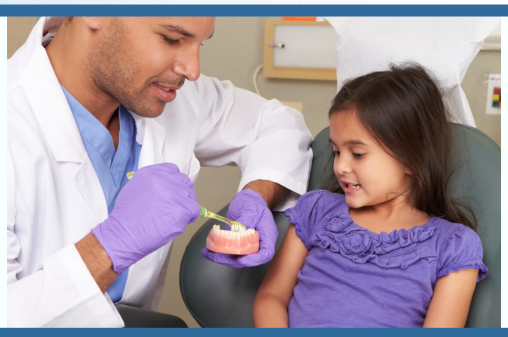
Arizona Department of Administration
Benefit Options
Benefit Services Division

2017
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
Broadspire Services, Inc. (ASRS participants)
1.877.232.0596
broadspire.secure.force.com/eep

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

Retirement Systems
Arizona State Retirement System (ASRS)
1.800.621.3778
Asrsaz.gov

Public Safety Personnel Retirement System (PSPRS)
602.255.5575
Psprs.com

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Welcome to the 2017 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, 2017. 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, covering specific benefits programs or important information. We encourage you to review all your options before making your benefit elections. Additional information specific to active, retiree, or COBRA enrollees is available in specially marked sections.

The actual benefits available to you and the descriptions of these benefits are governed in all cases by the Section 125 relevant plan descriptions and insurance contracts. The State of Arizona reserves the right to modify, change, revise, amend or terminate these benefits plans at any time.

For more detailed 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.

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The 2017 Plan Year is January 1 through December 31, 2017. The Arizona Department of Administration, Benefit Services Division is pleased to announce the following benefit changes effective the 2017 Plan Year.

Virtual Office Visits – Doctor on Demand
Benefit Options is pleased to offer a new benefit enhancement that allows you to have virtual access to medical care via your mobile device, tablet, or computer.

Doctor on Demand has partnered with each of our medical networks to offer 24/7 access to see a doctor right way. You will have access to a face-to-face video visit with a board-certified physician to diagnose, treat and prescribe for common medical issues such as cough, cold, flu, rash, pink eye, sports injury, bug bite, urinary tract infection, and sore throat. The cost for this visit is the same as a Primary Care Physician visit for all Benefit Options Health Plan participants. You can download the app from the App Store, Google Play, or access care via *DoctorOnDemand.com*.

Health Care Center and Pharmacy
The ADOA Benefit Services Division has launched a pilot program with Maricopa County to allow state employee access to the Premise Health Care Center, located one mile from the Capitol Mall.

Premise Health Care Center provides professional services for acute medical services such as a common cold, skin condition evaluations, minor injuries, immunizations and vaccinations, lab service, and onsite pharmacy.

The health center is conveniently located at 301 W. Jefferson #201 and takes same day appointments online at *https://pickatime.com/MaricopaHealthCenter* or by calling 480-347-4791.

HSA Medical Plan
Adjustments have been made to comply with 2017 IRS HSA Contribution Limits. Contribution limits for individuals increased to $3,400. For those with family coverage, the maximum contribution remains at $6,750.

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 provided the primary insured individual with the IRS 1095-C Form to report coverage information for the prior Plan Year.

Active Employees

All active employees regularly scheduled to work 20 hours or more per week for at least 90 days or longer (except those listed below as ineligible) and their qualified dependents may participate in the Benefit Options Programs.

1. Eligible Employee means an individual who is hired by the State, including the Universities, and is regularly scheduled to work at least 20 hours per week for at least 90 days.
2. Ineligible Employee means:

a) A patient or inmate employed at a state institution
b) A Seasonal Employee, unless they are determined to have been paid for an average of at least 30 hours per week using a 12-month measurement period
c) A Variable Hour Employee, unless they are determined to have been paid for an average of at least 30 hours per week using a 12-month measurement period

Retiree

Eligible Retirees

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

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

Eligibility Rules

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

Eligible Dependents

The following dependents may be added to your plans:

A. Your legal spouse as defined by Arizona Statute
B. Your child defined as:

a) Your natural child(ren) under 26 years old, including adopted child, step-child, foster child, or child for whom you have court-ordered guardianship.
b) Your child who is disabled and continues to be disabled as defined by 42 U.S.C. 1382c before the age of 26.

If you have a qualified dependent that is not currently enrolled in the Benefit Options Plan, he or she may be added during an Open Enrollment period. Dependents not enrolled

during Open Enrollment cannot be added until the next Open Enrollment unless there is a QLE. You have 31 days from the date of the QLE to change your enrollment through ADOA, Benefit Services Division. The change must be consistent with the event. Please refer to the Benefit Services website, *benefitoptions.az.gov,* for more information about QLEs.

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

Dependent Documentation Requirements

Proper documentation may be required after enrollment of a dependent if:

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

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

Please refer to the Summary Plan Document for a complete list of eligible and ineligible dependents and eligibility requirements

Employees will be required to provide Social Security Numbers (SSN) for all dependents enrolled in the Benefit Options medical plans. This requirement is in accordance with the Mandatory Insurer Reporting Law (Section 111 of Public Law 110-173) which was effective January 1, 2009.

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.

Qualifying Life Events

You may only change your benefit elections when you experience a Qualified Life Event (QLE). If you have not experienced a QLE, you must wait until the next open enrollment period to make benefit changes. Events that may be considered include but are not limited to:

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

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

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

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

Please consult with the Benefit Services Division to determine whether or not the life event you are experiencing qualifies under the Section 125 regulations.

Dual Coverage

If you and your spouse are both State employees and/or retirees, dual coverage of an employee, spouse and dependent, is not permitted under this Plan. An employee may elect coverage for their entire family, including the State employee spouse, or each State employee spouse may elect their own coverage.

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

Eligibility Audit

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

Subrogation

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

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

Return to Work Retirees

Former retired State employees returning to active State employment can receive health benefits through the Benefit Options Plan. If a retiree returns to work and meets the eligibility guidelines, they can elect to enroll in Active benefits and decline retiree benefits. Leaving State employment is considered a QLE. The QLE then allows members to enroll in retiree benefits again.

Continuing Eligibility through COBRA

In accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), if you experience a loss of coverage due to termination of employment or a qualifying event, you and/or your dependents may extend coverage under the Benefit Options Plan for a limited period of time.

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.
-

The ADOA Benefit Services Division will determine final eligibility for COBRA coverage. *to determine whether or not the life event you are experiencing qualifies under the Section 125 regulations.*

How the Plans Work

Medical Plan

There are three medical plans offered 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 benefit is the same.
*Available to Active Employees, Retirees, and COBRA participants.

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 before the copay or coinsurance applies. Under the PPO plan, you will pay the monthly premium and the plan deductible or 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 benefit is the same.
*Available to Active Employees, Retirees, and COBRA participants.

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 8.
*Available to Active Employees and COBRA participants.

Choosing the Best Plan for You and Your Family

To choose the right plan for you:

1. Assess the costs you expect in the coming year including: employee premiums, copays, and coinsurance. Refer to page 12 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 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 online.

Transition of Care (TOC)

If you are undergoing an active course of treatment with a doctor who is not contracted with one of the Networks, you can apply for transition of care. TOC forms are available on the Benefit Options website *benefitoptions.az.gov.*

If you are approved, you will receive in-Network benefits for your current doctor during a transitional period after January 1, 2017. 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.

ID Cards

ID cards are provided only to members who are newly enrolled or make a change to their benefit plan. Personal insurance cards arrive 7-14 business days after the benefit becomes effective.

A new card or replacement ID card can be obtained by contacting the appropriate vendor to request a card, print card via the vendor website, or by downloading the vendor app on your mobile device.

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 Health Savings Account:
– You have the option of establishing a Health Savings Account. To establish this account, members must complete the Customer Identification Process (see page 10).
– 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 (paycheck deductions).
– Receives qualified preventive services at no cost.
– May have lower out-of-pocket costs.
– Is eligible to open and contribute to a Health Savings Account.

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.

Non Permitted Coverage: Members and dependents (including spouses) enrolled in a HSA do not qualify for a traditional Medical Flexible Spending Account; instead they qualify for a Limited Flexible Spending Account. The only qualifying expenses for this Limited Flexible Spending Account are dental and vision care expenses.

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.

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 covered at no additional cost, 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 Services

Preventive service 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 Health Savings Account is only offered if you enroll in the High Deductible Health Plan.

HSA Overview

1. You open your Health Savings Account.
– 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. When your HSA is opened, the State will make pay period contributions to your HSA.
– For Employee only coverage, the State will contribute $27.69 per pay period.
– For Employee+adult, Employee+child, and Family coverage, the State will contribute $55.38 per pay period.
3. You can make additional contributions to your HSA through:
– Payroll deductions (pre-tax).
– Lump-sum deposits (tax deductible).
4. The IRS has released new 2017 Health Savings Account (HSA) Limits. Contribution limits for individuals will increase from $3,350 to $3,400. For those with family coverage, the maximum contribution remains the same at

$6,750.

5. 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.

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

– Monthly Account Statements
– Bill payment via check
– Stop payment via check
– Non-sufficient funds

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. The State will start contributing to your account on the first pay cycle following the plan year effective date. State contributions will only be made if you receive a paycheck.

Using Your HSA

– Use the 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: $3,400
Family: $6,750

Medical Plan Information

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	

		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	EmpOnly	None	$500[2]	$1,000[2]
	Emp+Adult Emp+Child Emp+Family	None	$1,000[2]	$2,000[2]
Out-of-pocket max	EmpOnly	None	$1,000[2,3]	$4,000[2]
	Emp+Adult Emp+Child Emp+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, *including telemedicine*	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 employee goes out-of-Network 0% covered, except in emergency situations.*
2 *Copayments apply after the Plan deductible is met. Copayments and Deductible apply to the out-of-pocket maximum.*
3 *The Plan pays 100% after out-of-pocket maximum is met.*
4 *All Mayo Clinic Primary Care Physicians (PCP) are contracted with Cigna HealthCare as specialists, therefore all primary care services administered by Mayo PCPs will be subject to the $30 specialist copayment.*

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

Medical Plan Comparison Charts

		HSA	HSA
Available Plans		**Aetna**	**Aetna**
		IN-NETWORK	**OUT-OF-NETWORK**
Plan Year deductible	EmpOnly	$1,300[1]	$2,600[1]
	Emp+Adult Emp+Child Emp+Family	$2,600[1]	$5,200[1]
Out-of-pocket max	EmpOnly	$2,000[1]	$5,000[1]
	Emp+Adult Emp+Child Emp+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.*

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 iPhone 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*

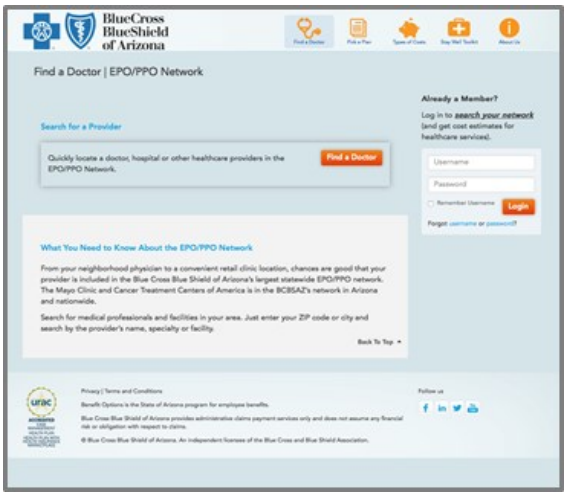
Lookup Provider
Use this tool to find out if your doctor, hospital, retail clinic, or urgent care provider is contracted with Blue Cross Blue Shield of Arizona.

