Arizona Department of Administration

Benefit Options

Benefit Services Division

2016 COBRA Participants Benefit Guide

Website and Contact Information

ADOA Contacts
Benefit Services Division
100 N. 15th Ave #260
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

Employee Assistance Program
602.771.9355
benefitoptions.az.gov/wellness/wellness%20eap.html

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/stateofaz
Policy Number 705963

Pharmacy Plan
MedImpact
1.888.648.6769
benefitoptions.az.gov

Vision Plan
Avesis, Inc.
1.888.759.9772
avesis.com
Advantage
Policy Number 11001-2178
Plan Number 938
Discount Policy Number 10000-4
Plan Number 9900

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

Flexible Spending Accounts
ASI Member Services
1.800.659.3035
asiflex.com
asi@asiflex.com

Life & Short-Term Disability Plans
The Hartford
1.866.712.3443
groupbenefits.thehartford.com/arizona/
Policy Number 395211

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

For University Employees
UNUM - Short-Term Disability
1.800.799.4455
unum.com

Aetna Life Insurance
1.800.523.5065
aetna.com

Arizona State University
HR Benefits Design & Management
Employees: 855.278.5081
Faculty: 480.727.9900
cfo.asu.edu/hr-benefits
HRESC@asu.edu

Northern Arizona University
Human Resources
928.523.2223
nau.edu/human-resources/

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

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

Welcome to the 2016 COBRA Participant Benefit Guide

This guide describes the comprehensive benefits package "Benefit Options" offered by the State of Arizona, Department of Administration - Benefit Services Division effective January 1, 2016. Included in this reference guide are explanations of the benefits programs, important plan information, contact addresses, phone numbers, web addresses, and comparison charts. This guide is intended to help you understand your benefits.

The guide is divided into chapters, each covering a specific benefits program or important information. We encourage you to review each chapter before making your benefit elections.

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 anytime.

For more information, please refer to your plan descriptions. 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 to the Benefit Options Website *benefitoptions.az.gov*. You may also contact Benefit Services to obtain a copy.

Benefit Services Division is pleased to announce that COBRA participants will not be subject to a rate increase for health, dental, and vision premiums for the 2016 Plan Year. Effective January 1, 2016, the PPO , and HSA Plans will experience rate reductions.

Plan Type	Tier	COBRA Participant Monthly Medical Premiums
PPO (Aetna, BCBS AZ, UnitedHealthcare)	Applicant only Applicant + Adult Applicant + Child Family	$674.22 $1,424.94 $953.70 1,662.60
HSA (Aetna)	Applicant only Applicant + Adult Applicant + Child Family	$399.84 $847.62 $566.10 $989.40

HSA Medical Plan

Adjustments have been made to comply with the 2016 IRS HSA Contribution Limits. Contribution limits for individuals remains at $3,350. For those with family coverage, the maximum contribution increased to $6,750.

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.

Eligibility

The following individuals would be considered qualified beneficiaries eligible for COBRA coverage:

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

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

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

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

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

Eligible Dependents

You can continue to cover the following dependents on your plans (if they were covered under your plan at the time employment ended):

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

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.

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

Qualified Medical Child Support Order (QMCSO)

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

Electing Your COBRA Benefits

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

Qualified beneficiaries have the opportunity to continue coverage after a qualifying life event which results in the loss of coverage. Qualified beneficiaries must inform the ADOA Benefit Services Division in writing no later than 60 days after the qualifying life event.

If notification is not received within the 60 days of the qualified life event, the qualified beneficiary will not be entitled to choose COBRA coverage.

COBRA coverage may be elected for some qualified beneficiaries but not others, as long as qualified beneficiaries were covered by the Plan on the date of the event (e.g., termination of employment, death, divorce) that led to the loss of regular coverage.

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

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

Changing Your COBRA Benefits

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

A Second Qualified Life Event

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

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

If You and Your Spouse are Both State Employees

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

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.

