Arizona Department of Administration
Benefit Options
Benefit Services Division

2016 Retired State Employees Benefit Guide

Website and Contact Information

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
benefitoptions.az.gov
BenefitsIssues@azdoa.gov

Benefit Options Wellness
602.771.9355
benefitoptions.az.gov/wellness

Medical Plans
Aetna
1.866.217.1953
aetna.com
Policy Number 476687

Payflex
1.866.217.1593
payflex.com

Blue Cross Blue Shield of Arizona
1.866.287.1980
azblue.com
Policy Number 30855

Cigna
1.800.968.7366
cigna.com/stateofaz
Policy Number 3331993

UnitedHealthcare
1.800.896.1067
welcometouhc.com
Policy Number 705963

Pre-Medicare Pharmacy Plan
MedImpact
1.888.648.6769
benefitoptions.az.gov

Medicare Pharmacy Plan
Medicare GenerationRx
Employer (PDP)
1.877.633.7943
medicaregenerationrx.com/stateofaz

Dental Plans
Delta Dental of Arizona
602.588.3620
1.866.9STATE9
deltadentalaz.com
Policy Number 77777-0000

Total Dental Administrators Health Plan, Inc. (TDAHP)
602.381.4280
1.866.921.7687
TDAdental.com/adoa
Policy Number 680100

Vision Plan
Avesis, Inc.
1.888.759.9772
avesis.com
Advantage
Policy Number 11001-2179
Plan Number 938
Discount Policy Number 10000-5
Plan Number 9900

Long-Term Disability Plans
Sedgwick CMS
(ASRS participants)
1.818.591.9444
Claimlookup.com

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

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

Public Safety Personnel Retirement System (PSPRS); Elected Officials Retirement Plan (EORP); Corrections Officer Retirement Plan (CORP)
3010 E. Camelback Rd, #200
Phoenix, AZ 85016
602.255.5575
1.877.925.5575
psprs.com

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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.

Benefit Options 2016 Retired Employees Benefit Guide

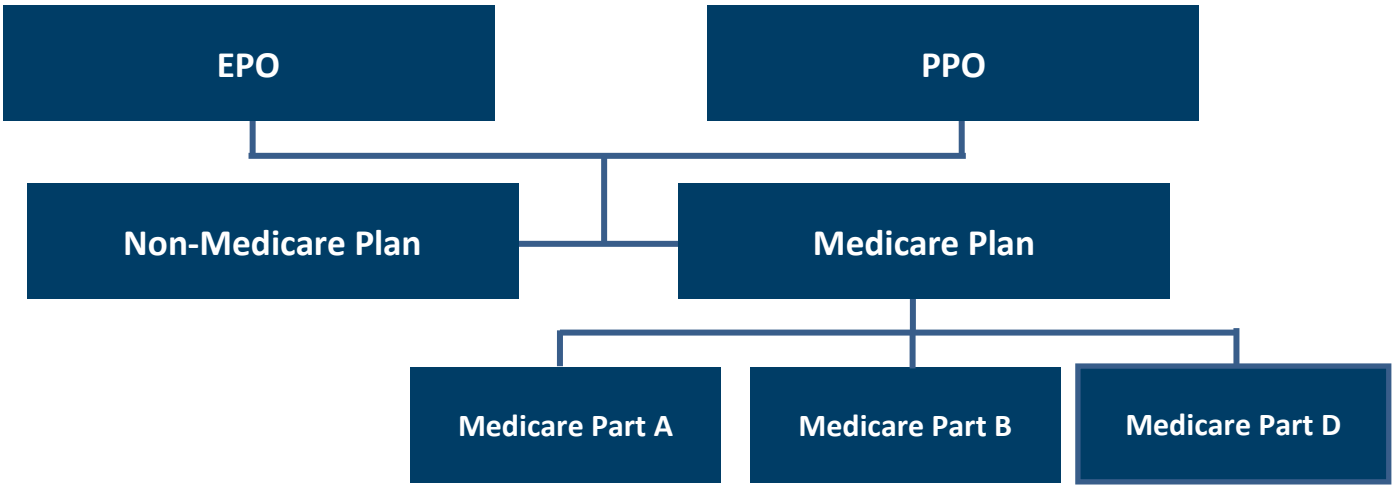
This guide is designed to provide an overview of the comprehensive benefits package, "Benefit Options", offered by the State of Arizona, Department of Administration, Benefit Services Division. The guide is intended to help you understand your benefits and is divided into chapters, each covering a specific benefits program or important information. We encourage you to review each section before making your benefit elections. For more detailed benefit information, please refer to your plan descriptions.

The effective date for the 2016 Plan Year is January 1, 2016 through December 31, 2016. The actual benefits available to you and the descriptions of these benefits are governed in all cases by the relevant plan descriptions and insurance contracts. The State of Arizona reserves the right to modify, change, revise, amend or terminate these benefits plans at any time.

If you need additional information, please visit our website at *benefitoptions.az.gov* or call us at 602.542.5008 or toll free at 1.800.304.3687.

Notice about the Summary of Benefits and Coverage and Uniform Glossary
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 require group health plans and health insurance issuers that offer coverage for groups and individuals to provide access to the SBC and Uniform Glossary. The SBC documents along with the uniform glossary are posted electronically on the Benefit Options Website *benefitoptions.az.gov*. You may also contact Benefit Services to obtain a copy.

Step 1: Determine the type of Medical Plan you need. All medical plans include Pharmacy coverage.



Important information for Medicare members:

- A copy of your Medicare card is required to be submitted to ADOA if electing a Medicare Plan.
- If you are eligible and choose not to elect Medicare Part B, you will be responsible for the cost of services covered by Medicare Part B.
- A Medicare GenerationRX application form must be signed and submitted for each Medicare eligible family member and returned to ADOA Benefit Services Division.

Step 2: Determine the type of Dental Plan you need.

Step 3: Determine the type of Vision Plan you need. The Vision Plan is only available if medical and/or dental coverage is selected.

Benefit Changes for Plan Year 2016

The Benefit Services Division is pleased to announce that State retirees will not be subject to a rate increase for insurance premiums for the 2016 Plan Year. Effective January 1, 2016, premiums for the Non-Medicare PPO Plan will experience rate reductions.

Premiums

Plan Type	Tier	Retiree Medical without Medicare		
		Current 2015	New 2016	Change
EPO	Retiree only	$593.00	$593.00	$0.00
	Retiree + one	$1,387.00	$1,387.00	$0.00
	Family	$1,869.00	$1,869.00	$0.00
PPO	Retiree only	$943.00	$825.00	**-$118.00**
	Retiree + one	$2,219.00	$2,009.00	**-$210.00**
	Family	$3,074.00	$2,197.00	**-$877.00**

Plan Type	Tier	Retiree Medical with Medicare Premiums		
		Current 2015 Premiums	New 2016 Premiums	Change
EPO	Retiree only	$442.00	$442.00	$0.00
	Retiree + one (both Medicare)	$878.00	$878.00	$0.00
	Retiree + one (one Medicare)	$1,024.00	$1,024.00	$0.00
	Family (Retiree or Dependents with Medicare)	$1,166.00	$1,166.00	$0.00
PPO	Retiree only	$789.00	$789.00	$0.00
	Retiree + one (both Medicare)	$1,576.00	$1,576.00	$0.00
	Retiree + one (one Medicare)	$1,740.00	$1,740.00	$0.00
	Family (Retiree or Dependents with	$1,980.00	$1,980.00	$0.00

PPO Dental Plan
Beginning in 2016, there are two changes to the Delta Dental PPO Plus Premier Dental Plan:

1. An additional emergency evaluation or consultation visit has been added.
2. A reduction in the number of bitewing x-rays from two x-rays to one x-ray per plan year. This change is based on recommendations from the American Dental Association.

Affordable Care Act Requirements
The Arizona Department of Administration Benefit Services Division is subject to reporting requirements of the employer shared responsibility provisions under the Affordable Care Act (ACA). Beginning in 2016, the Benefit Services Division will provide the primary insured individual with the IRS 1095-C Form to report coverage information for the 2015 Plan Year.

iRx Discount Program
You may be able to obtain a discount on certain brand and generic medications that are not covered by your ADOA pharmacy drug plan, through the iRx Program™. Pre-Medicare members can present their medical ID card and Medicare members can present their Medicare GenerationRx ID card at any participating pharmacy, along with their prescription for the medication. Savings are applied automatically when the item prescribed qualifies for a discount. The amount of the discount will vary based on pharmacy chosen and type of medication.

Medicare has neither reviewed nor endorsed this information.