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.

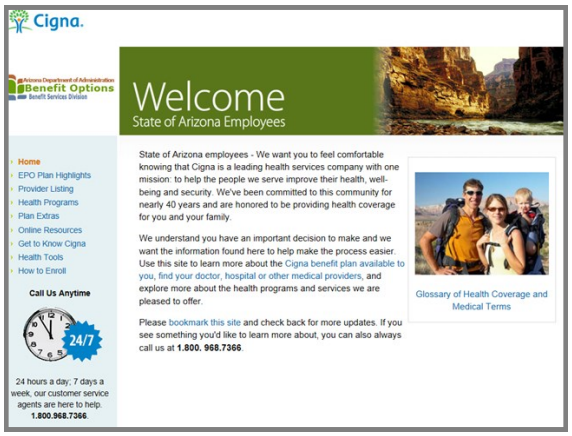
Wellness Tools
You can access wellness information through your personal HealthyBlue homepage.

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.

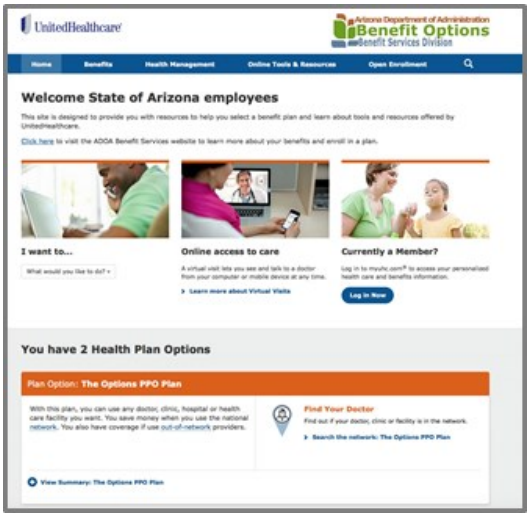
Want a place to keep your personal health information?

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.



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 18 if you or your dependent is interested.

NurseLine

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

Aetna 1.800.556.1555
Blue Cross Blue Shield of Arizona
1.866.422.2729, Option 9
Cigna 1.800.968.7366
UnitedHealthcare 1.800.401.7396

MedImpact

If you elect any Benefit Options medical plan, MedImpact will be the Network you use for pharmacy benefits. Enrollment is automatic when you enroll in the medical plan.

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

ID Card

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

How it Works

All prescriptions must be filled at a Network pharmacy by presenting your medical card. You can also fill your prescription through the mail order service. **The cost of prescriptions filled out-of-Network will not be reimbursed**.

No international pharmacy services are covered. Be sure to order your prescriptions prior to your trip and take your prescriptions with you.

The MedImpact plan has a three-tier formulary described in the chart on page 22. 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 Travel Abroad

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

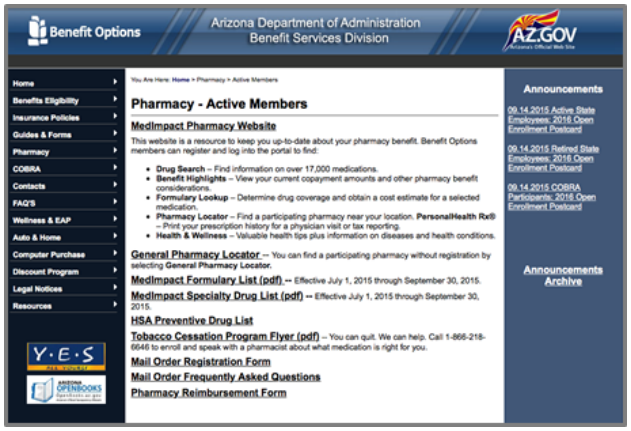
Health & Wellness
Learn valuable tips and information on diseases and health conditions.

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.



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

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

- You MUST use a Prepaid/DHMO Participating Dental Provider (PDP) to provide and coordinate all of your dental care in Arizona
- No annual deductible or maximums
- No waiting periods
- Pre-existing conditions are covered
- Specific copays for services
- Specific lab fees for prosthodontic materials

Each family member may choose a different general dentist from the TDAHP Arizona DHMO provider network. You can select or change your dentist by contacting TDAHP by telephone or using the "change my dentist" function on the website *TDAdental.com/adoa*. Members may self-refer to dental specialists within the Network. Specialty care copays are listed in the plan booklet. Specialty services not listed are provided at a discounted rate. This discount includes services at a Pedodontist, Prosthodontist, and TMJ care.

Indemnity/PPO Plan – Delta Dental PPO plus Premier

As a State of Arizona eligible member you can enroll in the Delta Dental of Arizona – PPO plus Premier plan with covered preventive services.

- Your preventive and diagnostic services are covered at 100% and are <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.*

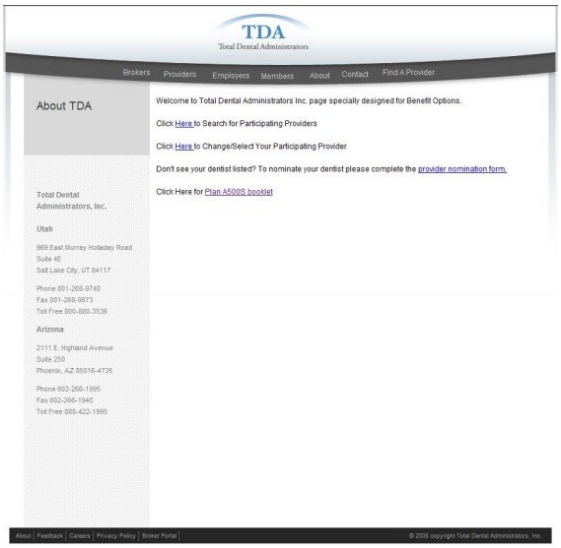
Total Dental Administrators Health Plan (TDAHP), Inc.
If you are enrolling with TDAHP go to *TDAdental.com/adoa* to access the online features described below:

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.

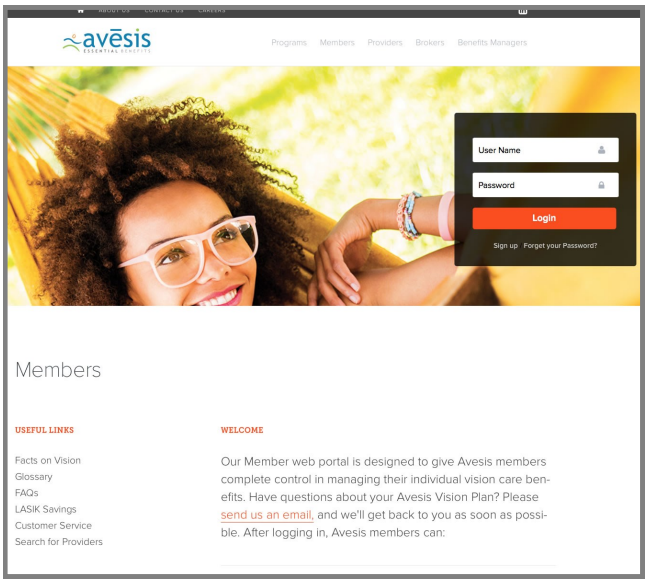
Verifying Eligibility
You can check your eligibility status before you schedule an exam or order new materials.

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*.

Arizona Department of Administration
Benefit Options
Benefit Services Division

Active State Employees

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Where to Enroll - State Employees

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

Y.E.S. Login

1. Open the Y.E.S. website at *yes.az.gov.*
2. Click Login located on the **right portion** of the Y.E.S. website.
3. In the Login window, enter your Username and Password, then click the Login tab.
4. Once you are logged into Y.E.S., click the Open Enrollment link on the left navigational bar.
5. Follow the instructions to begin your benefit elections.
6. Save and print your confirmation.

First Time Y.E.S. Users

1. Open the Y.E.S. website at *yes.az.gov.*

2. Click Login located at the bottom of the Y.E.S. homepage.

a) In the Login window, enter your Employee Identification Number (EIN) as your Username, which is the five or six digit number given to you by your Human Resources Office.

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

3. Once you are logged into Y.E.S., click the Open Enrollment link on the left navigation bar.

4. Follow the instructions to begin your benefit elections.

5. Save and print your confirmation.

How to Reset your Password

If you forgot your password, you may visit the Y.E.S. website to reset your password. In order to update your password, you must have previously answered the security questions. If you have not answered the questions, you must have your password reset manually. Contact the HRIS Help Desk by calling 602.542.4700 or via email at hrishelpdesk@azdoa.gov.

If you have answered the security questions, you may reset your password by completing the following steps:

1. Open the Y.E.S. website at yes.az.gov.
2. Click Login.
3. In the Login window, enter your User Name (EIN).
4. Click the Forgot/Change Password link.
5. Enter your New Password and then reenter to verify.
6. Answer BOTH Security Questions.
7. Click Update Password.

Arizona State University

1. Go to *cfo.asu.edu/enrollment-faqs* for step-by-step enrollment instructions (read "How do I enroll or make changes?").

2. Questions? **Call** Employee Services 855-278-5081 or Faculty Services 480-727-9900; **email** HRESC@asu.edu; **Learn more** at cfo.asu.edu/benefits-open-enrollment

Northern Arizona University

1. Log into LOUIE using your employee ID and password.

2. Select "Self Service" from the left menu.

3. Under "Benefits" select Benefits Enrollment.

4. On the Benefits Enrollment page there will be an Open Enrollment event. To begin click "Select."

5. **IMPORTANT:** After making your elections, click Submit.

6. After you verify your elections, click the Submit button again to authorize your elections.

7. When your confirmation appears, click "OK."

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

University of Arizona

1. Go to UAccess Employee at uaccess.arizona.edu/ and select "Employee/ Manager Self Service".

2. Log in with your UA NetID and password.

3. On the UA Employee Main Homepage, select the Benefits tile.

4. Select "Benefits Enrollment".

5. Click the "Select" button for your Enrollment event. If you do not see an open event, contact Human Resources at 520-621-3660 or to hrsolutions@email.arizona.edu.