COBRA Coverage for Dependent Children over 26

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

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

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

Your Contributions

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

When to Pay

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

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

MAXIMUM PERIOD OF CONTINUATION OF COVERAGE

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

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

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

Summary of Monthly Insurance Premiums

Monthly Medical Premiums

Plan	Tier	COBRA Participant Premium
EPO (Aetna, BCBS AZ, Cigna, UnitedHealthcare)	Applicant only Applicant + adult Applicant + child Family	$601.80 $1,277.04 $1,202.58 $1,658.82
PPO (Aetna, BCBS AZ, UnitedHealthcare)	Applicant only Applicant + adult Applicant + child Family	$674.22 $1,424.94 $953.70 1,662.60
HSA (Aetna)	App only Applicant + adult Applicant + child Family	$399.84 $847.62 $566.10 $989.40

Monthly Dental Premiums

Plan	Tier	COBRA Participant Premium
DHMO (Total Dental Administrators)	Applicant only Applicant + adult Applicant + child Family	$9.17 $18.34 $17.86 $27.51
PPO (Delta Dental PPO Plus Premier)	App only Applicant + adult Applicant + child Family	$36.66 $77.14 $61.69 $120.63

Monthly Vision Premiums

Plan	Tier	COBRA Participant Premium
Insured plan (Avesis)	Applicant only Applicant + adult Applicant + child Family	$4.07 $13.20 $13.02 $16.43
Discount card (Avesis)	Applicant	$0.00

What is continuation coverage?

Federal law requires that most group health plans (including this Plan) give employees and their eligible dependents the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee (or retired employee) covered under the group health plan, the covered employee's spouse, and the dependent children of the covered employee.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open enrollment and special enrollment rights.

How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued for up to a total of 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary (note: there are limitations on plans' imposing a preexisting condition exclusion and such exclusions will become prohibited beginning in 2014 under the Affordable Care Act),
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- the employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of participant or beneficiary not receiving continuation coverage (such as fraud).

How can you extend the length of COBRA continuation coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify Member Services at 602.542.5008 or 800. 304.3687 of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

An 11-month extension of coverage may be available if any of the qualified beneficiaries is

determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You or another member of your family must notify the ADOA Benefit Services Office of the disability determination by the Social Security Administration before the end of the 18-month COBRA coverage period. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Plan of that fact within 30 days after SSA's determination.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent's child ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage.

How can you elect COBRA continuation coverage?

To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage.

The required payment for each continuation coverage period for each option is described in this notice.

When and how must payment for COBRA continuation coverage be made?

First payment for continuation coverage
If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) COBRA begins the day after your active coverage ends and is not effective until payment is made. If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact Member Services at 602.542.5008 or 800.304.3687 to confirm the correct amount of your first payment.

Periodic payments for continuation coverage
After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in this notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the 1st day for that coverage period. You may instead make payments for continuation coverage for the following coverage periods, due on the following dates: If you make a periodic payment on or before the first day of the coverage period to which it applies your coverage under the Plan will continue for that coverage period without any break.

Billing statements are mailed as a courtesy. If you do not receive a bill, you may call Member Services at 602.542.5008 or 800.304.3687 for assistance.

Grace periods for periodic payments
Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment.

Payment Information
All Payments shall be made via check or money order payable to ADOA - HITF. If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

Payment address:
Arizona Department of Administration –
Health Insurance Trust Fund (HITF)
100 N. 15th Ave., #202
Phoenix, AZ 85007
Phone – 602.542.5008 or 800.304.3687

This plan is administered by:
Arizona Department of Administration –
Benefit Options
100 N. 15th Ave., #103
Phoenix, AZ 85007
Phone – 602.542.5008 or 800.304.3687

Declining COBRA coverage
To decline COBRA coverage, return the COBRA enrollment form with the "I decline COBRA coverage' option marked. COBRA coverage will not be available to you once it is declined.

Can I enroll in another group health plan?

You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage.

If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you're eligible, you'll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

What factors should I consider when choosing coverage options?

When considering your options for health coverage, you may want to think about:

- Premiums: Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.
- Provider Networks: If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
- Drug Formularies: If you're currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
- Severance payments: If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of time. In this scenario, you may want to contact the Department of Labor at 1.866.444.3272 to discuss your options.
- Service Areas: Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.
- Other Cost-Sharing: In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

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

If you have any questions or need additional information, please visit: *benefitoptions.az.gov* or *cms.hhs.gov/COBRAContinuationofCOV*.

For more information

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator.

If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, you should contact:

Arizona Department of Administration –
Benefit Services Division
100 N. 15th Ave., #103
Phoenix, AZ 85007
Phone – 602.542.5008 or 800.304.3687

For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at *dol.gov/ebsa* or call their toll-free number at 1.866.444.3272.

Keep Your Plan Informed of Address Changes

In order to protect you and your family's rights, you should keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. You can learn more about the Marketplace below.