Eligibility

Eligible Retirees
The following persons are eligible to participate in the Benefit Options Plan:

A. Retirees receiving a pension under a state-sponsored retirement plan and continuing enrollment in the Retiree health and/or dental plan.
B. Long-Term Disability (LTD) participants collecting benefits under a state-sponsored plan.
C. Eligible former elected officials and their qualified dependents if the elected official has at least five years of credited service in the Elected Officials Retirement Plan; was covered under a group health or accident plan at the time of leaving office; served as an elected official on or after January 1, 1983; and applies for enrollment within 31 days of leaving office or retiring.
D. Surviving spouses and qualified dependents provided they were covered at the time of the retiree's death.
E. Surviving spouses of former elected officials provided they were covered at the time of the official's death.
F. Surviving spouses and qualified dependents of an active member that is eligible to retire provided they were covered at the time of the employee's death.

Eligibility Rules
A. As an eligible retiree, if you elected ADOA's medical or dental insurance, you may make changes to your plan(s) during Open Enrollment or changes consistent with a Qualified Life Event (QLE).
B. If you have declined or cancelled ADOA's medical and/or dental coverage in the past, but have maintained either coverage through ADOA, you may re-elect medical and/or dental coverage during an Open Enrollment period.

If you have a qualified dependent that is not currently enrolled in the Benefit Options Plan, he or she may be added during an Open Enrollment period. Dependents not enrolled during Open Enrollment cannot be added until the next Open Enrollment unless there is a QLE. You have 31 days from the date of the QLE to change your enrollment through ADOA, Benefit Services Division. The change must be consistent with the event. Please refer to the Benefit Services website, *benefitoptions.az.gov,* for more information about QLEs.

Eligible Dependents
At Open Enrollment, you may add the following dependents to your plans (proper documentation may be required):

A. Your legal spouse
B. Your child defined as:
   a) Your natural, adopted and/or stepchild who is under 26 years old;
   b) A person under the age of 26 for whom you have court-ordered guardianship;
   c) Your foster children under the age of 26;
   d) A child placed in your home by court order pending adoption;
   e) Your natural, adopted and/or stepchild;
   f) Your child who is disabled as defined by 42 U.S.C. 1382c before the age of 26;
   g) Your child who continues to be disabled as defined by 42 U.S.C. 1382c;

h) Your child who is dependent for support and maintenance upon you;
i) Your child for whom you had custody before the child was 26.

Dependent Documentation Requirements
If your dependent child is approaching age 26 and has a disability, 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, which occurred prior to his or her 26th birthday, in accordance with 42 U.S.C. 1382c.

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 Benefit Services Division.

Qualified Medical Child Support Order (QMCSO)
You may not terminate coverage for a dependent covered by a QMCSO.

If You and Your Spouse are both State Retirees
Dual coverage is not permitted under this Plan. An employee may elect coverage for their entire family, including the State employee spouse, or each State employee spouse may elect their own coverage.

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

Eligibility Audit
Benefit Services 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 during the subrogation process. Failure to do so may result in legal action by the State to recover funds received by you.

Return to Work Retirees
Former retired State employees returning to active State employment can receive health benefits through the Benefit Options Plan. If a retiree returns to work and meets the eligibility guidelines, they can elect to enroll in Active benefits and decline retiree benefits. Leaving State employment is

considered a QLE. The QLE then allows members to enroll in retiree benefits again.

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.

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

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

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

Submitting a Change Request
Requested benefit changes must be submitted in writing to Benefit Services within 31 calendar days of the event.

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

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

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

Premium Changes Due to QLEs
Any change in premiums due to a QLE will be in effect the first of the month following the receipt of all QLE documentation.

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

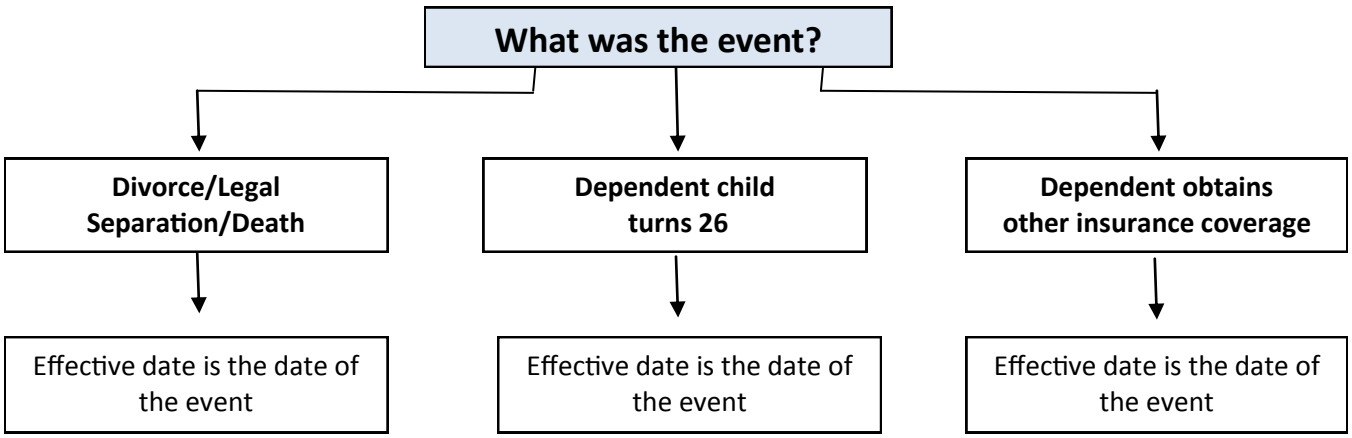
New Retiree's Option of Life Insurance Continuation
As a new retiring State of Arizona employee, you have the option of continuing all or a portion of your Life Insurance coverage with The Hartford. There are two options for continuation of coverage:

- 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.

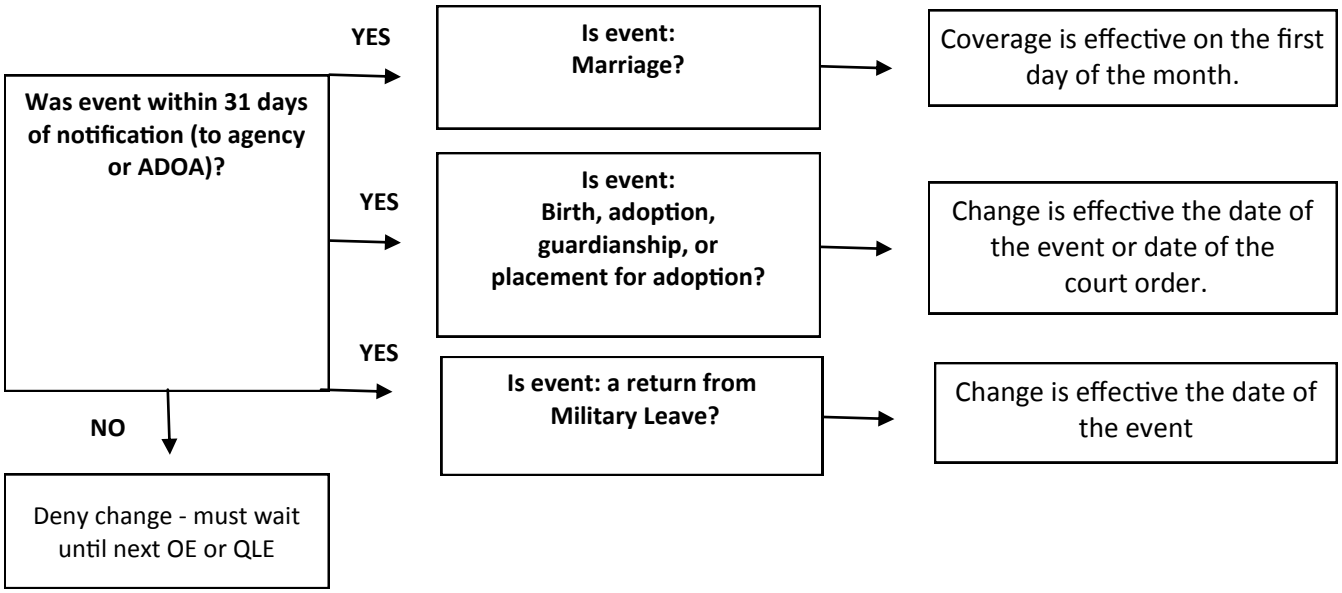
To apply for Conversion or Portability, you must apply within 31 days of the termination of your Life Insurance or within 15 days of the date you receive the COBRA notification. For questions or to apply, call The Hartford at 1.877.320.0484.

