Arizona Department of Administration

Human Resources Division - Benefit Services

2015

Retired State Employees

Benefit Guide

In This Guide:

- Benefit Expo Dates
- Benefit Changes
- Benefit Eligibility
- Medical & Prescription Benefits
- Medicare
- Dental Benefits
- Vision Benefits

ADOA-HRD
Human Resources

Benefit Options
Choice Value Health

Open Enrollment: October 27 through November 21, 2014

CONTACTS

ADOA Contacts
Human Resources Division - Benefit Services
100 N. 15th Ave #103
Phoenix, AZ 85007
602.542.5008 or
1.800.304.3687
Fax 602.542.4744
www.benefitoptions.az.gov
BenefitsIssues@azdoa.gov

Benefit Options Wellness
602.771.9355
www.benefitoptions.az.gov/wellness

Medical Plans
Aetna
1.866.217.1953
www.aetna.com
Policy Number 476687

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

Cigna
1.800.968.7366
www.cigna.com/stateofaz
Policy Number 3331993

UnitedHealthcare
1.800.896.1067
www.welcometouhc.com
Policy Number 705963

Pre-Medicare Pharmacy Plan
MedImpact
1.888.648.6769
www.benefitoptions.az.gov
ADOAcustomerservice@medimpact.com

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

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

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

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

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

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

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

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

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

INTRODUCTION

Welcome to the 2015 Retired Employees Benefit Guide!

This guide describes the benefits offered by the State of Arizona, Department of Administration, Human Resources Division, Benefit Services comprehensive benefits package "Benefit Options" effective January 1, 2015. Included in this reference guide, are explanations of the benefits programs, important plan information, contact addresses, phone numbers, web addresses, and comparison charts. This guide is intended to help you understand your benefits.

The guide is divided into chapters, each covering a specific benefits program or important information. We encourage you to review each section before making your benefit elections. For more information, please refer to your plan descriptions. If you need additional information, please visit our website at *benefitoptions.az.gov* or call us at 602.542.5008 or toll free at 1.800.304.3687.

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

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.

OPEN ENROLLMENT INFORMATION

Open Enrollment will begin Monday, October 27, at 8am and will end Friday, November 21, at 5pm (Arizona time). During the 2015 Open Enrollment, you will be **required to actively elect** your benefits for Medical and Vision benefits. If you do not take action on your dental benefits, no action is required, your current election will automatically continue.

Changes made during Open Enrollment will be effective for the plan year beginning January 1, 2015.

Benefit Expos
Open Enrollment Benefit Expos will be held to allow retirees an opportunity to meet with the medical, pharmacy, dental, vision, disability vendors, and representatives from Benefit Options. Booths will be set up to allow you to learn about your benefit options, ask questions, and choose the best plan for you.

Benefit Options Wellness will also be offering free flu shots as part of your BeWell Benefit. The Benefit Expo dates, times, and locations can be found on the "Dates and Events" section of this guide (pages 3-4).

Information for Open Enrollment
Your 2015 Open Enrollment benefit elections can be made online using the Y.E.S. website. Instructions are on page 13 of this guide entitled "Where to Enroll." The enrollment form should only be used if you are unable to access the Y.E.S. system.

You will need the following information:

- Your State issued Employee Identification Number (EIN). The number is located on the back of this guide or you can contact Human Resources Division, Benefit Services at 602.542.5008 to obtain your EIN.
- Dependents' names, dates of birth and Social Security Numbers. You will need this information to add eligible dependents to your benefits coverage.
- Other documentation may also be necessary in certain circumstances. Please refer to the "Eligibility" section of this guide on pages 9-12 for more information.

Once you have submitted your benefit elections and the Open Enrollment period ends, you will not be able to change your benefits.

Changes are only permitted with a Qualified Life Event (QLE) within 31 days, such as a marriage, divorce, birth, death, or change in employment status for you or your spouse. QLEs are outlined in more detail at *benefitoptions.az.gov.*

Special Notice
Retirees will be required to provide Social Security Numbers (SSN) for all dependents enrolled in the Medical Benefit Options 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.

Questions
For answers to your Open Enrollment questions, you may contact ADOA Human Resources Division, Benefit Services by calling 602.542.5008 or toll-free 1.800.304.3687 between 8am and 5pm Monday through Friday (Arizona time). You can also email your questions to BenefitsIssues@azdoa.gov.