What is the Health Insurance Marketplace?

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at *HealthCare.gov*. Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

When can I enroll in Marketplace coverage?

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. **After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away.** In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

If I sign up for COBRA continuation coverage, can I switch to coverage in the Marketplace? What about if I choose Marketplace coverage and want to switch back to COBRA continuation coverage?

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." But be careful though - if you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit *HealthCare.gov* or call 1.800.318.2596.

Understanding Your Options

For the plan year beginning January 1, 2016, COBRA participants will have the option of choosing from three plans, four Networks with nationwide coverage, 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			
NETWORK	EPO	PPO	HSA
Aetna	X	X	X
BCBSAZ	X	X	
Cigna	X		
UnitedHealthcare	X	X	

How the Plans Work

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

The EPO Plan

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

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. Choose the Network based on the physicians. The coverage is the same.

HSA (Health Savings Account)

This option is a High Deductible Health Plan for active employees. The Plan allows you open a Health Savings Account to use for qualified medical expenses with investment options available. Services can be obtained 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. In-Network preventive services are covered at 100%. More detailed information on the HSA is available on page 15.

Choosing the Best Plan for You and Your Family

To choose the right plan for you:

1. Assess the costs you expect in the coming year including: premiums, copays, and coinsurance. Refer to page 7 for monthly cost and page 19 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 (on the next page) to help you determine if your doctor is contracted with the Network.
3. Once you have selected which plan best suits your needs and your budget, make your benefit elections.

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

You will receive a new ID card for when COBRA starts.

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®*

Understanding the Health Savings Account Plan (HSA)

Things You Should Know:

1. The HSA Plan is a High Deductible Health Plan that works in conjunction with a HSA:
   - You have the option of establishing a HSA. To establish this account, members must complete the Customer Identification Process (see page 17).
   - HSA is a special type of savings account that allows tax-free contributions, earnings and healthcare related withdrawals.

2. The HSA offers financial advantages in that, an HSA member:
   - Pays lower employee premiums
   - Receives qualified preventive services for free.
   - May have lower out-of-pocket costs.
   - Is eligible to open and contribute to a HSA.

3. The HSA presents financial considerations in that:
   - HSA members pay copays and/or coinsurance after the deductible is met (qualified preventive services are covered at 100%).

4. The HSA might be right for you if:
   - You want to open a tax-advantaged HSA and save for future healthcare costs.
   - You are willing to accept some degree of financial risk.
   - You can afford to pay a high deductible if necessary.

5. The HSA may be wrong for you if:
   - You prefer copays because they are simple and predictable.
   - You are not willing to accept some degree of

financial risk.
- You cannot afford to pay a high deductible.
- You are entitled to benefits under Medicare.

Cost for Services/Prescriptions
The cost for services/prescriptions depends on three things:

1. Whether the service/prescription is:
- Qualified Preventive
- Non-Preventive
- Emergency

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

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

At the top of the table (on the next page) you can see that:
- In-Network qualified preventive services are free, even before the deductible is satisfied.
- In-Network qualified preventive prescriptions will cost the regular copay amounts ($10/$20/$40) up to the out-of-pocket maximum.
- Once the out-of-pocket maximum is satisfied, in-Network qualified preventive prescriptions are covered at 100% for the remainder of the Plan Year.

In the middle of the table you can see that:
- In-Network emergency services will not be covered until after the deductible is satisfied.
- Once the deductible is satisfied, in-Network emergency services will be 90% covered. The remaining 10% must be paid by the member.
- Once the out-of-pocket maximum is satisfied, in-Network emergency services will be 100% covered (no member cost).
- Before enrolling in the HSA, make sure you fully understand the costs/risks of this type of plan.

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

Understanding Health Savings Accounts (HSAs)
The HSA is only offered if you enroll in the High Deductible Health Plan.

HSA Overview
1. You open your HSA.
- You maintain ownership even after ending State employment.
- You can invest the money like you would invest money in an IRA, once funds reach $1,000.
- Your funds will earn interest.

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

3. The Internal Revenue Service sets annual contribution limits. Currently the limits are $3,350 for Employee only and $6,750 for all other tiers.

4. You can spend HSA funds on a tax-free basis for qualified healthcare-related expenditures (defined by the Internal Revenue Service).