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

Losing your Benefits



Adding your Benefits



Monthly Medical Premiums (Without Medicare)

		Premium Payment
EPO (Aetna, BCBSAZ, Cigna, UnitedHealthcare)	Retiree only	$593
	Retiree + One	$1,387
	Family	$1,869
PPO (Aetna, BCBSAZ, UnitedHealthcare)	Retiree only	$825
	Retiree + One	$2,009
	Family	$2,197

Monthly Medical Premiums (With Medicare)

		Premium Payment
EPO (Aetna, BCBSAZ, Cigna, UnitedHealthcare)	Retiree only	$442
	Retiree + One (Both Medicare)	$878
	Retiree + One (One Medicare)	$1,024
	Family (Two Medicare)	$1,166
PPO (Aetna, BCBSAZ, UnitedHealthcare)	Retiree only	$789
	Retiree + One (Both Medicare)	$1,576
	Retiree + One (One Medicare)	$1,740
	Family (Two Medicare)	$1,980

For the NAU Blue Cross Blue Shield plan rates visit:
nau.edu/human-resources/benefits/insurance/medical/

Monthly Dental Premiums

		Premium Payment
Total Dental Administrators Prepaid	Retiree only	$8.99
	Retiree + adult	$17.98
	Retiree + child	$17.51
	Retiree + family	$26.97
Delta Dental PPO plus Premier	Retiree only	$35.94
	Retiree + adult	$75.63
	Retiree + child	$60.48
	Retiree + family	$118.26

Monthly Vision Premiums

		Premium Payment
Insured Plan (Avesis)	Retiree only	$3.99
	Retiree + adult	$12.94
	Retiree + child	$12.76
	Family	$16.10
Discount Card (Avesis)	Retiree	$0.00

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

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

NET MONTHLY HEALTH INSURANCE COST WORKSHEET			
Your monthly medical plan premium from page 10			**A**
Your monthly dental plan premium from page 11	+		**B**
Total Premium **(A plus B)**			**C**
Your Basic Premium Benefit Subsidy (See chart on page 14)	-		**D**
Your Net Premium (C minus D)	=		**E**

What You Should Know About Premium Payments

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

- If you are an LTD member or Surviving Spouse not receiving a pension from a recognized state retirement plan, you are a direct pay member. You are responsible for the payment of your premium(s) by the first of each month. The monthly premium is stated on your enrollment form.
- If your monthly pension has insufficient funds to cover your health insurance premiums, then premiums will not be deducted. You will then become a direct pay member. The ADOA Benefit Services Division will mail a bill to you. It will be your responsibility to pay any outstanding premiums to Benefit Services. If you do not receive a bill by the twenty-fifth day of the month, you must contact Benefit Services.
- Should the retirement system begin deducting your premium from your pension and you have also received a bill as a direct pay member, please contact Benefit Services. Please see the section entitled, "Information for Direct Pay Members."

New Retirees/LTD Members

Depending on when the Retirement System receives your benefit elections, **you may owe one or more months of health and/or dental premiums**. After enrolling, check your pension deductions. If, by your second pension, the deduction has not occurred or the deduction is incorrect, immediately contact ADOA Benefit Services Division, at 602.542.5008.

Information for Direct Pay Members

If you are or become a direct pay member, you will receive a billing notice regarding future premium payments. If you do not receive a billing notice within 60 days, please call ADOA Benefit Services Division at 602.542.5008. Failure to remit premium payments will result in cancellation of your benefits and may affect your eligibility in the Benefit Options program.

Vision Premium Payments

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

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

Calculating your Premium Benefit Subsidy

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

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

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

- Your years of credited service in your

retirement system or plan if you are an ASRS or EORP member (years of service is not a criterion for CORP and PSPRS members).

- Your coverage type (i.e., single or family coverage).
- Medicare eligibility.

Basic Premium Benefit Amounts

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

Your Direct Deposit Summary

Pension payments are issued by ASRS or PSPRS. Before either of the retirement systems generates your pension, they apply your premium subsidy (refer to the worksheet on page 12). Once the premium subsidy is added into your pension, the retirement system pays for your dental premium first. ASRS or PSPRS will apply remaining money to pay for your medical premium.

- If your pension is large enough to cover the cost of both your dental and medical premiums, you will receive any remaining money.
- If your pension is not enough to pay for the full cost of your dental and medical premiums you will become a direct pay member.

Please refer to the "Payments" column of the pension Direct Deposit Summary.

An example of an ASRS Direct Deposit Summary is shown. Please note, under the Payment Sources column, the inclusion of additional monies reflected in the premium benefit (HI PREM BENEFIT). This amount is the premium benefit to which you may be entitled and it reduces the full monthly medical and/or dental premiums you pay.

Also note, under the deductions column, the full health insurance premium for your medical and/or dental coverage (HLTH INS PREM). Though the total premium for health insurance is shown, you are only paying the net premium after the premium benefit is applied.

IMPORTANT NOTICE

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

RETAIN FOR YOUR RECORDS THIS IS NOT A CHECK

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

JOHN Q PUBLIC
1234 E FIRST ST
MESA AZ 85205-6601

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

CRP16 AQ001 MNT

DIRECT DEPOSIT SUMMARY

PAYMENT DATE	SOCIAL SECURITY NUMBER	NET PAYMENT
OCTOBER 01, 2010	000-00-0000	2,259.76

PAYMENT DETAIL

PAYMENT SOURCES	CURRENT	YEAR-TO-DATE	DEDUCTIONS	CURRENT	YEAR-TO-DATE
ANNUITY	2,078.42	20,784.20	FEDERAL TAX	606.00	6,050.00
PBI/EPBI	921.12	9,211.20	STTAX-AZ	153.00	1,498.00
NONTAX EXCLU	113.83	1,138.30	HLTH INS PREM	194.61	1,946.10
HI PREM BENEFIT	100.00	1,000.00			
GROSS PAYMENT	**3,213.37**	**32,133.70**	**TOTAL DEDUCTIONS**	**953.61**	**9,494.10**

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

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

YOUR PAYMENT HAS BEEN ELECTRONICALLY TRANSMITTED:

Deposit Account 00000000000000
Bank TR# 000000000000

09

W/H ELECTIONS: FED CALCULATED - S/0+250.00
STATE FLAT PERCENTAGE - 5%

NON - NEGOTIABLE

To help you calculate your monthly benefit cost, use the three step worksheet on page 12. If you feel your pension is not accurate, you must notify your Retirement System (ASRS or PSPRS) as soon as possible. If your enrollment is not processed until after the third of the month, it is possible the correct premiums will not be deducted from your pension until the month following the effective date of your enrollment or change.

Eligibility

Medicare is health insurance available to people who are:

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

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

Eligibility Notification

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

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

Parts of Medicare

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

Medicare Part A (Hospital Insurance)

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

Medicare Part B (Medical Insurance)

- Helps cover doctors' services and outpatient care
- Helps cover some preventive services to help maintain your health (See Chart on page 18)

Medicare Part C (Medicare Advantage Plans)

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

Medicare Part D (Prescription Drug Coverage)

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

If you enroll in either Medicare Part C or Part D plans other than Medicare GenerationRx, you will not be eligible for Benefit Options Medical Coverage. (Example: if you enroll in the Humana Part D Plan outside of the Benefit Options program, you are not eligible to enroll in any of the ADOA Medical Plans.)

Medicare Payments

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

Benefit Options does not pay for Medicare Part B premiums. If you decline or disenroll from Medicare Part B, you will be financially responsible for **ALL** Part B premiums.

Medicare and ADOA

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

Medicare Primary

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

- Medicare is primary coverage
- Benefit Options is secondary coverage

How it Works

Medicare Parts A and B will only pay 80% of covered charges once you have met your deductible. Doctors often charge patients the remaining portion of the bill that Medicare has not paid. If you enroll in the Benefit Options plan the remaining portion less copays (20%) will be covered since Benefit Options becomes the secondary payor. Benefit Options will pay up to the total allowable amount less copays as determined by the Plan.

Copays

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

Medicare Crossover Program

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

Preventive Services Checklist

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

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

Medicare Part D

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

All ADOA's PDP Plan Medicare-eligible participants covered under the State of Arizona Benefit Options Program must enroll in Medicare Prescription Drug Plan (PDP) that combines a standard Medicare Part D plan with additional prescription drug coverage provided by Benefit Options. The plan name is Medicare GenerationRx (Employer PDP). We refer to this program as Medicare GenerationRx for Benefit Options.

Low Income Subsidy (LIS)
Medicare-eligible retirees and their Medicare-eligible dependents with limited income may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare may pay for up to 100% of drug costs, and coinsurance/copayments.

Eligible members are identified during the enrollment process. Plan participants that are eligible will receive a Low Income Subsidy (LIS) Rider with their Explanation of Coverage explaining their benefit.

For more information about Extra Help, members may contact their local Social Security office or call 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY/TDD users should call 1.877.486.2048, or visit *medicare.gov*.

Part D Income Related Monthly Adjustment Amount (IRMAA)
If your income is over $85,000 for an individual or $170,000 for married filing jointly, Medicare requires that you pay an additional premium based on your income. You will be notified by Social Security if this affects you.