Person with disabilities may request reasonable accommodations by contacting ADOA Human Resources Division, Benefit Services. If you need this information in an alternate format, please call 602.542.5008, Option 2.

DATES & EVENTS

Ask Questions. Learn More.
Would you like to know more about your 2015 benefits? The Benefit Options vendors will be on location to answer your questions. Speak with the benefit vendors face-to-face and get a free flu shot at a Benefit Expo near you. All Benefit Expo dates, times, and locations are listed below.

Phoenix
Saturday, October 25, 2014 9am-3pm
Phoenix Convention Center
South Building, Rooms 160-162
33 S. 3rd St., Phoenix, AZ 85004
Parking: Pass will be provided at the expo to present to parking attendant upon exit.

Glendale
Tuesday, October 28, 2014 9am-3pm
Renaissance Hotel
9495 W. Coyotes Blvd., Glendale, AZ 85305
Parking: The hotel garage is reserved for this event- no parking pass is required. Parking at the Gila River Arena lot is prohibited and is a tow-away zone.

Phoenix
Wednesday, October 29, 2014 9am-3pm
Capitol Mall
17th Ave., Phoenix, AZ 85007
(Between Jefferson St. and Washington St.)
Parking: Will be allowed at the Wesley Bolin Plaza parking area.

Mesa
Thursday, October 30, 2014 9am-3pm
Phoenix Marriott Mesa Hotel & Convention Center
200 N. Centennial Way, Mesa, AZ 85201
Parking: Free hotel parking.

Flagstaff
Friday, October 31, 2014 9am-3pm
Doubletree by Hilton
1175 W. Route 66, Flagstaff, AZ 86001
Parking: Free hotel parking.

Yuma
Monday, November 3, 2014 9am-3pm
Hilton Garden Inn/Pivot Point Conference Center
310 N. Madison, Yuma, AZ 85364
Parking: Free hotel parking.

Tucson
Wednesday, November 5, 2014 9am-3pm
Sheraton Tucson Hotel & Suites
5151 E. Grant Rd., Tucson, AZ 85712
Parking: Free hotel parking.

Tucson
Thursday, November 6, 2014 9am-3pm
Sheraton Tucson Hotel & Suites
5151 E. Grant Rd., Tucson, AZ 85712
Parking: Free hotel parking.