Summary of Pay Period Premiums (26 pay periods)[1]

Medical Pay Period Premiums					
Plan	**Tier**	**Employee Premium**	**State Premium**	**Total Premium**	**Agency HSA Contribution**
EPO (Aetna, BCBSAZ,Cigna, UnitedHealthcare)	Emp only	$18.46	$253.85	$272.31	-
	Emp+adult	$54.92	$521.54	$576.46	-
	Emp+child	$46.62	$338.77	$385.39	-
	Family	$102.00	$571.38	$673.38	-
PPO (Aetna, BCBSAZ, UnitedHealthcare)	Emp only	$47.08	$258.00	$305.08	-
	Emp+adult	$99.23	$545.54	$644.77	-
	Emp+child	$66.46	$365.08	$431.54	-
	Family	$115.85	$636.46	$752.31	-
HSA (Aetna)	Emp only	$9.23	$171.69	$180.92	$27. 69
	Emp+adult	$27.69	$355.85	$385.54	$55.38
	Emp+child	$23.54	$232.62	$256.16	$55.38
	Family	$51.23	$396.46	$447.69	$55.38

Dental Pay Period Premiums				
Plan	**Tier**	**Employee Premium**	**State Premium**	**Total Premium**
Total Dental Administrators Prepaid	Emp only	$1.86	$2.29	$4.15
	Emp+adult	$3.72	$4.58	$8.30
	Emp+child	$3.50	$4.58	$8.08
	Emp+family	$6.12	$6.32	$12.44
Delta Dental PPO plus Premier	Emp only	$14.30	$2.29	$16.59
	Emp+adult	$30.33	$4.58	$34.91
	Emp+child	$23.34	$4.58	$27.92
	Emp+family	$48.26	$6.32	$54.58

Vision Pay Period Premiums		
Plan	**Tier**	**Employee Premium**
Insured plan (Avesis)	Emp only	$1.84
	Emp+adult	$5.97
	Emp+child	$5.89
	Family	$7.43
Discount card (Avesis)	Emp	$0.00

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

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

Summary of Pay Period Premiums (26 pay periods)[1]

Supplemental Life and AD&D Plan	
Your Age	Cost per $5,000/pay period
29 AND UNDER	$0.18
30-34	$0.23
35-39	$0.25
40-44	$0.44
45-49	$0.60
50-54	$0.97
55-59	$1.38
60-64	$2.49
65-69	$2.49
70+	$3.95

Dependent Life and AD&D Plan The Hartford	
Coverage Amount	Cost per Pay Period
$2,000	$0.43
$4,000	$0.87
$6,000	$1.30
$10,000	$2.17
$12,000	$2.60
$15,000	$3.25
$50,000[2]	$10.85

Short-Term Disability Plan The Hartford
Employee Cost/Monthly
$0.39 per $100 of your earned monthly wages
Monthly premium = (Earned monthly wages/100) x $0.39
Example: Earned monthly wages = $1,000
Monthly premium = ($1,000/100) x $0.39 = $3.90

1 UA has 24 pay period deductions; ABOR, ASU, NAU and UA have other options for Life and Short-Term Disability insurance. Please refer to your Human Resources website for more information.

2 Only available if employee also carries a minimum of $35,000 in additional supplemental life.

The Hartford

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

Basic Life Insurance and AD&D

You are automatically covered for $15,000 of basic life insurance provided by the State at no cost to you. Non-smokers will receive an additional $1,000; eligibility is determined at the point of claim.

The State also pays for $15,000 of AD&D insurance coverage. A $15,000 Seat Belt Benefit may also be payable if you die in an automobile accident and are wearing a seat belt. You are automatically covered in these three programs if benefit eligible.

Supplemental Life Insurance

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

You may elect to increase or decrease your supplemental life and AD&D coverage only during Open Enrollment.

You may increase coverage in increments of $5,000 up to $20,000 not to exceed the maximum benefit of $500,000 or three times your annual salary, whichever is less. You can also decrease your coverage in increments of $5,000 or cancel coverage.

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

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

Remember: adding a beneficiary does not automatically delete a previously-designated beneficiary. If you wish to change a previously designated beneficiary, you must actively do so while enrolling or as needed throughout the year. Changes can be made on the Y.E.S. website.

Dependent Life Insurance

You may purchase life insurance coverage for your dependents in the amount of $2,000, $4,000, $6,000, $10,000, $12,000, $15,000, or $50,000. You do not have to elect any supplemental coverage with The Hartford for yourself in order to choose this dependent plan for up to $15,000. **For the $50,000 coverage, you must have a combined basic and supplemental coverage of at least $50,000**. Each person will be covered for the amount you choose for a small employee premium. In the event of a claim, you are automatically the beneficiary.

Life Insurance Waiver of Premium

The Hartford provides a Waiver of Premium provision under the Life Insurance provided to eligible State of Arizona employees. Waiver of Premium is a provision which allows insured employees to continue the employee's and the employee's dependent's Life Insurance coverage **without** paying a premium if the employee:

- becomes disabled (as defined in the Life Insurance Policy) prior to age 65 and provides proof within one year,

- remains disabled for at least six consecutive months (elimination period). Premium payment is required during the elimination period.

Coverage continues while the employee remains disabled for the duration specified in the contract even if the Group Life Policy terminates. Any dependent coverage will terminate if the Group Life Policy terminates.

What does disabled mean?
Disabled means you are prevented by injury or sickness from doing any work for which you are, or could become qualified by:
- education;
- training; or
- experience.

In addition, you will be considered disabled if you have been diagnosed with a life expectancy of 12 months or less.

The Hartford makes the determination of disability to qualify for Waiver of Premium for your Life Insurance.

Filing a Life Insurance Waiver of Premium Claim
If you are enrolled in The Hartford Long-Term Disability (LTD) plan, a Waiver of Premium will be automatically considered and no claim filing will be required. ***Approval for LTD does not automatically approve Waiver of Premium for Life Insurance***.

If you are not enrolled in The Hartford Long-Term Disability (LTD) plan because you are an Arizona State Retirement System (ASRS) participant, and you expect to be out for longer than 90 days from the date of illness or injury, it is necessary for you to initiate review for Waiver of Premium. Call The Hartford at 1.866.712.3443, 7am to 6pm, Monday through Friday.

Note: This summary is an overview of the Waiver of Premium provision under the State of Arizona Life Insurance policy with The Hartford. It is provided for illustrative purposes only and is not a contract. In the event of any difference between the summary and the Insurance certificate-booklet, the terms of the Insurance certificate-booklet apply.

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

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

The Hartford

Benefit Options offers short-term disability insurance by The Hartford. STD Insurance is voluntary insurance where you pay the entire premium.

If you are unable to work due to a non-work related injury (as determined by The Hartford), you may receive a weekly benefit for up to 26 weeks. If you are unable to work due to illness or pregnancy, you may receive a weekly benefit after your benefit waiting period for up to 18 or 22 weeks. The STD benefit pays up to 66-2/3% of your weekly pre-disability earnings. You must meet the actively-at-work provision.

Short-Term Disability

The Hartford Short-Term Disability premium will be reduced from $0.65 to $0.39 per $100 of your earned monthly wages. The example below shows this reduction results in a savings directly back to you.

EXAMPLE	2016	2017
Your Earned Monthly Wages	$2,000	$2,000
Your Monthly Premium	$13.00	$7.80
A $5.20 monthly savings.[1]		

1 Results will vary due to payroll rounding and individual wages.

How STD Works

If you elect Short-Term Disability (STD) insurance and The Hartford determines you are unable to work due to illness, pregnancy, or a non-work-related injury, you may receive a weekly benefit for up to 26 weeks for an injury, 22 or 18 weeks for illness. The STD benefits will pay up to 66-2/3% of your pre-disability earnings during your disability. The weekly minimum benefit is $57.69; the weekly maximum benefit is $769.27. There are no pre-existing conditions or limitations. You must meet the actively-at-work provision.

Offsets to Paid Benefits

Paid benefits will be offset after the benefit elimination period is exhausted by any sick, annual and donated leave paid to you.

Weekly Minimum	Weekly Maximum[1]
$57.69	$769.27

1 Benefits are reduced by 100% of any sick, annual, and donated leave paid to you after the benefit waiting period.

If The Hartford has determined an overpayment has been paid, The Hartford has the right to recover any amount from you. You have the obligation to refund The Hartford any such amount. Contact your agency regarding the requirements for using sick and annual time when on a leave of absence.

Coverage Effective Dates

If you previously waived STD coverage and enroll during Open Enrollment, your insurance becomes effective on January 1, 2017.

Benefit Effective Dates/Waiting Periods

Your benefits will start on your first day of disability due to **non work-related injury** or the 31st day of disability due to illness or pregnancy, if coverage was elected during your initial new hire/eligibility enrollment period. If you elect coverage after your initial new hire/eligibility enrollment period and become disabled during the first 12 months of being covered under the plan, your benefits will start on the 61st day of disability due to illness or pregnancy.

Disabled and Working Benefits

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

Weekly Benefit Calculation under the Disabled and Working Formula

$$\frac{(A - B)}{A} \times C$$

A = weekly pre-disability earnings (what the STD

plan benefit is based on).
B = your current weekly earnings (earnings while disabled).
C = the weekly STD benefit payable if a claimant were totally disabled.

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

Assume an employee is covered by the STD plan. The employee's covered earnings (base earnings) are $1,000 a week. The employee wants to return to work part-time and is able to do so on a reduced schedule.

A = $1,000; this is what the employee was making weekly prior to being disabled.
Assume B = $300; this is what the employee is making now on a part-time basis, reduced schedule, while still being considered disabled.
C = $667; this is the STD benefit the employee would receive if the employee was not working at all ($1,000 x the STD benefit percentage of 66 2/3%).

The Benefit the employee will receive under the Disabled and Working formula is:

$467=($1,000-$300) X $667 = $1,000

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

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

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

Arizona State Retirement System (ASRS) Participants

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

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

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

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

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

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

Changing Retirement Systems

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

Life/STD/LTD Online Features

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

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

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

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

Filing a Claim
File a claim in one of the following ways:
Call The Hartford: 1.866.712.3443
Online at: thehartfordatwork.com

Mobile App:
Download the free app from your mobile device by searching for "My Benefits at The Hartford" at the Apple® App StoreSM or Google PlayTM Store.

Your Booklets
Find booklets with important information about Life, Short-Term Disability and for non-ASRS employees Long-Term Disability information.

Claims
Learn how to file a claim.

Check Your Claim Status
View the status of all your claims submitted at *thehartfordatwork.com* or at My Benefits Claims Mobile App.

The Hartford has gone mobile with employee benefits! The new My Benefits claims mobile app is now available to download for free from the Apple® App StoreSM or Google PlayTM Store.

Now you can get the answers regarding your disability claim faster, right from your mobile device. Here are just some of the convenient and secure features of the new app:

- Start a Short-term Disability claim
- Check the status of your claim
- Review claim payment history
- Enroll in direct deposit and update bank information for your claim payment
- View Claim Handler contact information

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

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

MyTomorrow
The Hartford is providing you with an online tool to help you better understand your Short-term Disability and Supplemental Life insurance. This tool is designed to help you:
· Make smart, affordable benefit choices.
· Get empowered to help protect your income.

It's called **MyTomorrow**SM. Get quick access to key benefit details, real-life stories and more - *thehartford.com/benefits/Arizona.*

UNIVERSITY FACULTY AND STAFF: Please refer to your Human Resources website for additional

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

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

BeWell Programs and Services

The Health Impact Program (HIP) is a Wellness component of the total Benefit Options Plan. HIP is an incentive based employee wellness program for all benefits eligible State of Arizona employees. Through engagement and completion of designated activities, employees will earn points and have the opportunity to receive up to $200 upon reaching the 500 point goal by the end of the program. HIP is designed to promote and encourage health and well-being of state employees through sustained engagement in a variety of challenges, preventive health activities and screenings.

New for 2017!

Benefits Options has partnered with Total Well-Being as the State's Wellness portal vendor. Program participation will begin through registration on the new Total Well Being Strive online portal. This confidential, personalized system will grant employees access to the Health & Well-Being Assessment, wellness challenges, health information and resources, telephonic health coaching and also serve as the tool for self-reporting all other HIP approved activities. Accommodations will be made available to support employees with access issues. Look for more program details and guidelines in January by visiting *benefitoptions.az.gov/wellness*.

Mini-Health Preventive Screenings

The worksite mini-health screening focuses on prevention and early detection of heart disease and diabetes. Tests included in this screening are the full lipid panel, blood pressure, body composition, and blood glucose measures. Our vendor also offers optional screens such as osteoporosis, facial skin analysis, or a Prostate Specific Antigen (PSA).