For more information about Part D premiums based on income, visit *medicare.gov* on the web or call 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY/TDD users should call 1.877.486.2048. Members may also call Social Security at 1.800.772.1213. TTY/TDD users should call 1.800.325.0778.

The Medicare GenerationRx for Benefit Options plan provides equal to or better coverage than what is offered through Medicare Part D. Learn more about Medicare GenerationRx for Benefit Options on page 34.

Understanding Your Options

Retirees have the option of two statewide and nationwide plans, four Networks, and four coverage tiers. "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. A tier describes the number of persons covered by the medical plan.

Benefit Options Medical Plans		
	EPO	PPO
Aetna	X	X
BCBSAZ	X	X
Cigna	X	
UnitedHealthcare	X	X

How the Plans Work

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

The EPO Plan

If you choose the EPO plan under Benefit Options you must obtain services from a Network provider. Out-of-Network services are only covered in emergency situations. Under the EPO plan, you will pay the monthly premium and any required copay at the time of service. The EPO plan is available with all four Networks: Aetna, Blue Cross Blue Shield of Arizona, 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 out-of-Network services. Additionally, there are in-Network and out-of-Network deductibles 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, and UnitedHealthcare.

Choosing the Best Plan for You and Your Family

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

1. Assess the costs you expect in the coming year including: employee premiums, copays, and coinsurance. Refer to pages 10-11 for per pay period premiums and page 22 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, 2016. 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.*

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 for 2016.

Contacts
Aetna: 1.866.217.1953
Non-member: *aetnastateaz.com*
Existing member: *aetna.com*

Blue Cross Blue Shield of Arizona: 1.866.287.1980
Non-member: *adoa.azblue.com*
Existing member: *azblue.com*

Cigna: 1.800.968.7366
Non-member: *Cigna.com/stateofaz*
Existing member: *myCigna.com*

UnitedHealthcare: 1.800.896.1067
Non-member: *welcometouhc.com/stateofaz*
Existing member: *myuhc.com*®

Medical Plan Comparison Chart

		EPO[1]	PPO	PPO
Available Plans		**Aetna BCBSAZ Cigna UnitedHealthcare**	**Aetna BCBSAZ UnitedHealthcare**	**Aetna BCBSAZ UnitedHealthcare**
		IN-NETWORK	**IN-NETWORK**	**OUT-OF-NETWORK**
Plan Year deductible	RetireeOnly	None	$500[2]	$1,000[2]
	Retiree+Adult Retiree+Child Retiree+Family	None	$1,000[2]	$2,000[2]
Out-of-pocket max	RetireeOnly	None	$1,000[2,3]	$4,000[2]
	Retiree+Adult Retiree+Child Retiree+Family	None	$2,000[2,3]	$8,000[2]
Lifetime max		None	None	None
RETIREE 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 ER copay waived if admitted	Ambulance	$0	$0	10% after deductible
	ER	$125	$125	$125
	Urgent care	$40	$40	50% after deductible
Home health services Maximum visits per year		42	42	42
Hospital admission (Room and Board)		$150	$150	50% after deductible
Mammography		$0	$0	50% after deductible
Office visits Maximum of one co-pay/day/provider	PCP	$15	$15	50% after deductible
	Specialist[4]	$30	$30	50% after deductible
	Preventive	$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

1 *If member goes out-of-Network 0% covered, except in emergency situations.*
2 *Copayments apply after the Plan deductible is met. Copayments and Deductible apply to the out-of-pocket maximum.*
3 *The Plan pays 100% after out-of-pocket maximum is met.*
4 *All Mayo Clinic Primary Care Physicians (PCP) are contracted with Cigna HealthCare as specialists, therefore all primary care services administered by Mayo PCPs will be subject to the $30 specialist copayment.*

For the NAU only BCBS PPO Plan details, go to nau.edu/human-resources/benefits/benefit-plan-document/.

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

Non-member: *aetnastateaz.com*
Existing member: *aetna.com*

Visit:
DocFind
Use this online directory to find out if your physician or hospital is contracted with Aetna.

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 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 day NurseLine. Chat live with member service representatives for quick, easy and secure assistance by using the Live Help feature within the Aetna portal.

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 is an i-Phone application available for downloading.

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

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

Blue Cross Blue Shield of Arizona

Non-member: *adoa.azblue.com*
Existing member: *azblue.com*

Lookup Provider

To find out if your doctor, hospital, retail clinic, or urgent care provider is contracted with Blue Cross Blue Shield of Arizona use this tool.

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

ID Card

Order a new ID card or print a temporary one.

Care Comparison

This simple online tool gives you access to price ranges for many common health care services right down to the procedure and the facility in your area. You can also view cost information across many specialties including radiology, orthopedics, obstetrics, and general surgery.

Hospital Compare

In this tool you will find information on how well hospitals care for patients with certain medical conditions or surgical procedures, and results from a survey of patients about the quality of care they received during a recent hospital stay.

Claims Inquiry

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

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

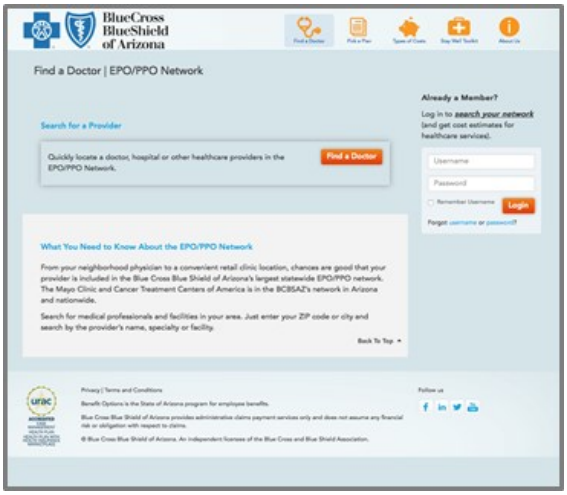
You can access wellness information through your personal HealthyBlue homepage.

Online Forms

You can find important forms and information online, including a medical claim form and medical coverage guidelines.

Help

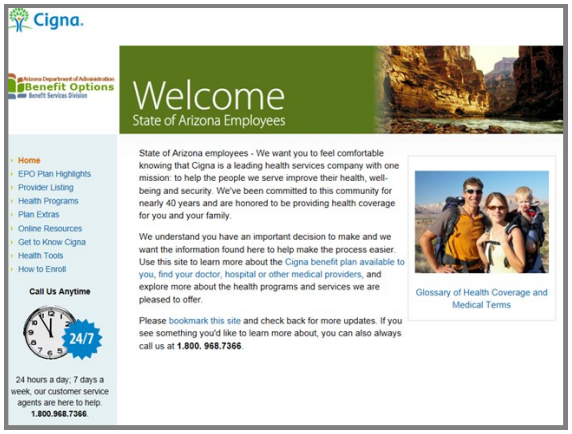
You can find information on how to contact Blue Cross Blue Shield of Arizona regarding your benefits, claims, or any other questions you may have.



Cigna

Non-member: *Cigna.com/stateofaz*
Existing member: *myCigna.com*

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



For retirees already enrolled in the Cigna plan, please visit *myCigna.com,* for 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. You can download a free, personalized smart phone app. From there, you can do almost anything on the go – from getting your ID cards, account balances, locating doctors and hospitals, and so much more. Get the myCigna Mobile app today!

Note: All Mayo Clinic Primary Care Physicians (PCP) are contracted with Cigna HealthCare as specialists, therefore all primary care services administered by Mayo PCPs will be subject to the $30 specialist copayment. If you choose a doctor that does not accept assignment from Medicare, your doctor may be allowed to bill you for additional costs up to the Medicare limiting charge.

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

Visit your support site: welcometouhc.com/ stateofaz
From this site you can access benefit information, learn about available tools, resources and programs, view open enrollment materials and more.

- View and compare benefit plan options
- Learn more about wellness programs, specialized benefits and online tools
- Search for physicians and facilities
- And, access our site for members, myuhc.com

Need a new doctor or a specialist?
You can search for doctors near you and even see which doctors have been recognized by the UnitedHealth Premium® program for quality and cost-efficiency.

Your health, your questions, your myuhc.com
Once you become a member, your first stop is your member website, *myuhc.com*. It's loaded with details on your benefit plan and much more.