DATES & EVENTS
Continued

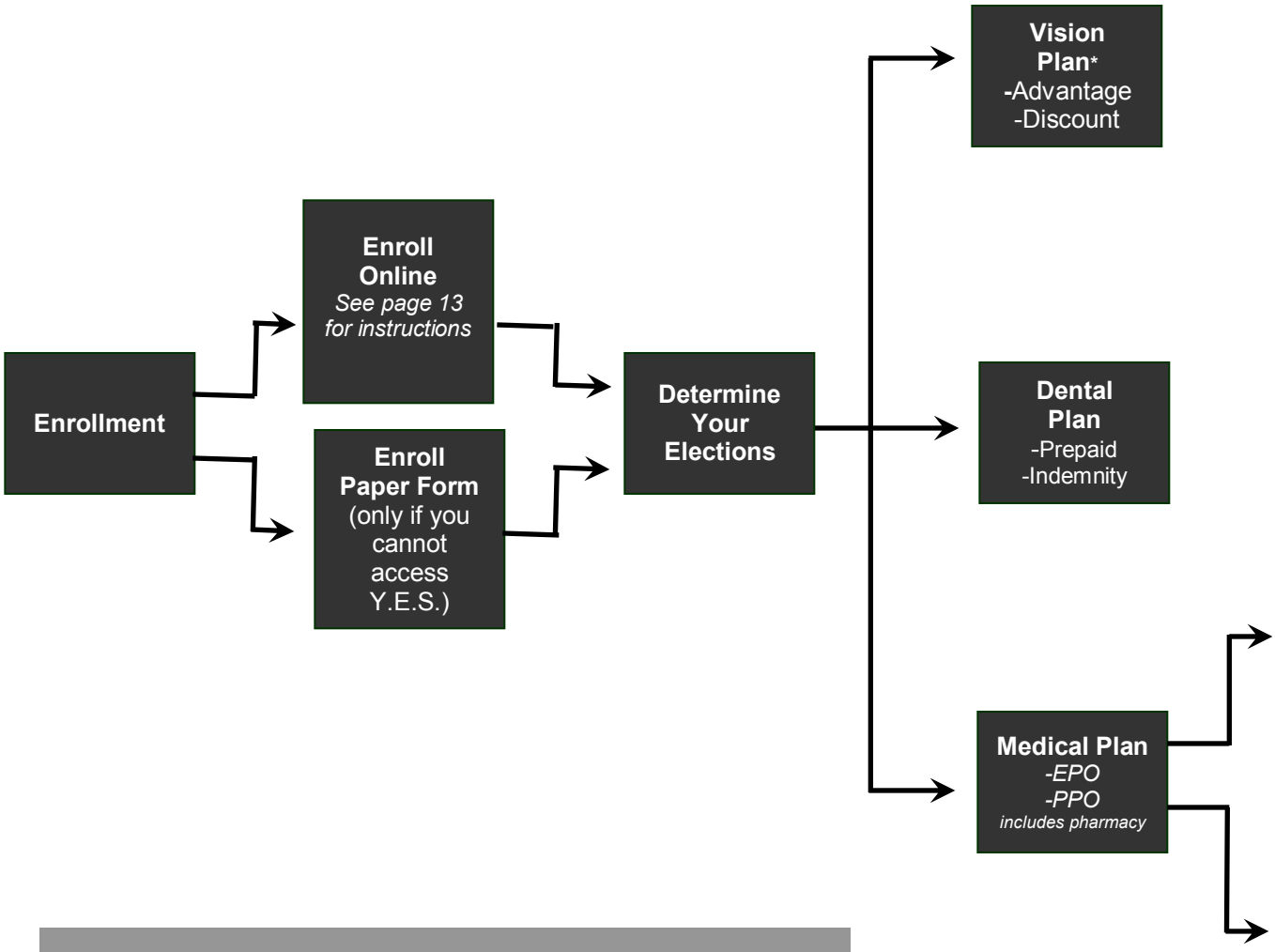
October 2014

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
20	21	22	23	24	25 Phoenix Convention Center 9am-3pm
27 Open Enrollment Starts	28 Glendale Renaissance Hotel 9am-3pm	29 Phoenix Capitol Mall 9am-3pm	30 Mesa Phoenix Marriott Mesa Hotel & Convention Center 9am-3pm	31 Flagstaff Doubletree by Hilton 9am-3pm	

November 2014

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
					1
3 Yuma Hilton Garden Inn/ Pivot Point Conference Center 9am-3pm	4	5 Tucson Sheraton Tucson Hotel & Suites 9am-3pm	6 Tucson Sheraton Tucson Hotel & Suites 9am-3pm	7	8
10	11	12	13	14	15
17	18	19	20	21 Open Enrollment Ends	