- You can use a debit card.
- Link personal bank account to HSA.
- Non-qualified withdrawals are allowed, however, they may be subject to tax and a 20% penalty.

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

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

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

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

About the HSA

The HSA offers the following features:

- No set-up fees
- No monthly administration fee
- No withdrawal forms
- HSA tracking through Aetna Navigator
- Cost Estimator Tool—Cost of Care

There are some fees associated with the HSA, such as:

- Monthy Account Statements
- Bill payment via check
- Stop payment via check
- Non-sufficient funds
- Deposit item returned
- For additional information, please visit the Benefit Options website

Non-Permitted Coverage

- You cannot have a regular Flexible Spending Account or Health Reimbursement Account. If you or your spouse has one of these you are not eligible to contribute to an HSA.
- If you are enrolled in Medicare or Medicaid, you are **not** eligible for an HSA. If you had an HSA when you enrolled in Medicare or Medicaid you can still use the funds. You just cannot contribute to the account. **Note**: If you are eligible for Medicare but not yet enrolled, you can still contribute to the HSA.
- If you are enrolled in Tricare you are not eligible for an HSA. (Tricare is health coverage for people in the military.) If you had an HSA when you started on Tricare you can still use the funds. You just cannot contribute to the account.

- If you receive care from the Veteran's Administration (VA), that may affect your HSA eligibility. Generally, when you receive VA care you are not eligible for an HSA for the next three months. This means that you cannot contribute for the next three months after having VA care.

How To Open Your HSA

Your HSA will be established in your name when you enroll in the High Deductible Health Plan and complete the Customer Identification Process (see below for additional information). You will receive a welcome kit by mail 3-4 weeks after the account is opened. State contributions will only be made if you receive a paycheck.

Using Your HSA

- Use the PayFlex Mastercard to pay for qualified out-of-pocket expenses.
- Invest your HSA funds in a variety of investment options once the funds reach $1,000.
- You can contribute to the HSA as long as you are enrolled in a qualified health plan (such as the HSA). You may use the HSA funds anytime.

Customer Identification Process

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

Here are some common reasons that may cause a delay in opening your HSA:

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

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

Annual Contribution Limits

Individual: $3,350
Family: $6,750

Medical Plan Comparison Charts

		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	Applicant Only	None	$500[2]	$1,000[2]
	Applicant+Adult Applicant+Child Family	None	$1,000[2]	$2,000[2]
Out-of-pocket max	Applicant Only	None	$1,000[2,3]	$4,000[2]
	Applicant+Adult Applicant+Child Family	None	$2,000[2,3]	$8,000[2]
Lifetime max		None	None	None
EMPLOYEE COST FOR CARE				
Behavioral health	Inpatient	$150	$150	50% after deductible
	Outpatient	$15	$15	50% after deductible
Chiropractic		$15	$15	50% after deductible
Durable medical equipment		$0	$0	50% after deductible
Emergency 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 COBRA participant 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/.

		HSA	HSA
Available Plans		**Aetna**	**Aetna**
		IN-NETWORK	**OUT-OF-NETWORK**
Plan Year deductible	Applicant Only	$1,300[1]	$2,600[1]
	Applicant+Adult Applicant+Child Family	$2,600[1]	$5,200[1]
Out-of-pocket max	Applicant Only	$2,000[1]	$5,000[1]
	Applicant+Adult Applicant+Child Family	$4,000[1]	$10,000[1]
Lifetime max		No maximum	No maximum
Behavioral health	Inpatient	10% coinsurance after deductible	50% coinsurance after deductible
	Outpatient	10% coinsurance after deductible	50% coinsurance after deductible
Chiropractic		10% coinsurance after deductible	50% coinsurance after deductible
Durable medical equipment		10% coinsurance after deductible	50% coinsurance after deductible
Emergency ER copay waived if admitted	Ambulance	10% coinsurance after deductible	10% coinsurance after deductible
	ER	10% coinsurance after deductible	10% coinsurance after deductible
	Urgent care	10% coinsurance after deductible	50% coinsurance after deductible
Home health services Maximum visits per year		42	42
Hospital admission (Room and Board)		10% coinsurance after deductible	50% coinsurance after deductible
Mammography		Preventive at no cost Non-Preventive 10% coinsurance after deductible	50% coinsurance after deductible
Office visits Maximum of one copay/day/provider	PCP	Preventive at no cost Non-Preventive 10% coinsurance after deductible	50% coinsurance after deductible
	Specialist[4]	Preventive at no cost Non-Preventive 10% after deductible	50% coinsurance after deductible
	Preventive	Preventive at no cost	50% coinsurance after deductible
	OB/GYN	Preventive at no cost Non-Preventive 10% after deductible	50% coinsurance after deductible
Outpatient services Freestanding ambulatory facility or hospital outpatient surgical center		10% after deductible	50% coinsurance after deductible
Radiology		10% after deductible	50% coinsurance after deductible

1 Copayments apply after the Plan deductible is met. Copayments and Deductible apply to the out-of-pocket maximum. The plan pays 100% after out-of-pocket maximum is met.

