAGE		<input type="checkbox"/> \$4.93	<input type="checkbox"/> \$13.79	<input type="checkbox"/> \$17.20

ADOA USE ONLY

APPROVED DENIED

COBRA EFF: _____ Length of COBRA: _____

Reviewed by:

AGENCY/PROCESS LEVEL	DATE MEMBER NOTIFIED	DATE RECEIVED	EFFECTIVE DATE
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2013 COBRA ENROLLMENT FORM

2013 ENROLLMENT / CHANGE FORM

YOUR PAYMENT TO BENEFIT OPTIONS

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

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

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

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

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

EMPLOYEE AUTHORIZATION AND SIGNATURE

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

SIGNATURE: _____ DATE: _____

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

2013 COBRA ENROLLMENT FORM

A NOTICE FOR MEMBERS: SUMMARY OF BENEFITS AND COVERAGE (SBC)

On February 9, 2011, as part of the Affordable Care Act (ACA), the federal government announced new rules regarding the disclosure of the Summary of Benefits and Coverage (SBC) and Uniform Glossary. These regulations apply to group health plans and health insurance issuers that offer coverage for groups and individuals. The purpose of these documents is to give consumers information so they can compare coverage options in different types of plans.

Frequently Asked Questions

What are the Summary of Benefits and Coverage (SBC)? It is a summary description of the health care benefits and coverage offered by your health insurance plan. It will include information like deductible amounts and co-insurance and co-payment obligations.

What is a Uniform Glossary? This is a list of commonly used health coverage and medical terms and their definitions. The U.S. Department of Health and Human Services has created the uniform glossary. The glossary includes definitions for health coverage and medical terms so you can compare and understand your coverage, your medical benefits and exclusions. The glossary is for information only and does not affect your coverage and benefits. If you ask for a written glossary, it must be provided to you within seven business days of your request to the Benefit Services Division.

When does the new rule about sending the SBC and Uniform Glossary go into effect? For group health plan members who enroll/re-enroll through an open enrollment, the new requirements go into effect on the first day of the open enrollment period, October 22, 2012, for disclosure to members.

For SBCs going to group health plan members who enroll outside of an open enrollment period, the new requirements go into effect on the day of the first plan year that begins on January 1, 2013.

Where can I find the SBC and Uniform Glossary? The SBCs for the EPO, PPO, and HSAO plans along with the uniform glossary will be posted electronically to the Benefit Options Website. www.benefitoptions.az.gov

When will I be provided an SBC? In addition to this notification, the Benefit Services Division will provide the SBC during the following events:

Upon Initial Enrollment:

- You will be provided an e-mail or written notification with instructions on how to access the SBC documents on the Benefit Options Website with enrollment materials.
- If information in the SBC changes between the time your group applies for coverage and your first day of coverage, you will be provided an updated SBC no later than the first day of coverage.

At Open Enrollment:

- If a written application is required for renewal (paper or online), you will be provided an e-mail or written notification with instruction on how to access the SBC documents on the Benefit Options Website.
- If renewal is automatic, you will be provided an e-mail or written notification with instructions on how to access the SBC documents on the Benefit Options Website 30 days prior to the new plan year.

If you have Special Enrollment or Qualified Life Event:

- You will be provided an e-mail or written notification with instructions on how to access the SBC documents on the Benefit Options Website no later than 90 days from enrollment.

Upon Request

- You will be provided a written SBC and/or Uniform Glossary within seven business days of your request. Please contact the Benefit Services Division to request a copy.

A NOTICE FOR MEMBERS: SUMMARY OF BENEFITS AND COVERAGE (SBC)

How will the SBC be formatted? The format of the SBC will meet ACA requirements. For instance, it will be no longer than four double-sided pages, have a 12-point font and use terms that are understandable to the average member.

What information must be part of the SBC? The SBC will include all the information required by ACA rules. Some of that information will include the description of coverage, deductible amounts, and co-insurance obligations.

How will I receive the SBC? SBCs will be posted electronically on the Benefit Options Website. Members may also request a written copy from Benefit Services. If you and your dependents live at the same address, you will receive one SBC. However, if any of your dependents' last known addresses are different from yours, separate SBCs will be sent to those dependents' last known addresses.

- **Active and University Employees**
An electronic notification will be sent to employees work e-mail listed in the personnel system. If no work e-mail is available a copy will be provided to the home address listed in the personnel system.
- **Retired Employees**
Written notification will be provided with your enrollment materials to the home address listed in the personnel system.
- **COBRA Members**
Written notification will be provided with your enrollment materials to the home address listed in the personnel system.

How do I request copies of the SBC? You may contact Benefit Services by phone, email, and fax or in person. Contact information has been included below.

100 N. 15th Ave #103

Phoenix, AZ 85007

602.542.5008 or

1.800.304.3687

Fax 602.542.4744

Website www.benefitoptions.az.gov

E-mail BenefitsIssues@azdoa.gov