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

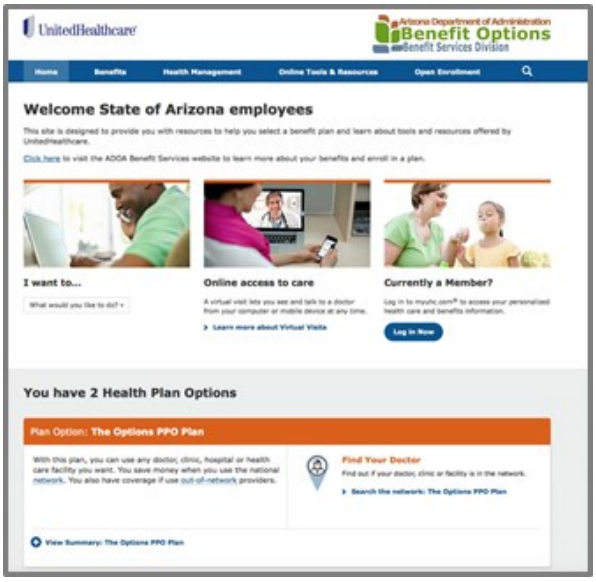
Want to get rid of that nagging pain, but worried about the cost?
You can see what a treatment or procedure typically costs and see what your share of expenses may be.

Looking for an easier way to manage claims?
You can track claims, mark claims you've already paid, and review graphs to better understand what you owe. You can even make claim payments online.

Want a place to keep your personal health information?
The *"Health & Wellness"* tab is your own personal website that is designed to:

- Inspire healthy action with a step-by-step program
- Encourage you to remain motivated through online health programs, and innovative tools and calculators that track your progress
- Reinforce your commitment by acknowledging your accomplishments

Always on the go? We can help you there too.
Whether you need to find urgent care, you forget your health plan ID card, or need to call customer service, the UnitedHealthcare Health4Me™ mobile app helps put your insurance information in the palm of your hand.



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, the medical Network you select during open enrollment serves their specific 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
Each Medical network provides 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 medical Network for authorization. Please refer to your Plan Document for the specific list of services that require prior authorization. Each Network has a dedicated line to accept calls and inquiries:

Aetna 1.800.333.4432
Blue Cross Blue Shield of Arizona 1.800.232.2345 ext. 4320
Cigna 1.800.968.7366
UnitedHealthcare 1.800.896.1067

Case Management
Case management is a collaborative process whereby a case manager from your selected medical Network 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 manager uses available resources to achieve cost effective health outcomes for both the member and the State of Arizona.

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
- Healthy Back

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

Your assigned disease manager may also:
- Provide tips on how to keep your diet and exercise program on track

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

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

Getting Involved
The Benefit Options disease management programs offered through each medical Network identify and reach out through phone calls and/or mail to members who may need help managing their health conditions.

The medical Networks 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 medical Networks directly to self enroll.

Please refer to your medical Network's phone number on page 27 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:

Aetna 1.800.556.1555

Blue Cross Blue Shield of Arizona
1.866.422.2729, Option 9

Cigna 1.800.968.7366

UnitedHealthcare 1.800.401.7396

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 50 million members nationwide, providing leading prescription drug clinical services, benefit design, and claims processing since 1989 through a comprehensive Network of pharmacies.

ID Card
You will not receive a pharmacy ID card. The MedImpact Customer Care information can be found on the back of the ID card provided by your medical network.

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 33. The copays listed in the chart are for a 31-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 MedImpact 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**
- 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 *walgreens.com* or via phone at 1.866.304.2846. Have your insurance card ready when you call.

Choice90

With this program, members 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.

Specialty medications are limited to a 31-day supply and may be obtained only at a Walgreens retail pharmacy or through the Walgreens Specialty Central Fill facility 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 Travel 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 extra medication you will need *provided 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.

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

NAU Retiree BCBS Members only

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

The BCBSAZ Prescription Medication Guide can be used to determine your copay and this guide can be found on the BCBS website at *bcbsaz.com.* Go to four level prescription drug benefits.

Up to a 90-day supply of maintenance drugs (the same drug and drug strength) may be obtained through the Walgreens Prescription Drug Mail-Order Program. Maintenance drugs are drugs you take consistently. The copay for the 90-day supply is equivalent to one month's copay for Level 1 and 2 Prescriptions and equal to two co-pays for Level 3 and Level 4 prescriptions.

Members can view pharmacy information located at *benefitoptions.az.gov*. 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. Your prescription history can be printed for annual tax purposes.

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.

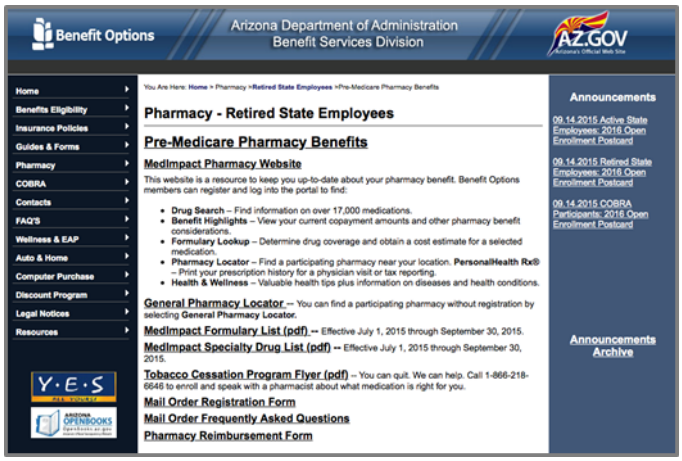
Health & Wellness
Learn valuable tips and information on diseases and health conditions.

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.



NAU Retirees Blue Cross Blue Shield Members Only
Refer to more information by accessing Blue Net, Blue Cross Blue Shield of Arizona's online member website at *bcbsaz.com*. Information on the pharmacy plan and copay levels for prescriptions can be found at *bcbsaz.com.* Go to 4-level prescription drug benefit.

Pre-Medicare Pharmacy Benefits Summary

	ADOA Benefit Options (Aetna, Blue Cross Blue Shield of Arizona, Cigna, UnitedHealthcare)	BCBS/NAU Only *bcbsaz.com*
Pharmacy Benefits Administered By	MedImpact	Blue Cross Blue Shield
Retail Requirements	In-Network pharmacies only: one copay per prescription	In-network only: one copay per prescription
Mail Order	Two copays for 90-day supply	One copay for 90-day supply
Choice90	Two & 1/2 copays for 90-day supply	Not Available
Generic	$10 copay	$10 copay
Preferred Brand*	$20 copay	$25 "brand"
Non-Preferred Brand*	$40 copay	$45 for non-preferred brand "A"
		$85 for non-preferred brand "B"
Annual Maximum	None	None

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

Note: Copays for compounded medications are based on the formulary placement of the main compound ingredient.

Medicare GenerationRx (Employer PDP) for Medicare eligible retirees & Medicare eligible dependents

If you elect any Benefit Options medical plan, you will be automatically enrolled in Medicare GenerationRx for Benefit Options.

Medicare GenerationRx is sponsored by Stonebridge Life Insurance Company, a Medicare approved Part D sponsor. Effective October 1, 2015, Stonebridge Life Insurance Company is merging with Transamerica Life Insurance Company. You may see materials with both insurance carriers during the transition period. Transamerica Life Insurance Company is a PDP plan sponsor with a Medicare contract. Enrollment in this plan depends on contract renewal. All Medicare GenerationRx communications will include the Medicare GenerationRx logo.

How it Works

Medicare-eligible retirees and their Medicare-eligible dependents enrolled in Medicare GenerationRx will each receive their own prescription drug ID card.

The new ID card will be issued by Medicare GenerationRx, and will NOT replace your medical card. The new prescription drug ID card is in addition to your medical card. Show your Medicare GenerationRx card when you fill your prescription medications at the pharmacy.

Members will need to use their new Medicare GenerationRx prescription ID card if they're enrolled in Medicare GenerationRx Part D Prescription Drug Program for Benefit Options. Members will receive their new card within 10 days of their effective date.

All prescriptions must be filled at a Network pharmacy by presenting your Medicare GenerationRx prescription ID card. You can also fill your prescription through the Walgreens mail order service.

The Medicare GenerationRx for Benefit Options plan has a four-tier formulary.

The Plan provides you full coverage so there is no Coverage Gap, or "Donut Hole." This allows your cost sharing to remain consistent. You pay the same copays throughout the year during all the Medicare Part D stages.

If you reach the catastrophic coverage stage ($4,850 in total out-of-pocket costs for 2016), your Benefit Options copayment will be the maximum amount charged.

Benefits, formulary pharmacy network, premium and/or co-payments/co-insurance may change on January 1 of each year.

This information is not a complete description of benefits. Contact the plan for more information.

Limitations, copayments, and restrictions may apply. For more information contact Medicare GenerationRx.

Formulary

The formulary is the list of medications chosen by a committee of doctors and pharmacists to help maximize the value of your prescription benefit.

Members will use Medicare GenerationRx's four-tier formulary. Generic and brand name medications are available at a lower cost.