Medical Online Features

You can review your personal profile, 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*

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.

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.

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.

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

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

Blue Cross Blue Shield of Arizona

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

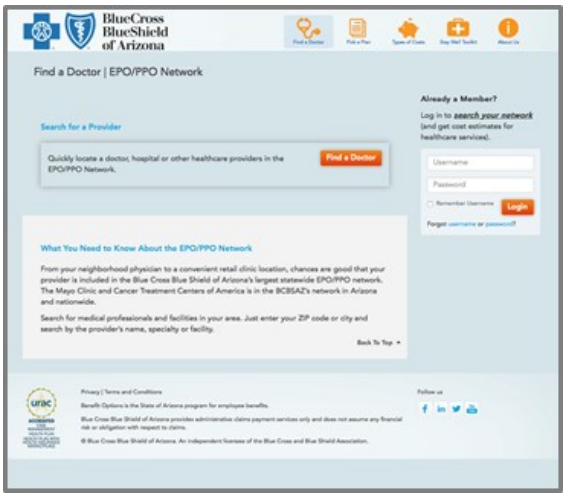
Lookup Provider
Use this tool to find out if your doctor, hospital, retail clinic, or urgent care provider is contracted with Blue Cross Blue Shield of Arizona.

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.

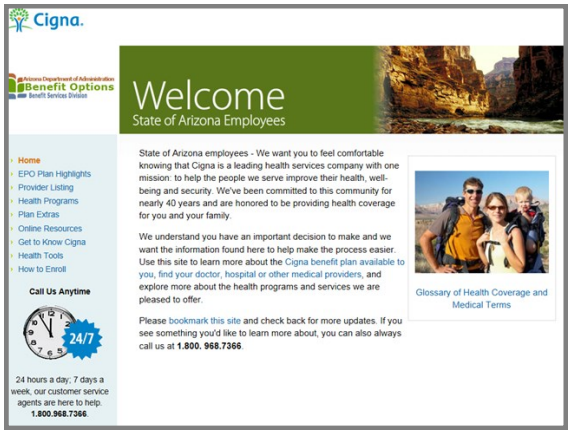
Wellness Tools
You can access wellness information through your personal HealthyBlue homepage.

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 employees 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.

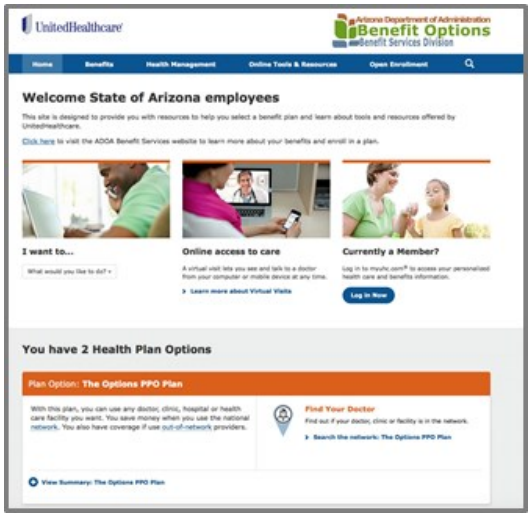
Want a place to keep your personal health information?

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.



Health4Me

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 25 if you or your dependent is interested.

NurseLine

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

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

Network Options Outside of Arizona

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

EPO PLAN	LOCATION	NETWORK
Aetna	Nationwide	Aetna Select Open Access
Blue Cross Blue Shield of Arizona	Nationwide	BlueCard
Cigna	Nationwide	Cigna Open Access Plus
UHC	Nationwide	UHC Choice

PPO PLAN	LOCATION	NETWORK
Aetna	Nationwide	Aetna Choice POS II Open Access
Blue Cross Blue Shield of Arizona	Nationwide	BlueCard
UHC	Nationwide	UHC Options PPO

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

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 30. 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** (offer available to HSA members only when copays apply).
- Payments can be made by check or credit card: Visa, MasterCard, American Express, or Discover.
- Register your e-mail address to receive information on your orders.
- Order refills online at *walgreens.com* or via phone at 1.866.304.2846. Have your insurance card ready when you call!