Mobile Onsite Mammography (MOM)

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

Prostate Onsite Project (POP)

Early detection is the best defense against prostate cancer. Wellness contracts with POP to provide free, convenient prostate cancer screenings at the worksite with a mobile medical unit. The doctor on board performs a PSA blood test, digital rectal exam (DRE), testicular exam, and a doctor consultation.

Fees for Wellness Services

There are no costs to you for the preventive onsite wellness services. If you choose optional screenings you will pay the vendor directly. *PPO members who have not reached their deductible will pay co-insurance.*

Flu Vaccine Program
September - December, 2017

Wellness provides free flu shots at many State worksites and public clinic locations for employees. Locations and more information can be found on the Wellness website at *benefitoptions.az.gov/wellness*. Employees can choose from four session dates and register for one session monthly. First time eMindful users will be required to create a new account, using their Employee Identification Number (EIN) as

the "Unique ID" when prompted. University employees must use their Health Insurance ID Number (UA employees) OR Campus ID number (ASU employees) as their "Unique ID." To register go to *adoa.emindful.com*.

Employee Assistance Program (EAP)
EAP is a confidential Wellness benefit that provides short-term counseling to employees, their spouses, and their dependents. Employees can access twelve free counseling sessions to help with personal issues, coping with a loss, stress and anxiety, or financial concerns. ADOA offers an EAP contract which serves most State agencies.

The ADOA EAP website and phone number are available 24/7 for local resources, informational articles, and counseling at *guidanceresources.com* or 1.877.327.2362. The ADOA company code for use of services is HN8876C*. Other EAP contracts that serve State agencies can be found at benefitoptions.az.gov/ wellness.*

Benefit Options Wellness wants you to be your best. The contracted EAP providers offer free, confidential, short-term counseling services for you and your family. The free counseling can help handle concerns or issues constructively, before they become a major problem. In addition to counseling, EAP offers work-life benefits and referrals to local affordable resources.

Please call your agency's Employee Assistance Program phone number listed below:

Agency	Contracted EAP	Phone Number	TDD/TTY
ADOA* ADEQ ADOT AHCCCS DCS DES DOC DPS	ComPsych To access helpful online resources and to see all of the services ComPsych provides, visit *guidanceresources.com*. Register using company code HN8876C. You can also log in and view a webinar to learn more about ComPsych services by clicking on "Understanding Your GuidanceResources Program," which is located on the right hand side of the web page under "Recommended."	877-327-2362	800-697-0353
ASU	Employee Assistance Onsite Visit *cfo.asu.edu/hr-eao.* The ASU Employee Assistance Office provides both personal and work-related counseling and managerial consultation. Services include assessment, referral, brief counseling, worksite crisis support and educational workshops to all benefits eligible faculty, staff, their dependents and household members. All services are voluntary, confidential and provided at no cost to eligible participants.	480-965-2271	
UA	Employee Assistance Onsite Visit *lifework.arizona.edu/ea*. Services are free, voluntary, and confidential and are available to all benefits-eligible UA employees as well as departments or workgroups.	520-621-2493	
NAU	Employee Assistance Program https://connect.az.gov/	928-523-1552	

**Agencies, Boards, and Commissions not listed above are covered under the ADOA ComPsych contract.*

UNIVERSITY FACULTY AND STAFF: *Please refer to your Human Resources website for employee assistance and wellness services available to you.*
ASU/ABOR: *https://cfo.asu.edu/employee-assistance-wellness*
NAU: *https://nau.edu/EAW/Welcome/*
UA: *https://lifework.arizona.edu/ea/employee_assistance, https://lifework.arizona.edu/wsw*

Flexible Spending Accounts

Employees have the option to open Medical and/or Dependent Care (child care) Flexible Spending Accounts (FSAs) administered by ASI.

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

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

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

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

Medical FSA

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

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

Dependent Care FSA

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

Note: Dependent medical and/or other expenses should be submitted through the medical FSA not the dependent care FSA. IRS regulations may require your contribution be reduced by ADOA as a result of IRS non-discrimination testing requirements.

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

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

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

File a Claim

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

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

Submitting a Claim Form

You can:

- Fax your claim and documentation, toll-free to ASI at 1.877.879.9038
- Mail the claim form and documentation to the location indicated on the claim form, or
- Submit your claims online at *asiflex.com*. You need your ASI-assigned PIN, along with your State of Arizona employee Identification number (EIN), if you have not previously set up a user name and password. All documentation must be scanned into a PDF format.
- File a claim using the ASIFlex mobile app on your smart phone or tablet.

Reimbursement

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

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

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

You have from January 1, 2017 through December 31, 2017 to use account funds.

All the claims for medical and dependent care expenditures must be filed with ASI prior to March 31, 2018 for reimbursement.

End of Employment

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

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

Note: Members and dependents (including spouses) enrolled in a Health Savings Account (HSA) do not qualify for a traditional Medical FSA; instead they qualify for a Limited Flexible Spending Account. The only qualifying expenses for a Limited Flexible Spending Account are dental and vision care expenses. Please see page 49 for more details.

ASIFlex Mobile App

Using your **phone or tablet**, the ASIFlex mobile app allows you to file claims and view your FSA account!

The claim filing feature allows you to capture documentation using the mobile device's camera feature and submit that documentation with the claim. The mobile app also allows you to use the microphone feature on smart devices to enter claims. This means you can choose to speak, rather than type, some of the claim information. In addition to filing claims, you can view the annual election amount, account balance, payments, contributions and previously submitted claims.

The app is free and available online at *asiflex.com* or through Google Play™ or the Apple Store℠.

FLEXIBLE SPENDING ACCOUNTS

	MEDICAL CARE	DEPENDENT CARE
Maximum Contributions	$2,550 annually	$5,000 annually ($2,500 if married and filing separately)
Minimum Contributions	$130 annually	$260 annually
Use of the Account	• To pay (with pre-tax money) for health-related expenses that are not covered or only partially covered, including expenses for your spouse or children not enrolled in your medical, dental, or vision plans	• To pay expenses for care of dependent provided by a non-dependent • To pay care provided for your children under the age of 13 for whom you have custody, for a spouse who is disabled or other dependents who spend at least eight hours a day in your home • To pay dependent care provided so that you can work
Samples of Eligible Expenses	• Copays • Deductibles • Coinsurance • Dental fees • Eyeglasses, exam fees, contact lenses and solution, LASIK surgery • Orthodontia	• Services provided by a day care facility. Must be licensed if the facility cares for six or more children • Babysitting services while you work • Day Camp
What's Not Covered	• Premiums for medical or dental plans • Items not eligible for the healthcare tax exemptions by IRS • Long-term care expenses	• Private school tuition including kindergarten • Overnight camp expense • Babysitting when you are not working • Transportation and other separately billed charges • Residential nursing home care
Restrictions/ Other Information	• See IRS Publication 502 (expenses in this plan qualify based on when the services are provided regardless of when you pay for the expense) or go to ASI's website at *asiflex.com* for specific details on what expenses are allowed • You cannot transfer money from one account to the other • Your election amount may be increased (but not decreased) if you have a qualified life event	• See IRS Publication 503 (expenses in this plan qualify based on when the services are provided regardless of when you pay for the expense) or go to ASI's website at *asiflex.com* for specific details on what expenses are allowed • You may not use the account to pay your spouse, your child who is under 19 or a person whom you could claim as a dependent for tax purposes • You cannot change your election unless you have a qualified life event • Your election may be changed by ADOA as a result of non-discrimination testing requirements

Deciding How Much to Deposit Into Your Flexible Spending Accounts

Estimate the amount you expect to pay during the plan year for eligible, uninsured out-of-pocket medical and/or dependent expenses. This estimated amount cannot exceed the established limits (Medical limit = $2,550; Dependent Care limit = $5,000). Be conservative in your estimates, since any money remaining in your accounts will be forfeited.

Note: IRS Regulations may require us to reduce your contribution.

TAX-FREE MEDICAL EXPENSE WORKSHEET	TAX-FREE DEPENDENT CARE WORKSHEET
Estimate your eligible, uninsured out-of-pocket medical expenses for the plan year, which is January 1, 2017 through December 31, 2017.	Estimate your eligible dependent care expenses for the plan year, which is January 1, 2017 through December 31, 2017.
YOUR OUT-OF-POCKET MEDICAL, DENTAL AND VISION EXPENSES $ _____ $ _____ $ _____ $ _____ $ _____ $ _____	**NUMBER OF WEEKS** You will have dependent (child, adult or elder) care expenses for the plan year. Remember *to subtract holidays, vacations, and other times you may not be paying for eligible dependent care.* Weeks _____
SUBTOTAL Your total contribution during the year cannot exceed $2,550. $ _____	**MULTIPLY** by the amount of money you expect to spend each week $_____
DIVIDE By the number of paychecks (26) you will receive during the plan year.	**SUBTOTAL** Total contribution cannot exceed IRS limits for the calendar year and your employer's plan year. $_____
This is your pay period contribution - $ _____	**DIVIDE** By the number of paychecks (26) you will receive during the plan year. **This is your pay period contribution -** $ _____

Limited Flexible Spending Account

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

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

Limited FSA Highlights

- Allows you to set aside pre-tax dollars, reducing your taxable wages and, therefore, decreasing your taxes.
- You can specify the annual dollar amount of earnings to be deposited. This amount is deducted in 26 equal payments, one each pay period.
- At your request, your FSA reimbursement may be deposited into your checking or savings account by enrolling in Direct Deposit. To obtain an application, visit the ASI website at *asiflex.com.*
- Monies not claimed within the plan year will be forfeited in accordance with the IRS regulations.

Limited Medical FSA

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

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

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

File a Claim

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

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

Submitting a Claim Form

You can:

- Fax your claim and documentation, toll-free to ASI at 1.877.879.9038;
- Mail the claim form and documentation to the location indicated on the claim form, or
- Submit your claims online at *my.asiflex.com*. You need your ASI-assigned PIN, along with your State of Arizona employee identification number (EIN), if you have not previously set up a user name and password.
- File a claim using the ASIFlex mobile app on your smart phone or tablet.
- All documentation must be scanned into PDF format.

Reimbursement

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

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

received.

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

You have from January 1, 2017 through December 31, 2017 to use account funds. All the claims for medical expenditures must be filed with ASI prior to March 31, 2018 for reimbursement.

End of Employment

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

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

ASIFlex Mobile App

Using a **phone or tablet**, the ASIFlex mobile app allows participants to file claims and view their FSA account.

The claim filing feature allows a participant to capture documentation using the mobile device's camera feature and submit that documentation with the claim. The mobile app also allows participants to use the microphone feature on smart devices to enter claims. This means participants can choose to speak, rather than type, some of the claim information. In addition to filing claims, participants can view the annual election amount, account balance, payments, contributions and previously submitted claims.

The app is free and available online at *asiflex.com* or through Google Play™ or the Apple Store℠.

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

Computers via Payroll Deduction

As a State of Arizona employee you have access to Purchasing Power, a unique purchase program that allows you to buy new, brand name computers and pay for them over time through the ease of payroll deduction.

Discover A Better Way to Buy™

The need for a computer purchase can happen when you least expect it. When you can't spare the up-front cash for this kind of surprise, discover Purchasing Power. Unlike a discount program, Purchasing Power allows you to pay for your purchase over time through manageable payments that come directly from your paycheck.