Tier Number / Name	Retail (up to 31-day supply)	Mail Order (up to 90-day supply)	Choice90Rx – extended supply at retail (up to 90-day supply)
Tier 1: Generic	$10	$20	$25
Tier 2: Preferred Brand	$20	$40	$50
Tier 3: Non-Preferred Brand	$40	$80	$100
Tier 4: Specialty - Over $600 [1]	$40	Not available	Not available

1 Total Medical cost.

Generally, your formulary will not change during the year except for cases in which you can save additional money or to ensure your safety. If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 60 days before the change becomes effective.

Some drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization**
  Prescriptions for certain medications may require clinical approval before they can be filled, even with a valid prescription. You or your physician will need to obtain approval from Medicare GenerationRx before these drugs can be covered by the plan.

- **Step Therapy Program**
  The program promotes the use of safe, cost-effective and clinically appropriate medications. This requirement encourages you to try less costly but just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called **"step therapy"**.

- **Quantity Limits**
  For certain drugs, Medicare GenerationRx limits the amount of the drug that Medicare GenerationRx will cover.

To see what medications are on the formulary and get additional information about drug restrictions, go to *medicaregenerationrx.com/stateofaz* or call Medicare GenerationRx's Member Services at 1.877.633.7943. TTY users should call 711. Member Services is available 24 hours a day, 365 days a year. Sharing this information with your doctor helps ensure you are getting the best value, which saves money for you and your plan.

The formulary may change at any time. You will receive notice when necessary.

Finding a Pharmacy
Medicare GenerationRx has over 65,000 pharmacies in its network. Members may continue to fill their prescriptions at their current pharmacy as long as it is a MedicareGenerationRx for Benefit Options network pharmacy.

Members may request a pharmacy directory from Member Services or use the online Pharmacy Locator at *medicaregenerationrx.com/stateofaz*.

The pharmacy network may change at any time. You will receive notice when necessary.

Pharmacy Mail Order Service
A convenient and less expensive mail order service is available for members who need medications for ongoing 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, but verification is required every 30 days.
- Auto refill is not available.
- Request up to a 90-day supply of medication for **two copays.** (Example: A 31-day supply retail prescription for a $10 copay versus a 90-day supply mail order prescription for a $20 copay)
- 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 *Walgreens.com* or via phone at 1.866.304.2846. Have your prescription card ready when you call!

Choice90Rx
With this program, members who require medications for an ongoing health condition can obtain a 90-day supply of medication at a local retail pharmacy for **two and a half copays.**

For more information or to find a participating Choice90Rx pharmacy, please visit our web site at *medicaregenerationrx.com/stateofaz*, refer to your Pharmacy Directory or call Medicare GenerationRx Member Services at 1.877.633.7943, 24 hours a day/365 days a year. TTY/TDD users should call 711.

Specialty Pharmacy Program
If you are taking a medication that is on the Specialty tier of your prescription benefit, you may use Walgreens Specialty pharmacy, or any specialty pharmacy in the Medicare GenerationRx specialty pharmacy network.*

*Other pharmacies are available in our network.

To enroll in Walgreens Specialty Pharmacy's Patient Care Programs, please call 1.888.782.8443 to speak with a Patient Care Coordinator. Walgreens Specialty Pharmacy will reach out to your health care provider to get a new prescription for you or have your specialty prescriptions transferred from your current pharmacy. For more information on Walgreens Specialty Pharmacy, visit *walgreens.com/specialty*.

Specialty medications are limited to a 31-day supply.

Under Medicare Part D
Extra Help (Low Income Subsidy)
Eligible retirees and their dependents with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for up to 100% of drug costs including coinsurance/ copayments.

Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many Medicare eligible retirees and their dependents are eligible for these savings and don't even know it.

Members eligible for "Extra Help" are identified during the enrollment process. Plan participants that are eligible will receive a Low Income Subsidy (LIS) Rider with their Explanation of Coverage explaining what their benefit will be.

For more information about Extra Help, members may contact their local Social Security office or call **1.800.MEDICARE** (1.800.633.4227), 24 hours per day, 7 days a week. TTY/TDD users should call 1.877.486.2048, or visit *medicare.gov*.

Part D Income Related Monthly Adjustment Amount (IRMAA)
Some Medicare eligible members and their dependents pay an extra amount for Part D because of their yearly income. If a member's modified adjusted gross income is $85,000 or above for an individual (or married individuals filing separately) or $170,000 or above for married couples, they must pay an extra amount directly to the government (not the Medicare plan) for Medicare Part D coverage.

- If a member is required to pay the extra amount and does not pay it, they **will** be disenrolled from the plan and lose prescription drug coverage.
- If the member needs to pay an extra amount, Social Security, not the Medicare plan, will send the member a letter telling them what that extra amount will be.
- For more information about Part D premiums based on income, visit *medicare.gov* on the web or call 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048. Members may also call Social Security at 1.800.772.1213. TTY users should call 1.800.325.0778.

The booklet ***Medicare & You 2016*** gives information about the Medicare premiums in the section called "2016 Medicare Costs." This explains how the Medicare Part B and Part D premiums differ for Medicare eligible members and their dependents with different incomes.

Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those

new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You 2015* from the Medicare website (*medicare.gov*). Or, you can order a printed copy by phone at 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.

Many members are required to pay other Medicare premiums. Some plan members (those who aren't eligible for premium-free Part A) pay a premium for Medicare Part A. Most plan members also pay a premium for Medicare Part B.

Members who owe the income-related monthly adjustment amount (IRMAA or "extra amount") will receive a letter **directly from the Social Security Administration (SSA)**. Medicare GenerationRx is not aware whether the member qualifies for this additional premium or not as it is managed strictly through the SSA.

Medicare GenerationRx is only made aware of IRMAA if the member is disenrolled for non-payment. See Ch. 4, Section 11 of the Evidence Of Coverage for more information about the extra amount.

If a member feels they should not have to pay the additional premium, they should call the SSA number listed in the letter.

SSA will either make an appointment for the member at their local SSA office or they will transfer them to the local SSA phone number for an income re-determination. A member's income may have increased/ decreased due to capital gains (e.g. sale of a home, cashing in a 401k, marriage, divorce or death).

Extended Vacation or Travel Abroad

If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need.

Whether you go to a retail pharmacy or use mail order for your prescriptions, you will need to notify Medicare GenerationRx 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.

Medicare GenerationRx will generally be able to authorize a VACATION OVERRIDE allowing you to have the extra medication you will need *provided 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. Copays will be the same as you would normally pay times the number of refills you need.

Medicare GenerationRx cannot pay for any prescriptions that are filled by pharmacies outside the United States, even for a medical emergency.

Contact information

Medicare GenerationRx Member Services is available to address pharmacy plan questions. Representatives are available **24 hours a day, 365 days a year** at **1.877.633.7943. TTY users should call 711.** Language translation services are available.

Medicare Eligible Pharmacy Plan Information

Pharmacies and providers may call the Medicare GenerationRx Pharmacy and Provider Help Desk at **1.888.678.7789**. Representatives are available **24 hours a day, 365 days a year. TTY users should call 711.**

To view your Medicare GenerationRx for Benefit Options plan benefits find a participating pharmacy or look up the price of your drugs, visit *medicaregenerationrx.com/stateofaz.*

iRx Discount Program
You may be able to obtain a discount on certain brand and generic medications that are not covered by your ADOA pharmacy drug plan, through the iRx Program™. Present your Medicare GenerationRx ID card at any participating pharmacy, along with your prescription for the medication. Savings are applied automatically when the item prescribed qualifies for a discount. The amount of the discount will vary based on pharmacy chosen and type of medication.

Medicare has neither reviewed nor endorsed this information.

Members can view pharmacy information at *medicaregenerationrx.com/stateofaz.*

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

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

Prescription History
View your prescription history, including all of the medications received by each member, under PersonalHealth Rx. Your prescription history can be printed for annual tax purposes.

Drug Price Check
Review prescription choices and compare drug prices. Search by drug name to view formulary status, tier and your cost.

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. Auto refill is not available.

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.

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

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

- You **MUST** use a Prepaid/DHMO Participating Dental Provider (PDP) to provide and coordinate all of your dental care in Arizona
- No annual deductible or maximums
- 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 from the TDAHP Arizona DHMO provider network. 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
As a State of Arizona eligible member you can enroll in the Delta Dental of Arizona – PPO plus Premier plan with covered preventive services.

- Your preventive and diagnostic services are covered at 100% and are **not** subtracted from your annual maximum
- Your annual maximum benefit is $2,000 per benefit year
- No deductible for diagnostic and routine services
- $50 deductible per person and no more than $150 per family
- The maximum lifetime benefit for orthodontia is $1,500
- A third dental cleaning per benefit year is available for eligible members
- A no missing tooth clause is included
- You can elect to see a licensed dentist anywhere in the world
- Delta Dental has the largest network in Arizona with 3,200+ participating dentists
- You can maximize your benefits when you select a PPO Provider
- Delta Dental dentists have agreed to accept a negotiated fee (after deductibles and copays are met) and in most circumstances can't balance bill you in excess of the allowed fee
- Claims are filed by the network dentist and they are paid directly, making it easier for you

To find a Delta Dental dentist near you, visit *deltadentalaz.com/find*.