Choice90

With this program, employees who require medications for an on-going health condition can obtain a 90-day supply of medication at a local retail pharmacy for **two and a half copays.** For more information, contact MedImpact Customer Care Center at 1.888.648.6769.

Medication Prior Authorization

Prescriptions for certain medications may require clinical approval before they can be filled, even with a valid prescription. These prescriptions may be limited to quantity, frequency, dosage or may have age restrictions. The authorization process may be initiated by you, your local pharmacy, or your physician by calling MedImpact at 1.888.648.6769.

Step Therapy Program

Step Therapy is a program which promotes the use of safe, cost-effective and clinically appropriate medications. This program requires that members try a generic alternative medication that is safe and equally effective before a brand name medication is covered. For a complete list of drugs under this program, please refer to the formulary at *benefitoptions.az.gov*.

Specialty Pharmacy Program

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

The program includes monitoring of specific injection drugs and other therapies requiring complex administration methods and special storage, handling, and delivery.

Specialty medications are limited to a 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 Working Abroad

Whether you go to a retail pharmacy or use mail order for your prescriptions, you will need to notify MedImpact in writing of why you are requesting an additional supply of medication, the date when you are leaving, and how long you plan to be gone. MedImpact will be able to authorize a VACATION OVERRIDE allowing you to have the extra medication you will need *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 are using Mail Order, contact MedImpact at least three weeks in advance.

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

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 located. 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
MedImpact BIN Number	003585
Retail PCN Number	28914

Walgreens

Mail Order	1.866.304.2846
Specialty Pharmacy	1.888.782.8443

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

1 *Offer available to HSA members only when copays apply.*

2 *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.*

Pharmacy Online Features

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.

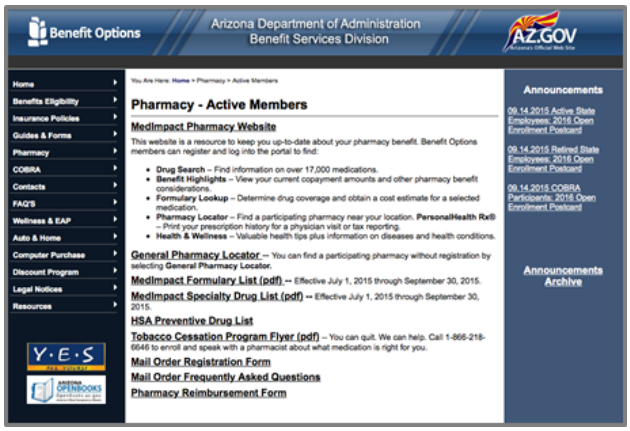
Health & Wellness
Learn valuable tips and information on diseases and health conditions.

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.



COBRA participants may choose between two plan types: the Prepaid/DHMO and the Indemnity/Preferred Provider Organization (PPO) plans. You must choose the same plan as when you were an active employee. 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 <u>not</u> 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 cannot 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, please 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.

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

ID Card

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

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.*

Total Dental Administrators Health Plan (TDAHP), Inc.

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

Participating Providers

You can search for a specific dentist contracted under this plan (Prepaid/DHMO).

Select or Change Participating Provider

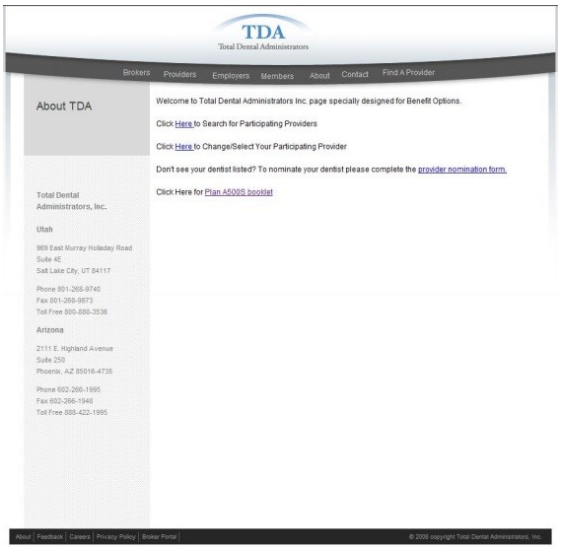
You can select or change your specific participating provider.