- Your job is your credit - No credit check required. Simply meet the qualifying criteria to participate.
- Make an informed purchase - The price you see is the price you'll pay. While you'll pay a bit more than retail for the convenience of paying over time, you won't be hit with ballooning interest or hidden fees as you find with traditional financing programs, like credit cards or rent-to-own.
- Never pay a late fee again - Manageable payments come out of your paycheck in equal installments over 12 months.

Benefit at a Glance

- Manageable payments deducted from your paycheck
- 12 months to pay
- No credit check, no hidden fees
- Easy online ordering with delivery to your home

Easy Qualifications

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

For more information or to order, please use the following contact information:

Benefit Options:
Benefitoptions.az.gov
Select Computer Purchase

Purchasing Power:
Toll Free Number: 1.866.670.3479
Arizona.PurchasingPower.com

UNIVERSITY FACULTY AND STAFF: Please refer to your Human Resources website for the Computer Purchase Program options available to you.

Auto and Home Insurance Program*

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

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

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

Benefits-At-A-Glance
- Ability to apply year-round
- Exclusive savings
- Convenient payroll deduction
- Wide-array of coverages
- Money-saving discounts
- 24 hour claims assistance
- Portable policies
- Free, no-obligation quotes from licensed insurance professionals

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

How to Request Quotes and Apply
Each provider offers licensed customer representatives to answer your questions, help you explore any lower cost options, and issue your policy right over the phone. Contact each provider to compare coverages and rates.

Travelers:	1.888.695.4640
Liberty Mutual Insurance:	1.800.786.1855

**Coverage is subject to applicable law, underwriting guidelines and state availability.*

***Certain carriers offer identity protection services at no additional cost to policyholders in certain states and with certain policy forms.*

****Flood insurance is offered through the National Flood Insurance Program (NFIP), which is administered by the federal government. All rates and rules are established by the NFIP.*

Legal Disclosures
The carriers listed operate independently and are not responsible for each other's financial obligations.

Liberty Mutual Insurance
Discounts and savings are available where state laws and regulations allow, and may vary by state. To the extent permitted by law, applicants are individually underwritten; not all applicants may qualify. Please consult a Liberty Mutual sales representative for additional information.

Coverage provided and underwritten by Liberty Mutual Insurance Company and its affiliates, 175 Berkeley Street, Boston, MA 02116.
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Travelers
Insurance is underwritten by The Travelers Indemnity Company or one of its property casualty affiliates, One Tower Square, Hartford, CT 06183. Coverages, discounts, special program rates or savings, billing options and other features are subject to availability and individual eligibility. © 2015 The Travelers Indemnity Company. All rights reserved. Travelers and the Travelers Umbrella logo are registered trademarks of The Travelers Indemnity Company in the U.S. and other countries.

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

Deferred Compensation Plan

You've probably heard of the different types of retirement plans: 457(b), 403(b), 401(a) and Roth 457 Deferred Compensation Plans. As an Arizona state public employee, the State of Arizona Deferred Compensation Plans were created specifically for you.

What Are The Plans

The State of Arizona offers retirement plans for employees like you to set aside money from each paycheck toward retirement. These plans can help bridge the gap between what you have in your pension and Social Security, and how much you'll need in retirement. The available plans include:

457(b) Traditional Deferred Compensation Plan – tax-deferred, available to State employees.

457(b) Roth Deferred Compensation Plan — after-tax, available to State employees.

401(a) Deferred Compensation Plan – tax-deferred, and available to State employees meeting certain age requirements. This plan also has an irrevocable requirement where, once you start making contributions, you cannot stop them or change the amount of the deductions until you sever employment.

403(b) Deferred Compensation Plan – tax-deferred, and available to State employees who work at the Arizona Department of Education or the School for the Deaf & Blind. Not available for the University faculty and staff (please refer to your Human Resources website for more information about the University-sponsored voluntary 403(b) retirement savings program.)

How Does It Work

There are three simple steps to participating in a deferred compensation plan:

Enroll in your plan – It's easy to participate in deferred compensation. You can enroll on-line or on paper, just visit ArizonaDC.com for either option. Contributions are automatically deducted from each paycheck and deposited to your account, so you don't have to remember to write a check.

Use the Paycheck Impact Calculator, available at ArizonaDC.com, to see how saving pre-tax will affect your paycheck.

Invest your money – Once you are enrolled, you can choose from a wide variety of funds from the list of investment options available within your plan. You can also, once enrolled, use the Morningstar® Retirement Manager℠ to get a personalized retirement strategy, including recommendations for your retirement income goal, savings rate and portfolio asset mix. Keep in mind, any investment involves risk and there's no guarantee that any fund will achieve its investment objectives.

Receive income – Many public employees retire earlier than those in the private sector, and if that's the case, you'll want to invest enough to live in retirement on your terms. When investing in a 457(b) plan, distributions are available upon severance from employment, regardless of age! Before you begin taking payments, review our Retirement Checklist (available on ArizonaDC.com in our Library) to make sure you're ready to transition from saving to spending.

Why Should I Participate?

The State of Arizona Deferred Compensation Plans help put you in control of when, where and how much you invest. And that's just the beginning—here are four more reasons why it's smart to participate in your deferred compensation plan:

You can start anytime – Your deferred compensation plans will work for you whether you're approaching retirement or just getting started.

Every little bit helps – Even investing a small amount of money can really add up over time. And if you increase your contributions on a regular basis, the overall impact to your paycheck may not seem too painful.

Consider putting raises or bonuses into deferred compensation – it's an easy way to invest a little more.

This plan is made for you – Unlike other retirement plans, a 457(b) deferred compensation plan takes into account that you may retire sooner than workers in the private sector. Generally, you don't have to worry about paying a penalty for retiring early or beginning to take income from the plan before age 59½ (unlike 401(k) plans). Withdrawals are taxable income to you in the year the payments are made.

You will get On Your Side service – Nationwide is ready and willing to answer your questions. They have been helping public sector employees save for retirement for more than 30 years and their local Retirement Specialists have helped educate thousands of employees about investing through their retirement plans. Feel free to call today — they do not charge a fee to work with a Retirement Specialist.

Let's Talk

Give Nationwide a call at 1.800.796.9753 or in Phoenix at 602.266.2733.

Go to *arizonadc.com* to understand more details of the retirement plans and the benefits, use the calculators and tools (including the Interactive Retirement Planner and new Health Care Estimation Tool), view investment options and get started today by enrolling or making account updates.

Discount Program (State-Sponsored)

A Discount Program is available to State employees, University employees, and retirees.

The PerksConnect card or free mobile app allows access to local and national discounts on products and services which may include, but are not limited to:

- Automotive
- Dry Cleaning
- Entertainment
- Golf
- Health & Beauty
- Professional Services
- Pet Care
- Restaurants / Dining
- Shopping
- Travel

For more information visit *benefitoptions.az.gov*.

Value-Added Services

Benefit Options vendors offer a variety of value-added services, discounts, and other health and wellness options to the benefits you receive.

Medical

Discount percentages and availability can vary based on location. For additional information, please visit your medical Network website. Some services include:

- Alternative care and services: Chiropractic, Acupuncture, Massage Therapy
- Fitness memberships and equipment
- Dental care
- Hearing care
- Vision care
- Weight management and nutrition

Life Insurance

The Hartford offers life planning tools and services to help guide employees through major life decisions. For additional information, please visit *groupbenefits.thehartford.com/arizona*:

- EstateGuidance® Will Services
- Travel Assistance with ID Theft Protection and Assistance
- Ability Assist® Counseling Services
- Funeral Planning and Concierge Services
- Beneficiary Assist® Counseling Services

Arizona Department of Administration
Benefit Options
Benefit Services Division

Retired State Employees

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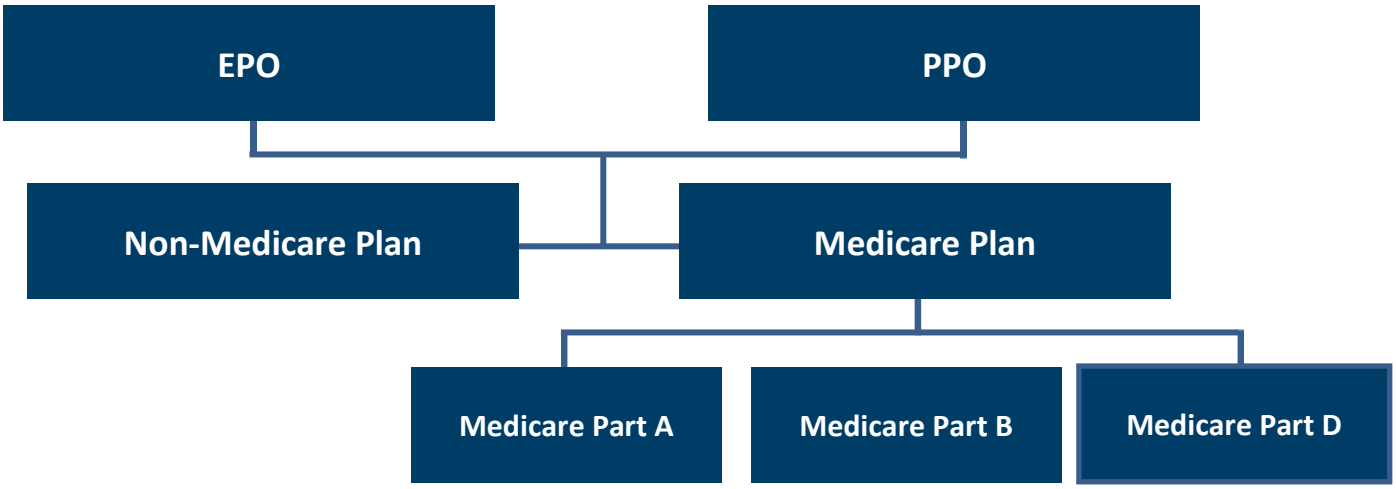
2017 Retiree Plans

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



Important information for Medicare members:

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

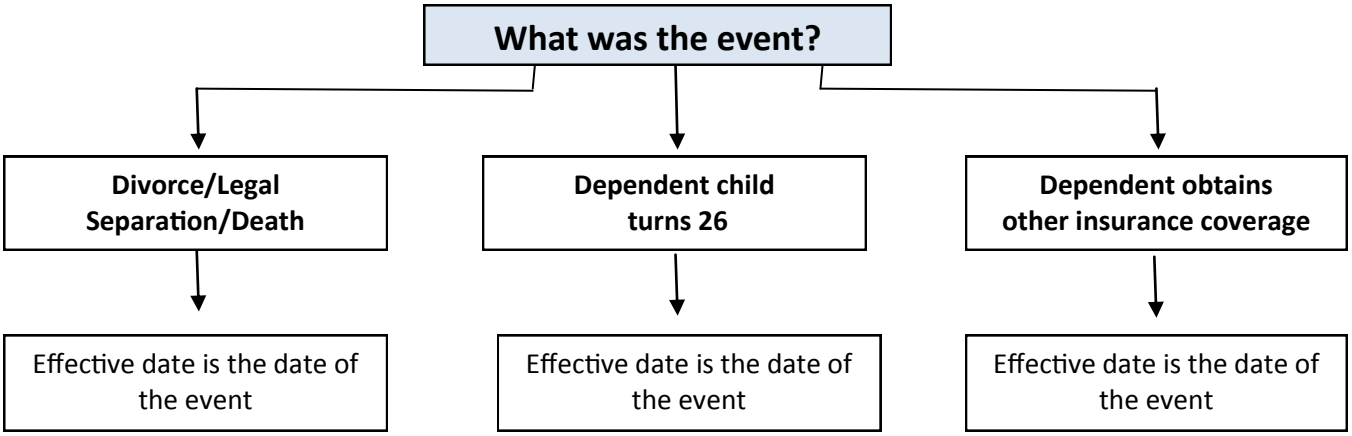
Step 2: Determine the type of Dental Plan you need.