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.

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

Dental Plan Online Features

Total Dental Administrators Health Plan (TDAHP), Inc.

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

Participating Providers
You can search for a specific dentist contracted under the Arizona DHMO provider network.

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 A500AZ
Learn about the plan by clicking on this option.

Delta Dental PPO plus Premier

Managing your benefits online is easy and convenient with Delta Dental! After the benefit year begins on January 1, please visit *deltadentalaz.com* to create your ID and password in the **Member Connection**, a secure website that gives you access to the following tools and materials:

- View and/or print your **benefits and eligibility**
- Go paperless and sign up for **electronic Explanation of Benefits** (EOBs)
- **24/7 claims information**: Check your claims by dates, print copies of EOBs for you or your dependents, or download a claim form
- Use the **Find a Dentist** tool to search Delta Dental's national dentist directory

Plus:

- Download the **Delta Dental Mobile App**
- Check out the **Delta Dental of Arizona Blog** at *deltadentalazblog*.com
- Assess your risk for dental diseases with the **Oral Health Assessment Tool** at *MyDentalScore.com/DeltaDental*

Dental Plans Comparison Chart

	TDA	Delta Dental
PLAN TYPE	Prepaid/DHMO	Indemnity/PPO
DEDUCTIBLES	None	$50/$150
MAXIMUM BENEFITS		
Annual Combined Basic and Major Services	No Dollar Limit	$2,000 per person
Orthodontia Lifetime	No Dollar Limit	$1,500 per person
PREVENTIVE CARE CLASS I		
Oral Exam	$0	$0 - Deductible Waived[1]
Emergency Exam	$0	$0 - Deductible Waived[1]
Prophylaxis/Cleaning	$0	$0 - Deductible Waived[1]
Fluoride Treatment	$0 (to age 15)[2]	$0 (to age 18) - Deductible Waived[1]
X-Rays	$0	$0 - Deductible Waived[1]
BASIC CLASS II SERVICES		
Office Visit	$0	$0[1]
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%
BASIC CLASS III SERVICES		
Office Visit	$0	$0[1]
Crowns	$270 + $185 Lab Fee ($455)	50%
Dentures	$300 + $275 Lab Fee ($575)	50%
Fixed Bridgework	$270 + $185 Lab Fee ($455) per unit	50%
Crown/Bridge Repair	$75	50%
Implants	$140 - $1,300	50%[3]
ORTHODONTIA		
	Child: $2,800 - $3,400 Adult: $3,200 - $3,700	See lifetime
TMJ SERVICES		
Exam, services, etc.	20% Discount	100%

1 *Routine visits, exams, cleanings, and flouride treatments are covered two times per Plan Year at 100%. X-rays (Bitewing, Periapicals) are covered once per Plan Year at 100%.*

2 *Fluoride treatment covered 100% once per Plan Year up to age 15. Additional treatment subject to applicable copayments.*

3 *Subject to both the benefit year allowance and the lifetime maximum limit of $1,000 per tooth. Subject to all provisions, terms and conditions of the Plan Description.*

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

Avesis Advantage Program
Retirees 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
- Unlimited discounts on additional optical purchases

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 Advantage Program, you will automatically be enrolled in the Discounted Plan at no cost. This program will provide each member with substantial discounts on vision exams and corrective materials. **No enrollment is necessary.**

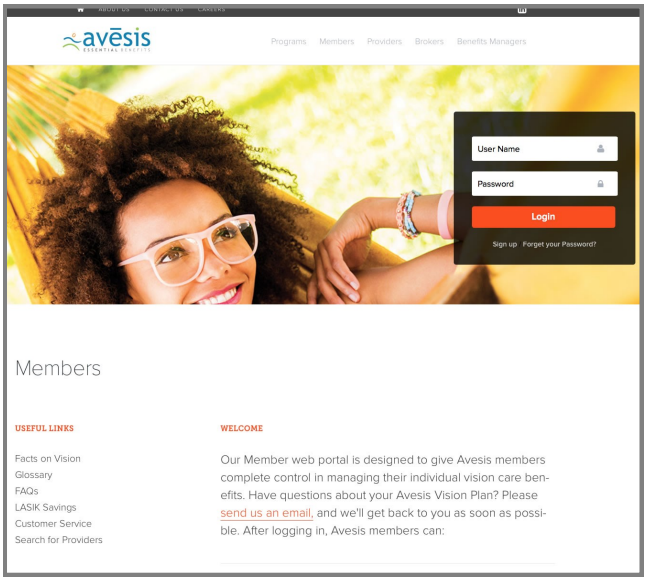
How to Use the Discount Program
1. Find a provider – Go to *avesis.com* or call customer service at 1.888.759.9772.
2. Schedule an appointment—Identify yourself as an Avesis discount card holder employed by the State of Arizona.

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.

Refractive Surgery Benefit
LASIK surgery benefits are available to Advantage Program or Discount Program members. To find a LASIK provider - visit *Qualsight.com/Avesis* or call 1.877.712.2010.

New Avesis Discount Hearing Plan
Whether you are enrolled in the Advantage Program or the Discount Program, members have access to a new Hearing Discount Plan. To utilize the Hearing Discount Plan, call 1.866.956.5400 and identify yourself as an Avesis member employed by the State of Arizona to access your benefits.

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



Online Features

Members can view **Avesis** information by visiting *avesis.com/members.html.* Login with your EIN and your last name to have access to:

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

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

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

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

Glossary
You can learn about vision terminology.

Facts on Vision
Learn about different vision facts.

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

Vision Plans Comparison Chart

	Advantage Program In-Network	Advantage Program Out-of-Network	Discount Program[1, 3]
Examination Frequency	Once per Plan Year	Once every 12 months	Once per Plan Year
Lenses Frequency	Once per Plan Year	Once every 12 months	Once per Plan Year
Frame Frequency	Once per Plan Year	Once every 12 months	Once per Plan Year
Examination Copay	$10 copay	Up to $50 reimbursement	20% discount
Optical Materials Copay (Lenses & Frame Combined)	$0 copay	N/A	Refer to schedule below
Standard Spectacle Lenses			
Single Vision Lenses	Covered-in-full	Up to $33 reimbursement	20% discount
Bifocal Lenses	Covered-in-full	Up to $50 reimbursement	20% discount
Trifocal Lenses	Covered-in-full	Up to $60 reimbursement	20% discount
Lenticular Lenses	Covered-in-full	Up to $110 reimbursement	20% discount
Progressive Lenses	Uniform discounted fee schedule	Up to $60 reimbursement	20% discount
Selected Lens Tints & Coatings	Uniform discounted fee schedule	No benefit	20% discount
Frame			
Frame	Covered up to $100-$150 retail value ($50 wholesale cost allowance)	Up to $50 reimbursement	20% discount
Contact Lenses (in lieu of frame/spectacle lenses)			
Elective	10-20% discount and $150 allowance[2]	Up to $150 reimbursement	10-20% discount
Medically Necessary	Covered-in-full	Up to $300 reimbursement	10-20% discount
LASIK/PRK			
LASIK/PRK	Up to $600	Up to $600 reimbursement	10-20% discount

1 *Members that choose not to enroll in the Advantage Vision Care Program will automatically be enrolled in the Discount Plan at no cost.*
2 *Includes fit, follow-up and materials.*
3 *No out-of-network benefits for the Discount Vision Care Program.*

International Coverage

MEDICAL CARE	
EPO Plans	
Aetna	Emergency & Urgent Only
BCBSAZ	Emergency & Urgent Only
Cigna	Emergency & Urgent Only
UnitedHealthcare	Emergency & Urgent Only
PPO Plans	
Aetna	Emergency & Urgent Only at in-Network Benefit Level[1]
BCBSAZ	Emergency & Urgent Only at in-Network Benefit Level[1]
UnitedHealthcare	Emergency & Urgent Only at in-Network Benefit Level[1]
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 *bcbs.com/bluecardworldwide/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-participant provider benefits
VISION CARE	
Avesis	Covered as out-of-Network and will be reimbursed based on the Avesis reimbursement schedule

1 All other services should be verified by Third Party Administrator.

This section of the ADOA Guide has been added so that ADOA retirees enrolled in the ASRS health insurance program may see the provisions of the ASRS and ADOA health insurance plans and their respective premiums.

The ASRS provides the following program options for non-Medicare and Medicare eligible Arizona State Retirement System (ASRS), Public Safety Personnel Retirement System (PSPRS), Elected Officials Retirement Plan (EORP), Corrections Officer Retirement Plan (CORP), University Optional Retirement Plans (UORP), or any member who receives a long-term disability (LTD) benefit from the ASRS program and who may not be enrolled in health insurance benefits through his or her former employer.