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** (iOS and Android) to access your ID card, view coverage and claims details, or find a dentist from your phone or tablet
- Check out the **Delta Dental of Arizona Blog** at *deltadentalazblog*.com for oral health articles and tips
- Assess your risk for dental diseases with the **Oral Health Assessment Tool** at *MyDentalScore.com/DeltaDental*

Vision Plan Information

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

Avesis Advantage Program

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

Program Highlights

- Yearly coverage for a vision exam, glasses or contact lenses
- Extensive provider access throughout the state
- 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 descriptions at *benefitoptions.az.gov.*

Vision Plan 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.*

Vision Online Features

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

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

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

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

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

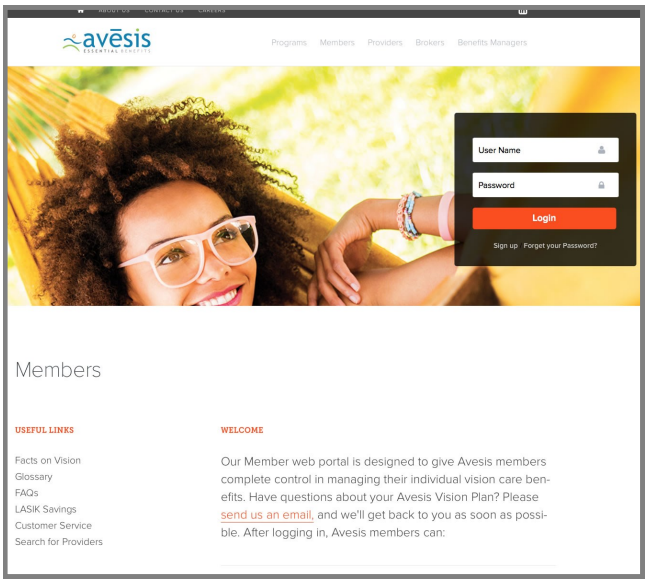
Verifying Eligibility
You can check your eligibility status before you schedule an exam or order new materials.

Plan Policy
You can view your plan policy.

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.



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]
HSA Plan	
Aetna	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.*

Important Plan Information for Participants and Beneficiaries

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 may 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.

Consolidated Omnibus Budget Reconciliation Act (COBRA) 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. 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.

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*.

Accidental Death and Dismemberment (AD&D)
Additional coverage to the Life Insurance policy that pays benefits to the beneficiary for an accidental death or accidental dismemberment, which is the loss of the use of certain body parts.

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.

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

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

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

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

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

Deductible
Fixed dollar amount a member pays before the health plan begins paying for covered medical services. Copays and/or coinsurance amounts may or may not apply (see comparison charts on page 19).

Dependent
An individual other than a health plan subscriber who is eligible to receive healthcare services under the subscriber's contract. Refer to page 3 for eligibility requirements.

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

Emergency
A medical or behavioral condition of sudden onset that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a person who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health

of the insured person in serious jeopardy, serious impairment to bodily functions, serious disfigurement of the insured person, serious impairment of any bodily organ or part of the insured person, or in the case of a behavioral condition, placing the health of the insured person or other persons in serious jeopardy.

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

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

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

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

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

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

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

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

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

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

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

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

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.

Out-of-Pocket Maximum
The annual amount the member will pay before the health plan pays 100% of the covered

expenses. Out-of-pocket amounts do not carry over year to year.

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

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

Pre-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.

Qualified Beneficiary
A COBRA eligible employee and/or dependents who was covered on a Benefit Options medical, dental, and/or vision plan on the day before a qualifying event occurred resulting in the lost of coverage.

Seasonal Employee
An individual who is employed by the State for not more than six months of the year and whose State employment is dependent on an easily identifiable increase in work associated with a specific and reoccurring season. Seasonal employees do not include employees of educational organizations who work during the active portions of the academic year.

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

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

Variable Hour Employee
An individual employed by the state, if based on the facts and circumstances at the employee's start date, for whom the State cannot determine whether the employee is reasonably expected to be employed an average of at least 30 hours per week, including any paid leave, over the applicable 12-month measurement period because the employee's hours are variable or otherwise uncertain.

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