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

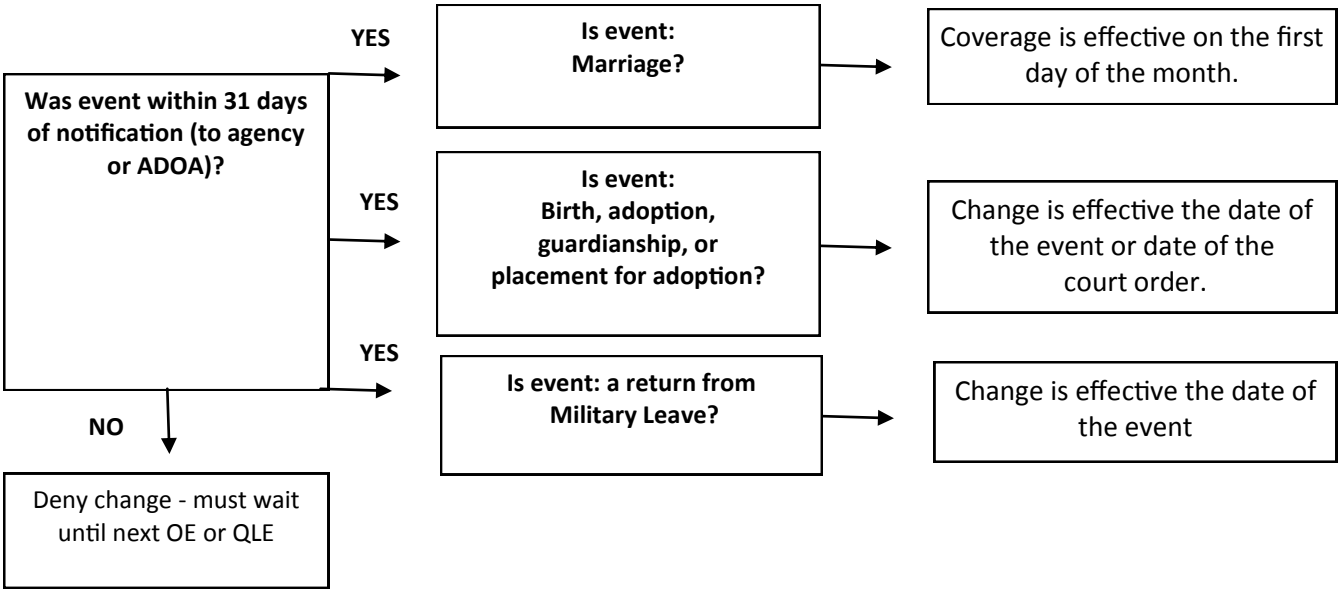
If you are a *new retiree* and you do not select "Enroll" or "Decline" for any of the medical, dental, or vision coverage, it will automatically be declined.

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

Losing your Benefits



Adding your Benefits



Monthly Medical Premiums (Without Medicare)

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

Monthly Medical Premiums (With Medicare)

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

Monthly Dental Premiums

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

Monthly Vision Premiums

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

Understanding Your Insurance Cost

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

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

NET MONTHLY HEALTH INSURANCE COST WORKSHEET			
Your monthly medical plan premium from page 59			**A**
Your monthly dental plan premium from page 60	+		**B**
Total Premium **(A plus B)**			**C**
Your Basic Premium Benefit Subsidy (See chart on page 63)	-		**D**
Your Net Premium (C minus D)	=		**E**

What You Should Know About Premium Payments

- You are responsible to pay all premiums. Failure to keep your premiums current will result in cancellation of your insurance coverage. If the sum of your premium benefit subsidy and pension is greater than or equal to the total monthly premium, you will be considered a non-direct pay member. Non-direct pay members do not receive a bill.
- If you are an LTD member or Surviving Spouse not receiving a pension from a recognized state retirement plan, you are a direct pay member. You are responsible for the payment of your premium(s) by the first

of each month. The monthly premium is stated on your enrollment form.

- If your monthly pension has insufficient funds to cover your health insurance premiums, then premiums will not be deducted. You will then become a direct pay member. The ADOA Benefit Services Division will mail a bill to you. It will be your responsibility to pay any outstanding premiums to Benefit Services. If you do not receive a bill by the twenty-fifth day of the month, you must contact Benefit Services.
- Should the retirement system begin deducting your premium from your pension and you have also received a bill as a direct pay member, please contact Benefit Services. Please see the section entitled, "Information for Direct Pay Members."

New Retirees/LTD Members

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

Information for Direct Pay Members

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

For more information regarding your subsidy, contact ASRS by visiting *azasrs.gov* or calling 602 -240-2000 or 1-800-621-3778 if outside of Phoenix. For hearing impaired, call TTY 602-240-5333.

Vision Premium Payments

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

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

Calculating your Premium Benefit Subsidy

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

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

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

- Your years of credited service in your retirement system or plan if you are an ASRS or EORP member (years of service is not a criterion for CORP and PSPRS members).
- Your coverage type (i.e., single or family coverage).
- Medicare eligibility.

Basic Premium Benefit Amounts

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

Your Direct Deposit Summary

Pension payments are issued by ASRS or PSPRS. Before either of the retirement systems generates your pension, they apply your premium subsidy (refer to the worksheet on page 61). Once the premium subsidy is added into your pension, the retirement system pays for your dental premium first. ASRS or PSPRS will apply remaining money to pay for your medical premium.

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

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

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

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

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

IMPORTANT NOTICE

RETAIN FOR YOUR RECORDS THIS IS NOT A CHECK

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

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

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

CRP16 AQ001 MNT

DIRECT DEPOSIT SUMMARY

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

PAYMENT DETAIL

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

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

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

YOUR PAYMENT HAS BEEN ELECTRONICALLY TRANSMITTED:

Deposit Account 00000000000000 Bank TR# 000000000000

09

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

NON - NEGOTIABLE

To help you calculate your monthly benefit cost, use the three step worksheet on page 61. If you feel your pension is not accurate, you must notify your Retirement System (ASRS or PSPRS) as soon as possible. If your enrollment is not processed until after the third of the month, it is possible the correct premiums will not be deducted from your pension until the month following the effective date of your enrollment or change.

Eligibility

Medicare is health insurance available to people who are:

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

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

Eligibility Notification

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

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

Parts of Medicare

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

Medicare Part A (Hospital Insurance)

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

Medicare Part B (Medical Insurance)

- Helps cover doctors' services and outpatient care
- Helps cover some preventive services to help maintain your health (See Chart on page 67)

Medicare Part C (Medicare Advantage Plans)

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

Medicare Part D (Prescription Drug Coverage)

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

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

Medicare Payments

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

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

Medicare and ADOA

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

Medicare Primary

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

- Medicare is primary coverage
- Benefit Options is secondary coverage

How it Works

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

If you are enrolled in Medicare Part A only, you are still Medicare-eligible. If you decline Part B, you will be responsible for Part B covered charges.

Copays

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

Medicare Crossover Program

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

Preventive Services Checklist

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

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

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

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

Low Income Subsidy (LIS)

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

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

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

Part D Income Related Monthly Adjustment Amount (IRMAA)

If your income is over $85,000 for an individual or $170,000 for married filing jointly, Medicare requires that you pay an additional premium based on your income. You will be notified by Social Security if this affects you.

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

The Medicare GenerationRx for Benefit Options plan provides equal to or better coverage than what is offered through Medicare Part D. Learn more about Medicare GenerationRx for Benefit Options on page 73.

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 72. The copays listed in the chart are for a 31-day supply of medication bought at a retail pharmacy.

Formulary

The formulary is the list of medications chosen by a committee of doctors and pharmacists to help you maximize the value of your prescription benefit. These generic and brand name medications are available at a lower cost. The use of non-preferred medications will result in a higher copay. Changes to the formulary can occur during the plan year. Medications that no longer offer the best therapeutic value for the plan are deleted from the formulary. Ask your pharmacist to verify the current copay amount at the time your prescription is filled.

To see what medications are on the formulary, go to *benefitoptions.az.gov* or contact the MedImpact Customer Care Center and ask to have a copy sent to you. Sharing this information with your doctor helps ensure you are getting the best value, which saves money for you and your plan.

Finding a Pharmacy

To find a pharmacy refer to *benefitoptions.az.gov*. See online features for more information.

The MedImpact Customer Care Center is available 24 hours a day, 7 days a week. The toll-free telephone number is 1.888.648.6769.

Pharmacy Mail Order Service

A convenient and less expensive mail order service is available for employees who require medications for on-going health conditions or who will be in an area with no participating retail pharmacies for an extended period of time.

Here are a few guidelines for using the mail order service:

- Submit a 90-day written prescription from your physician.
- Request up to a 90-day supply of medication for **two copays**
- Payments can be made by check or credit card: Visa, MasterCard, American Express, or Discover.
- Register your e-mail address to receive information on your orders.
- Order refills online at *walgreens.com* or via phone at 1.866.304.2846. Have your insurance card ready when you call.

Choice90

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

Medication Prior Authorization

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

Step Therapy Program

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

Specialty Pharmacy Program

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

Specialty medications are limited to a 31-day supply and may be obtained only at a Walgreens retail pharmacy or through the Walgreens Specialty Central Fill facility by calling 1.888.782.8443.

A Specialty Care Representative may contact you to facilitate your enrollment in the Specialty Pharmacy Program. You may also enroll directly into the program by calling 1.888.782.8443.

Limited Prescription Drug Coverage

Prescription drug coverage will generally be limited to medications that do not have an equally effective over-the-counter substitute.

Non-Covered Drugs

Certain medications are not covered as part of the Benefit Options plan. If you find such a drug has been prescribed for you, discuss an alternative treatment with your doctor.

Contacts

MedImpact	
Customer Care Center and Prior Authorization	1.888.648.6769
Walgreens	
Mail Order	1.866.304.2846
Specialty Pharmacy	1.888.782.8443

NAU Retiree BCBS Members only

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

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

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

Pre-Medicare 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.

NAU Retirees Blue Cross Blue Shield Members Only

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

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

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

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

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

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

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

How it Works

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

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

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

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

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

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

If you reach the catastrophic coverage stage ($4,850 in total out-of-pocket costs for 2017), your Benefit Options copayment will be the maximum amount charged.

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

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

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

Formulary

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

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

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

1 Total Medical cost.

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

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

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

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

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

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

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

Finding a Pharmacy
Medicare GenerationRx has over 65,000 pharmacies in its network. Members may

continue to fill their prescriptions at their current pharmacy as long as it is a MedicareGenerationRx for Benefit Options network pharmacy.

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

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

Pharmacy Mail Order Service

A convenient and less expensive mail order service is available for members who need medications for ongoing health conditions or who will be in an area with no participating retail pharmacies for an extended period of time.