2015 RETIREE



Learn more…

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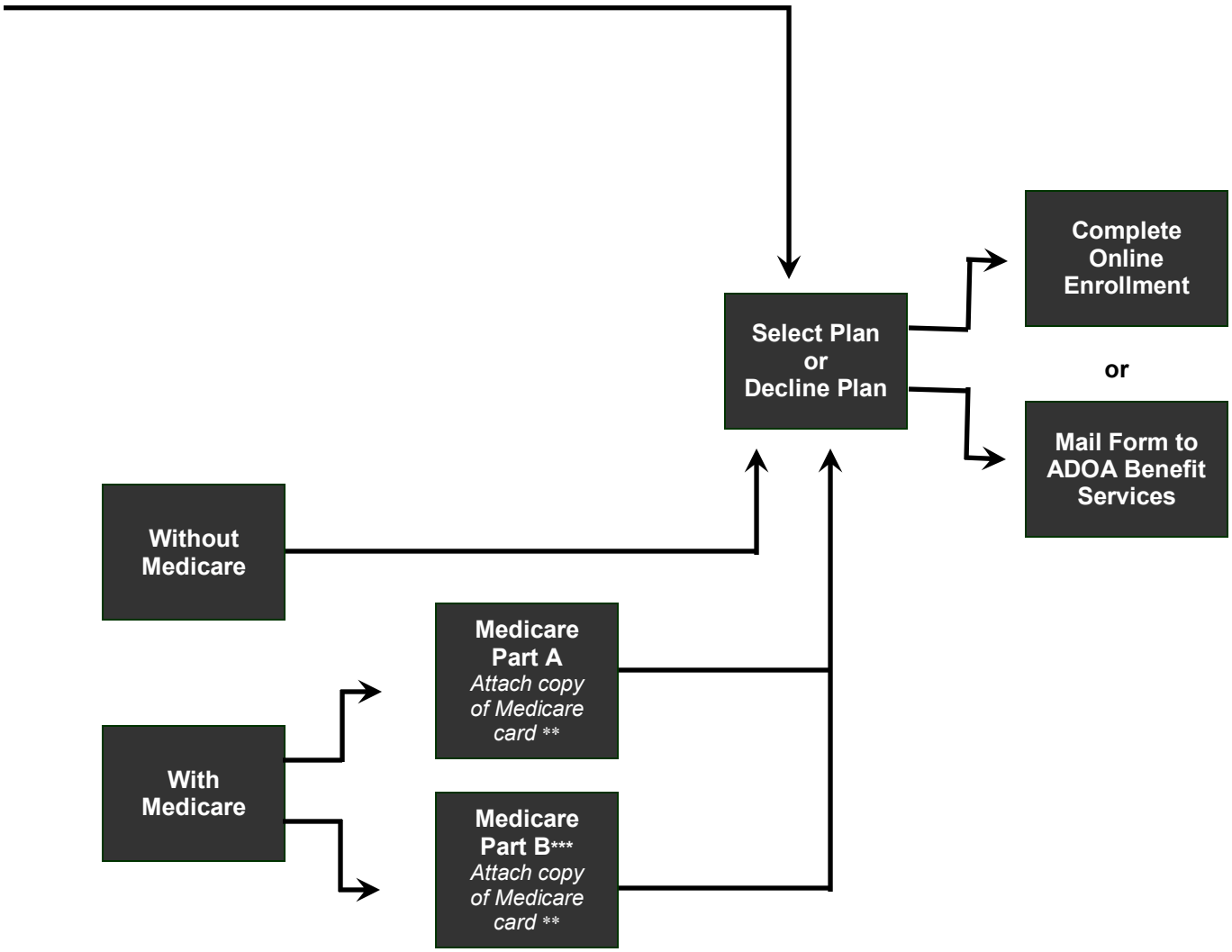
**Only available if medical and/or dental coverage is selected.*
***Medicare card required if electing a Medicare Plan with ADOA.*
****If you are eligible for Medicare Part B and choose not to elect it, you will be responsible for the cost of services covered by Medicare Part B.*

ENROLLMENT AT-A-GLANCE



Medicare Eligible Members
If you are newly electing medical coverage, you must submit a Medicare GenerationRx application form for each Medicare eligible family member.

BENEFIT CHANGES FOR PLAN YEAR 2015

The State of Arizona has awarded new contracts effective January 1, 2015 for Employee Health Benefits, Pharmacy Benefit Management Services, Employee Vision Benefits, Life, and Long-Term Disability Insurance.

Premiums

- No premium increases for medical or dental
- Reduction in premium for vision
- Reduction in premium for life and short-term disability

Active Enrollment

Participants are required to go online and actively elect their benefits for medical and vision. **If you do not re-elect coverage during this enrollment opportunity, you will lose coverage for these plans.** You are not required to take action on your dental benefits, your current election will automatically continue.

Changes made during this Open Enrollment will be effective January 1, 2015. See page 13 for online enrollment instructions.

Hearing Aid Benefit

Due to Affordable Care Act rules and regulations, the Plan has been amended to remove the $1,500 annual limitation for hearing aids effective January 1, 2014. Hearing aid devices are limited to one per ear, per Plan Year when determined to be medically necessary.

Medical Networks

The only change to the medical networks is Blue Cross Blue Shield of Arizona will administer their own network. The health plan networks continue to offer statewide and national coverage. When choosing a plan networks continue to offer statewide and national coverage. When choosing a network, it is important to check with your current provider to determine if he/she is contracted with your network of choice. More information about the medical plans can be found on pages 26-32 of this guide.

Pharmacy Benefit Management

The State has selected MedImpact to continue the administration of your pharmacy benefit. MedImpact continues to use the Walgreens Health Initiative system for both mail-order and specialty drug purchases. Members who use these services will experience no disruption.