Non-Medicare Eligible Medical Plans

Unitedhealthcare Choice Plan (in-network & in-state only)

Choice is an in-network only plan that gives members the freedom to see any physician, specialist, hospital or other healthcare professional in the network, without a referral. You must use contracted Choice providers within the state of Arizona except for urgent care and emergency services.

UnitedHealthcare Choice Plus PPO (out-of-state)

Choice Plus PPO has coverage for in-network providers, as well as, non-network providers. It also gives members the freedom to see any physician, specialist, hospital or other healthcare professional in the network, without a referral. But Choice Plus gives members the added flexibility to seek care from doctors and hospitals outside the network, and still receive coverage. In order to control costs, additional out-of-pocket costs apply for non-network care.

Medicare Eligible Medical Plans

UnitedHealthcare Group Medicare Advantage (HMO) Plan

This plan is for members enrolled in Medicare Parts A & B and in which UnitedHealthcare has entered in a contract with The Centers for Medicare and Medicaid Services (CMS), the federal agency that administers Medicare. This contract authorizes UnitedHealthcare to provide complete health services to persons who are entitled to Original (traditional) Medicare benefits and who chose to enroll in the Group Medicare Advantage (HMO) Plan. By enrolling in the Group Medicare Advantage (HMO) Plan, you have made a decision to receive all your routine health care from UnitedHealthcare contracted providers. If you receive services from a non-contracted provider without prior authorization (except for emergency services, out-of-area urgently needed services and renal dialysis), neither UnitedHealthcare nor Medicare will pay for those services.

UnitedHealthcare Senior Supplement Plan

This plan is for members who are enrolled in both Medicare Parts A & B. By enrolling in the Senior Supplement plan you have the freedom to obtain medical care from any physician and hospital that accepts Medicare. The plan is a Medicare medical plan which includes an approved Medicare prescription Part D drug Plan.

Indemnity Dental Plans

The two Indemnity Dental Plan options: Freedom Basic (the “Low” option) and Freedom Advance (the “High” option). These

plans pay the indicated percentages of Allowable Charges for covered services. Benefits are paid after any applicable deductible has been met, up to the Annual Maximum Benefit which is $2,500 for the Freedom Advance plan and $1,000 for the Freedom Basic plan. You are responsible for any applicable coinsurance percentages not covered by the plan. You also have access to the Assurant Dental Network, for additional savings on your dental care.

Prepaid Dental Plans

The Prepaid Dental Plans provide a variety of benefits through a network of participating dentists. Arizona retirees may choose between two Prepaid Dental Plans – Heritage Secure with Specialty Benefit Amendment (SBA) or the DHMO Dental Plan 220 with orthodontics copayments. You may change your dentist throughout the plan year. All services must be performed by a participating provider, (note: the exception to this requirement for the DHMO Dental Plan 220 with Ortho). You pay a fixed copayment directly to the network dentist for covered dental procedures. The Prepaid Dental Plans vary by state and are available to retirees in AZ, CA, CO, FL, GA, KS, MO, NE, NV, NM, OH, OK, OR, TX, and UT.

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

No Longer Eligible for LTD Benefits and Not Able to Retire

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

Returning to Work

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

Waiver of Premiums

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

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

Disability Benefits from Social Security and Eligibility for Medicare

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

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

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

Receiving Social Security Disability

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

If you participate or enroll in any of the Benefit Options Plans, you are entitled to the following documents and information.

Health Insurance Marketplace Coverage
Key parts of the health care law allows you a way to buy health insurance through the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, a notice that provides some basic information about the new Marketplace and the Benefit Options health coverage is available at *benefitoptions.az.gov*.

Summary of Benefits and Coverage and Uniform Glossary
As part of the Affordable Care Act, the federal government announced new rules regarding the disclosure of the Summary of Benefits and Coverage (SBC) and Uniform Glossary. These regulations require group health plans and health insurance issuers that offer coverage for groups and individuals to provide access to the SBC and Uniform Glossary. The SBC documents along with the uniform glossary are posted electronically to the Benefit Options Website *benefitoptions.az.gov*. You may also contact Benefit Services to obtain a copy.

Summary Plan Description (SPD)
The SPD, or Plan Document, is a summary of important benefit features of your plan. The SPD may be revised at any time for plan clarification purposes. An updated copy of the SPD is available to you electronically on the Benefit Options website *benefitoptions.az.gov*. You may also contact Benefit Services to obtain a printed copy of the document.

Legal Notices regarding the Benefit Options Program can be found under the **"Legal Notices"** tab of the member website: *benefitoptions.az.gov***.** These notices include:

Health Insurance Portability & Accountability Act (HIPAA)
This notice protects the privacy of individually identifiable health information, and establishes who can use the personal health information and how it can be used.

Medicare Notice of Creditable Coverage
This notice has information about the prescription drug coverage through the Benefit Options program for participants with Medicare. It explains the options you have under Medicare prescription drug coverage (Medicare Part D) and can help you decide whether or not you want to enroll.

COBRA (Consolidated Omnibus Budget Reconciliation Act) Coverage Notice
Notice of the Arizona Benefit Options Program COBRA Coverage.

Patient Protection & Affordable Care Act (PPACA)
Notices of the Arizona Benefit Options Program in reference to PPACA.

Privacy Policy
A federal law known as the HIPAA Privacy Rule requires that the health care Plans provide you with a notice of Privacy Practices. The notice describes how your medical information may be used or disclosed by the plans, as well as your rights and the plans' legal duties with respect to your medical information. You can link to an electronic copy of the notice at *benefitoptions.az.gov*.

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(s) 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.

Centers for Medicare & Medicaid Services (CMS)
The Federal agency that administers Medicare. You may contact Medicare at 1.800.MEDICARE (1.800.633.4227) or *medicare.gov.*

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.

Coverage Gap (Donut Hole)
Medicare GenerationRX for Benefit Options does not have a donut hole. You will continue to pay the same cost sharing throughout the plan year.

Creditable Coverage
Prescription drug coverage (for example, from an employer) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

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 chart on page 22).

Dependent
An individual other than a health plan subscriber who is eligible to receive healthcare services under the subscriber's contract. Refer to pages 5-7 for eligibility requirements.

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

Disenrollment
The process of ending your membership in Benefit Options medical and pharmacy plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Drug Tier
Every drug on the list of covered drugs (formulary) is in a drug tier. In general, the higher the drug tier, the higher your cost for the drug.

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 prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a "generic" drug works the same as a brand name drug and usually costs less.

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

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

Income Related Monthly Adjustment Amount (IRMAA)
Individuals with income greater than $85,000 and married couples with income greater than $170,000 must pay a higher Medicare Part B (medical insurance) and Medicare prescription drug coverage premium amount. This additional amount is called the income related monthly adjustment amount.

Late Enrollment Penalty
An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive "Extra Help" from Medicare to pay your prescription drug plan costs, the late enrollment penalty rules do not apply to you. If you receive "Extra Help" you do not pay a penalty, even if you go without "creditable" prescription drug coverage.

Low Income Subsidy (LIS)
A program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

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
A program that allows members to get up to 90-days of covered prescription drugs sent directly to their home address. Auto refills not available.

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

Medicare
The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-State Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare, a Medicare Cost Plan, a PACE plan, or a Medicare Advantage Plan and prescription drug coverage through a Medicare Advantage Prescription Drug plan (MA-PD) or a stand alone Prescription Drug Plan (PDP) that works with Original Medicare.

Member
A person who is enrolled in the health plan.

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.

Network Pharmacy
A pharmacy that participates in your plan's network. In most cases, you need to use a network pharmacy to pay the amounts specified by your plan. A list of network pharmacies can be found in the Pharmacy Directory.

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.

Part D Drugs
Drugs that can be covered under Part D. We may or may not offer all Part D drugs (see your formulary for a specific list of covered drugs). Certain categories of drugs were specially excluded by Congress from being covered as Part D drugs.

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-Certification/Prior Authorization
The prospective determination performed by the Medical Vendor to determine the medical necessity and appropriateness of a proposed treatment, including level of care and treatment setting.

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

Choice90RX Retail Pharmacy
A program that allows members to get up to a 90-day supply of covered prescription drugs from a participating retail pharmacy.

Social Security Administration
The Federal agency that determines, among other things, whether you are entitled to and eligible for Medicare benefits.

Specialty Drugs
High-cost drugs that are used to treat complex conditions, such as anemia, cancer, hepatitis C, and multiple sclerosis, and that usually require injection and special handling. Plans can include these drugs in a separate "specialty" drug tier if their cost is above an amount specified by Medicare.

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

Wellness
A Benefit Options program focused on providing a variety of preventive health activities, screenings, and educational opportunities.

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