Here are a few guidelines for using the mail order service:

- Submit a 90-day written prescription from your physician, but verification is required every 30 days.
- Auto refill is not available.
- Request up to a 90-day supply of medication for **two copays.** (Example: A 31-day supply retail prescription for a $10 copay versus a 90-day supply mail order prescription for a $20 copay)
- Payments can be made by check or credit card: Visa, MasterCard, American Express, or Discover.
- Register your e-mail address to receive information on your orders.
- Order refills online at *Walgreens.com* or via phone at 1.866.304.2846. Have your prescription card ready when you call!

Choice90Rx

With this program, members who require medications for an ongoing health condition can obtain a 90-day supply of medication at a local retail pharmacy for **two and a half copays.** For more information or to find a participating Choice90Rx pharmacy, please visit our web site at *medicaregenerationrx.com/stateofaz*, refer to your Pharmacy Directory or call Medicare GenerationRx Member Services at 1.877.633.7943, 24 hours a day/365 days a year. TTY/TDD users should call 711.

Specialty Pharmacy Program

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

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

Specialty medications are limited to a 31-day supply.

Under Medicare Part D

Extra Help (Low Income Subsidy)

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

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

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

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

Part D Income Related Monthly Adjustment Amount (IRMAA)

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

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

The booklet ***Medicare & You 2017*** gives information about the Medicare premiums in the section called "2017 Medicare Costs." This explains how the Medicare Part B and Part D premiums differ for Medicare eligible members and their dependents with different incomes.

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

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

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

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

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

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

Extended Vacation or Travel Abroad

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

Whether you go to a retail pharmacy or use mail order for your prescriptions, you will need to notify Medicare GenerationRx in writing of why you are requesting an additional supply of medication, the date when you are leaving, and how long you plan to be gone.

Medicare GenerationRx will generally be able to authorize a VACATION OVERRIDE allowing you to have the extra medication you will need *provided you have the appropriate number of refills remaining.*
Order refills at least two weeks in advance of your departure. If there is a problem, such as, *not enough refills*, you will have enough time to phone your physician. Copays will be the same as you would normally pay times the number of refills you need.

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

Contact information

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

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

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

iRx Discount Program

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

Medicare has neither reviewed nor endorsed this information.

Medicare Pharmacy Online Features

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

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

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

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

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

Mail Order
A link will direct you to the Walgreens website where you may register for mail order service by downloading the registration form and following the step-by-step instructions. Auto refill is not available.

Locate a Nearby Pharmacy
Locate a pharmacy near your home address, out-of-town vacation address, or your dependent's address.

Generic Resource Center
Learn more about generic drugs and savings opportunities.

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

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

Non-Medicare Eligible Medical Plans

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

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

UnitedHealthcare Choice Plus PPO (out-of-state)

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

Medicare Eligible Medical Plans

UnitedHealthcare Group Medicare Advantage (HMO) Plan

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

UnitedHealthcare Senior Supplement Plan

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

Indemnity Dental Plans

The two Indemnity Dental Plan options: Freedom Basic (the “Low” option) and Freedom Advance (the “High” option). These plans pay the indicated percentages of Allowable Charges for covered services. Benefits are paid after any applicable deductible has been met, up to the Annual Maximum Benefit which is $2,500 for the Freedom Advance plan and $1,000 for the Freedom Basic plan. You are responsible for any applicable coinsurance percentages not covered by the plan. You also have access to the Assurant

Dental Network, for additional savings on your dental care.

Prepaid Dental Plans

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

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

No Longer Eligible for LTD Benefits and Not Able to Retire

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

Returning to Work

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

Waiver of Premiums

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

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

Disability Benefits from Social Security and Eligibility for Medicare

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

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

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

Receiving Social Security Disability

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

Arizona Department of Administration
Benefit Options
Benefit Services Division

COBRA Participants

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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). Qualified beneficiaries must inform the ADOA Benefits Services Division no later than 31 days from the QLE.

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. Qualified beneficiaries must inform the ADOA Benefits Services Division no later than 31 days from the QLE.

Summary of Monthly Insurance Premiums

Medical 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

Dental 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

Vision 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. Qualified beneficiaries must inform the ADOA Benefits Services Division no later than 60 days from the QLE.

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.

Health Insurance Marketplace

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.

Network Options Outside 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

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.

Health Insurance Portability & Accountability Act (HIPAA)

This notice describes how medical information about you may be used and disclosed, how you may gain access to this information, and the measures taken to safeguard your information. Benefit Options knows that the privacy of your personal information is important to you. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires health plans to notify plan participants and beneficiaries about its policies and practices to protect the confidentiality of their health information. For purposes of this Notice, health information refers to any information that is considered Protected Health Information (PHI) as defined in the Privacy Rule of the Administrative Simplification provision of HIPAA. Throughout this Notice, all references to Benefit Options refer to the administrators of the Program. Please review it carefully.

Use and Disclosure of Health Information

Benefit Options may use your health information for purposes of making or obtaining payment for your care, and for conducting health care operations. We have established a policy to guard against unnecessary disclosure of your health information.

How the Plan May Use and Disclose Health Information

To Make or Obtain Payment

Benefit Options may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, Benefit Options may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

To Conduct Health Care Operations

Benefit Options may use or disclose health information for its own operations to facilitate and, as necessary, to provide coverage and services to all Benefit Options' participants.

Health care operations include activities such as:

- Quality assessment and improvement activities;
- Activities designed to improve health or reduce health care costs;
- Clinical guideline and protocol development, case management and care coordination;
- Contacting health care providers and participants with information about treatment alternatives and other related functions;
- Health care professional competence or qualifications review and performance evaluation;
- Accreditation, certification, licensing or credentialing activities;
- Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits;
- Reviews and auditing, including compliance reviews, medical reviews, legal services and compliance programs;
- Business planning and development including cost management and planning analyses and formulary development. In addition, summary health information may be provided to third parties in connection

with the solicitation of health plans or the modification or amendment of the existing plan;
- Business management and general administrative activities of Arizona Benefit Options, including customer service and resolution of internal grievances.

As an example, Benefit Options may use your health information to conduct case management, quality improvement and utilization review, and provider credentialing activities or to engage in customer service and grievance resolution activities.

For Treatment Alternatives
Benefit Options may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

For Distribution of Health-Related Benefits and Services
Benefit Options may use or disclose your health information to provide you with information on health-related benefits and services that may be of interest to you.

When Legally Required
Benefit Options will disclose your health information when it is required to do so by any federal, state or local law.

To Conduct Health Oversight Activities
Benefit Options may disclose your health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. However, we may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

In Connection With Judicial and Administrative Proceedings
As permitted or required by state law, Benefit Options may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when Benefit Options makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

For Law Enforcement Purposes
As permitted or required by state law, Benefit Options may disclose your health information to a law enforcement official for certain law enforcement purposes, including but not limited to if Benefit Options has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

In the Event of a Serious Threat to Health or Safety
Benefit Options may, consistent with applicable law and ethical standards of conduct, disclose your health information if Benefit Options, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

For Specified Government Functions
In certain circumstances, federal regulations require Benefit Options to use or disclose your health information to facilitate specific government functions related to the military and veterans, to national security and intelligence activities, to protective services for the president and others, and to correctional institutions and inmates.

For Workers Compensation
Benefit Options may release your health information to the extent necessary to comply

with laws related to workers compensation or similar programs.

Authorization to Use or DiscloseHealth Information
Other than as previously stated, Benefit Options will not disclose your health information without your written authorization. If you authorize Benefit Options to use or disclose your health information, you may revoke that authorization in writing at any time.

Your Rights with Respect to YourHealth Information
You have the following rights regarding your health information that Benefit Options maintains:

Right to Request Restrictions
You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on Benefit Options' disclosure of your health information to someone involved in the payment of your care. However, Benefit Options is not required to agree to your request.

Right to Receive Confidential Communications
To safeguard the confidentiality of your health information, you may request that Benefit Options communicate in a specified manner or at a specified location. Alternatively, for example, you may request that all health information be mailed to your work location rather than your home. If you wish to receive confidential communications, please make your request in writing. Benefit Options will accommodate reasonable requests, when possible.

Right to Inspect and Copy Your Health Information
You have the right to inspect and copy your health information. If you request a copy of your health information, Benefit Options may charge a reasonable fee for copying, assembling costs and, if applicable, postage associated with your request.

Right to Amend Your Health Information
If you believe that your health information records are inaccurate or incomplete, you may request that Benefit Options amend the records. That request may be made as long as the information is maintained by Benefit Options. Benefit Options may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created by Benefit Options, if the health information you are requesting to amend is not part of Benefit Options' records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if Arizona Benefit Options determines the records containing your health information are accurate and complete.

Right to an Accounting
You have the right to request a list of disclosures of your health information made by Benefit Options for any reason other than for treatment, payment or health operations. The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time going back more than six (6) years. Benefit Options will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. Benefit Options will inform you in advance of the fee, if applicable.

Right to a Paper Copy of This Notice
You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically.

Benefit Options Duties
Benefit Options is required by law to maintain the privacy of your health Information as set forth in this Notice and to provide to you this Notice of its duties and privacy practices.

Changes to This Notice
Benefit Options reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If Benefit Options changes its policies and procedures, Benefit Options will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change.

Complaints
You have the right to express complaints to Benefit Options and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Benefit Options encourages you to express any concerns you may have regarding the privacy of your information.

Note: You will not be penalized or retaliated against in any way for filing a complaint.

Medicare Notice of Creditable Coverage

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

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage
Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium. ADOA has determined that the prescription drug coverage offered by the Benefits Options Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare Drug Plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

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

When Will You Pay a Higher Premium (Penalty) To Join a Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with Benefit Options and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.
If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

Consolidated Omnibus Budget Reconciliation Act (COBRA) Coverage Notice

COBRA coverage is available when a "qualifying event" occurs that would result in a loss of coverage under the health plan, such as end of employment, reduction of the employee's hours, employee becoming entitled to Medicare, marriage, divorce, legal separation, annulment, and death.

Federal law requires that most group health plans give qualified beneficiaries the opportunity to continue their group health coverage when there is a qualifying event. Depending on the type of qualifying event, "qualified beneficiaries" can include an employee covered under the group health plan and his/her enrolled dependents. Certain newborns, newly adopted children, and children of parents under Qualified Medical Child Support Orders (QMCSOs) may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.

COBRA coverage is the same coverage that the State of Arizona offers to participants.

Each qualified beneficiary who elects COBRA coverage will have the same rights under the Plan as other participants, including open enrollment and HIPAA special enrollment rights. The description of COBRA coverage contained in this notice applies only to group health coverage offered by the State of Arizona (medical, dental, vision and healthcare Flexible Spending Account [FSA]). The Plan provides no greater COBRA rights than what COBRA requires – nothing in this notice is intended to expand your rights beyond COBRA's requirements.

Electing COBRA Coverage
To elect COBRA coverage, you must complete the election form according to the directions on the election form and mail or deliver by the date specified on the election form to the ADOA Human Resources Division, Benefit Services. Each qualified beneficiary has a separate right to elect COBRA coverage.

For example, the employee's spouse may elect COBRA coverage even if the employee does not and can elect coverage on behalf of all the qualified beneficiaries. COBRA coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries.

You may elect COBRA under the group health coverage (medical, dental, vision and health care FSA) in which you were covered under the Plan on the day before the qualifying event. Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under another group health plan (but

only after any applicable pre-existing condition exclusions of that other plan have been exhausted or satisfied).

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

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

Special Considerations in Deciding Whether to Elect COBRA
In considering whether to elect COBRA coverage, you should take into account that a failure to elect COBRA will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage. Election of COBRA coverage may eliminate this gap. Second, you may lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get COBRA coverage for the maximum time available to you. Finally, you should take into account that you may have special enrollment rights under federal law. You may have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group coverage ends because of the qualifying event.

You will also have the same special enrollment right at the end of COBRA coverage if you get COBRA coverage for the maximum time available to you.

How Long Will COBRA Coverage Last
COBRA coverage will generally be continued only for up to a total of 18 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage under the Plan as a result of the qualifying event can last up to 36 months from the date of Medicare entitlement.

This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months before the termination of employment or reduction of hours. In the case of a loss of coverage due to an employee's death, divorce or legal separation, or a dependent child ceasing to be a dependent under the terms of the Plan, COBRA coverage may be continued for up to a total of 36 months. Regardless of the qualifying event, health care FSA COBRA coverage may only be continued to the end of the plan year in which the qualifying event occurred and cannot be extended for any

reason. This notice shows the maximum period of COBRA coverage available to qualified beneficiaries. COBRA coverage will automatically terminate before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing COBRA coverage, under another group health plan (but only after any applicable pre-existing condition exclusions of that other plan have been exhausted or satisfied),
- the State ceases to provide any group health plan for its employees; or
- during a disability extension period (the disability extension is explained below), the disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled.

COBRA coverage may also be terminated for any reason that traditional enrollment would be terminated (for example, the Plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage in a case of fraud).

You must notify the COBRA administrator(s) in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare (Part A, Part B or both) or becomes covered under another group health plan (but only after any preexisting condition exclusions of that other plan have been exhausted). COBRA coverage will terminate (retroactively if applicable) as of the date of Medicare entitlement or as of the beginning date of the other group health coverage (after satisfaction of any applicable preexisting condition exclusions). The plan will require repayment of all benefits paid after the termination date, regardless of whether or when you provide notice of Medicare entitlement or other group health plan coverage.

Extending the Length of COBRA Coverage
If you elect COBRA coverage, an extension of the period of coverage may be available if a qualified beneficiary is or becomes disabled or a second qualifying event occurs. You must notify the COBRA administrators in writing of a disability or a second qualifying event in order to extend the period of COBRA coverage.

Failure to provide notice of a disability or second qualifying event will affect the right to extend the period of COBRA coverage (the period of COBRA health care FSA cannot be extended end of the current plan year under any circumstances).

Disability
If any of the qualified beneficiaries is determined by the Social Security Administration to be disabled, the maximum COBRA coverage period that results from the covered employee's termination of employment or reduction of hours (generally 18 months as described above) may be extended up to a total of 29 months.

The disability must have started at some time before the 61st day of COBRA coverage obtained due to the covered employee's termination of employment or reduction of hours with the State and must last until the end of the 18-month period of COBRA coverage.

Each qualified beneficiary who has elected COBRA coverage will be entitled to the disability extension if one of them qualifies. The disability extension is available only if you notify the COBRA administrator(s) in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- the date of the Social Security administration's disability determination;
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours; and

the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination or reduction of hours. You must also provide this notice within the original 18 months of COBRA coverage obtained due to the covered employee's loss of coverage in order to be entitled to a disability extension.

The notice must be provided in writing and must include the following information:

- the name(s) and address(es) of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event;
- the name and address of the disabled qualified beneficiary;
- the date that the qualified beneficiary became disabled;
- the date that the Social Security Administration made its determination of disability;
- a statement as to whether or not the Social Security Administration has subsequently determined that the qualified beneficiary is no longer disabled; and
- the signature, name and contact information of the individual sending the notice.

Your notice must include a copy of the Social Security Administration's determination of disability. You must mail this notice within the required time periods to the ADOA Benefits Office.

If the above procedures are not followed or if the notice is not provided within the 60-day notice period, there will be no COBRA coverage disability extension. If the qualified beneficiary is determined by the Social Security administration to no longer be disabled, you must notify the COBRA administrator(s) of that fact within 30 days after the Social Security Administration's determination. The notice must be provided in the same manner as, and include the same information required for, a notice of disability as described above.

Second Qualifying Event

An extension of coverage will be available to spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the first 18 months (or, in the case of a disability extension, the first 29 months) of COBRA coverage following the covered employee's loss of coverage.

The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months from the date COBRA coverage began. Such second qualifying events include the death of a covered employee, divorce or legal separation from the covered employee, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan.

This extension due to a second qualifying event is available only if you notify the COBRA administrator(s) in writing of the second qualifying event within 60 days after the date of the second qualifying event. The notice must include the following information:

- the name(s) and address(es) of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event;
- a description of the second qualifying event;
- the date of the second qualifying event;
- the signature, name and contact information of the individual sending the notice.

In addition, you must provide documentation supporting the occurrence of the second qualifying event, if the ADOA Human Resources Division, Benefit Services requests it. Acceptable documentation includes a copy of the divorce decree, death certificate, or dependent child's birth certificate, driver's License, marriage license or letter from a university or institution indicating a change in student status. You must mail this notice within the required time periods to the ADOA Human Resources Division, Benefit Services. If the above procedures are not followed or if the notice is not provided within the 60-day notice period, there will be no

extension of COBRA coverage due to a second qualifying event.

COBRA Coverage Cost
Generally each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary is required to pay may not exceed 102 percent (or, in the case of an extension of COBRA coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant who is not receiving COBRA coverage. The required monthly payment for each group health benefit provided under the Plan under which you are entitled to elect COBRA is noted on the Enrollment/Change form.

Making Your COBRA Coverage Payment
If you elect COBRA coverage, you do not have to send any payment with the election form. However, you must make your first payment for COBRA coverage no later than 45 days after the date of your election (this is the date the election form is postmarked, if mailed, or the date your election form is received by the individual at the address specified for delivery on the election form, if hand delivered). If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election, you will lose all COBRA rights under the Plan. Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. You are responsible for making sure that the amount of your first payment is correct.

Please contact the ADOA Human Resources Division, Benefit Services for information about your COBRA payment including how much you owe.

Monthly Payments for COBRA Coverage
After you make your first payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of COBRA coverage.

The amount due for each coverage period for each qualified beneficiary will be shown in the notice you receive. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage.

If you make a monthly payment on or before the first day of the month to which it applies, your COBRA coverage under the Plan will continue for that month without any break. You will be billed for your COBRA coverage. It is your responsibility to pay your COBRA premiums on time.

Grace Periods for Monthly Payments
Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days after the first day of the month to make each payment for that month. Your COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment.

However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that your coverage will be suspended.

If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan. If mailed, your payment is considered to have been made on the date that it is

postmarked. If hand delivered, your payment is considered to have been made when it is received. Payments received or postmarked after the due date will not be accepted. You will not be considered to have made any payment if your check is returned due to insufficient funds or otherwise.

More Information About Individuals Who May be Qualified Beneficiaries

A child born to, adopted by, or placed for adoption with a covered member during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered member is a qualified beneficiary, the covered member has elected COBRA coverage for himself or herself and enrolls the child within 30 days of the birth, adoption or placement for adoption. To be enrolled in the Plan, the child must satisfy the otherwise applicable eligibility requirements (for example, age).

Alternative Recipients Under QMCSOs

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

This notice does not fully describe COBRA coverage or other rights under the Plan. More information about COBRA coverage and your rights under the Plan is available from the ADOA Human Resources Division, Benefit Services.

Patient Protection & Affordable Care Act (PPACA)

Grandfather Status Notice

The Arizona Department of Administration believes the Benefit Options plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (PPACA). As permitted by the PPACA, a grandfathered health plan can preserve certain health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that your plan may not include certain requirements of the PPACA that apply to other plans; for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other requirements in the PPACA; for example, the elimination of lifetime limits on benefits. Questions regarding which requirements do and do not apply to a grandfathered health plan and what might cause a plan to change from a grandfathered health plan status can be directed to ADOA Benefits at 602-542-5008 or benefitsissues@azdoa.gov.

Notice of Rescission

Under the PPACA, Benefit Options cannot retroactively cancel or terminate an individual's coverage, except in cases of fraud and similar situations. In the event that the Benefit Options plan rescinds coverage under the allowed grounds, affected individuals must be provided at least 30 days advanced notice.

Form W-2 Notice

Pursuant to the PPACA for tax years starting on and after January 1, 2011, in addition to the annual wage and tax statement employers must report the value of each employee's health coverage on form W-2, although the amount of health coverage will remain tax-free. The W-2s due in early 2012 will be the first to report coverage costs for the prior calendar year.

Notice About the Early Retiree Reinsurance Program

You are a plan participant, or are being offered the opportunity to enroll as a plan participant, in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a Federal program that was established under the Affordable Care Act. Under the Early Retiree Reinsurance Program,

the Federal government reimburses a plan sponsor of an employment-based health plan for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, your plan sponsor may choose to use any reimbursements it receives from this program to reduce or offset increases in plan participants' premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs. If the plan sponsor chooses to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a plan participant, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and this plan sponsor chooses to use the reimbursements for this purpose. A plan sponsor may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in its own costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families. If you have received this notice by email, you are responsible for providing a copy of this notice to your family members who are participants in this plan.

HIPAA Special Enrollment Rights Notice

If you decline enrollment in the State of Arizona's health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents maybe able to enroll in the State of Arizona Employee's health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 31 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption or placement for adoption. You must request health plan enrollment with 31 days after the marriage birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 31 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in the State of Arizona's health plan if you become eligible for a state premium assistance program under Medicaid of CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: if your dependent becomes eligible for a special enrollment rights, you may add the dependent to your current coverage or change to another health plan.

Women's Health and Cancer Rights Act (WHCRA)

The Women's Health and Cancer Rights Act of 1998 (WHCRA) was signed into law on October 21, 1998. The WHCRA which amends ERISA, requires group health plans that provide coverage for mastectomies to also provide coverage for reconstructive surgery and prostheses following mastectomies.

Because your group health plan offers coverage for mastectomies, WHCRA applies to your plan. The law mandates that a participant who is receiving benefits, on or after the law's effective date, for a covered mastectomy and who elects breast reconstruction in connection with the mastectomy will also receive coverage for:

1. Reconstruction of the breast on which the mastectomy has been performed
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
1. Prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas

This coverage will be provided in consultation with the patient and the patient's attending physician and will be subject to the same annual deductible, coinsurance and/or copayment provisions otherwise applicable under the policy/plan.

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Wellness

Health Impact Program (HIP) is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include screening for height, weight, blood pressure and a blood test - lipid profile- including cholesterol, glucose, and an optional Prostate SpecificAntigen (PSA) and HemoglobinA1C screens. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of up to $200 for completing 500 activity points. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will be eligible to receive the Health Impact incentive.

Additional incentives of prize drawings may be available for employees who participate in certain health-related activities or events or achieve certain health outcomes if applicable. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable

accommodation or an alternative standard by contacting Wellness at wellness@azdoa.gov. The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as health coaching. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and [name of employer] may use aggregate information it collects to design a program based on identified health risks in the workplace, [name of wellness program] will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) registered nurses and health coaches in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision.

Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Amanda Accatino at Amanda.Accatino@azdoa.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 12).

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.

Eligible Employee
Refer to page 3 for eligibility requirements.

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.

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.

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

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

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

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.

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

100 N. 15th Avenue, Suite 260
Phoenix, AZ 85007
Phone: 602-542-5008
Toll-free: 800-304-3687