Vision

The State has selected Avesis to continue to provide two vision programs. Beginning in 2015, Avesis is offering the following benefit enhancements:

- Premium reductions and a 4-tier plan structure (see page 17)
- LASIK benefit increase to $600. This benefit is in addition to the corrective eyewear benefit.
- Hearing Discount Program available at no cost for all eligible employees and their dependents

BENEFIT CHANGES FOR PLAN YEAR 2015

Life and Disability Insurance

The State has selected The Hartford to continue to provide Long-Term Disability, to eligible employees. The following benefit changes will be effective for any disability occurring on or after January 1, 2015.

Life Insurance Waiver of Premium

The definition for the Waiver of Premium has been revised to meet the definition of Total Disability. More information about this change can be found on page 57 of this guide.

ELIGIBILITY

Domestic Partners and Eligible Dependents

Pursuant to a change in Arizona law, A.R.S. § 38-651(O), domestic partners are not eligible dependents under the State of Arizona's benefit plan. As a result, this Arizona law precludes previously qualified same-sex and opposite-sex domestic partners from receiving benefits that were created by administrative rulemaking.

Accordingly, the State of Arizona will not be offering benefits to opposite-sex domestic partners. The State of Arizona intended that this law apply equally to same-sex domestic partners. However, a United States Federal District Court, in *Diaz v. Brewer, et al.* (2:09-cv-02402 JWS), imposed a preliminary injunction preventing the State of Arizona from implementing A.R.S. § 38-651(O) as applied to qualified same-sex domestic partners. The case is still in litigation and the State intends to defend its right to fully implement the statute and discontinue offering benefits to all domestic partners.

Important Disclosure and Disclaimer to Qualified Same-Sex-Domestic Partners:

As a result of the U.S. District Court preliminary injunction, the State of Arizona is compelled at this time to continue offering benefits to qualified same-sex domestic partners. Qualified same-sex domestic partners are herein ADVISED and CAUTIONED that the preliminary injunction possibly could be lifted after open enrollment or during the Plan Year. If that were to occur, the State of Arizona would no longer be compelled by the U.S. District Court injunction and the State of Arizona reserves the right to immediately discontinue offering benefits to same-sex domestic partners during the Plan Year and thereafter.
This also would include dependent children of the non-employee qualified same-sex domestic partner unless those individual(s) were an actual dependent of the State employee as defined under the State's benefit plan.

Qualified same-sex domestic partners and their dependents should not have an expectation that coverage will continue or an expectation that the benefits have vested for an entire plan year because the preliminary injunction may be lifted in the future.

Eligible Retirees

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

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 5 years of credited service in the Elected Officials Retirement Plan; was covered under a group health or accident plan at the time of leaving office; served as an elected official on or after January 1, 1983; and applies for enrollment within 31 days of leaving office or retiring.
D. Surviving spouses and qualified

ELIGIBILITY
Continued

dependents provided they were covered at the time of the retiree's death.

E. Surviving spouses of former elected officials provided they were covered at the time of the official's death.

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 coverages in the past, but have maintained either coverage through ADOA, you may re-elect medical and/or dental coverages during an Open Enrollment period.

C. If you have a qualified dependent that is not currently enrolled in Arizona Benefit Options, 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 Qualified Life Event (QLE). You have 31 days from the QLE to change your enrollment through ADOA, Human Resources Division, Benefit Services. The change must be consistent with the event. Please refer to the Benefit Services website for more information about QLEs.

Eligible Dependents

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

A. Your legal spouse

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

a. Shares the employee's or retiree's permanent residence;

b. Has resided with the employee or retiree continuously for at least 12 consecutive months before filing an application for benefits and is expected to continue to reside with the employee or retiree indefinitely as evidenced by an affidavit filed at the time of enrollment;

c. Has not signed a declaration or affidavit of domestic partnership with any other person and has not had another domestic partner within the 12 months before filing an application for benefits;

d. Does not have any other domestic partner or spouse of the same or opposite sex;

e. Is not legally married to anyone or legally separated from anyone else;

f. Is not a blood relative any closer than would prohibit marriage in Arizona;

g. Was mentally competent to consent to the contract when the domestic partnership began;

h. Is not acting under fraud or duress in accepting benefits;

i. Is at least 18 years of age; and

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

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

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

   iii. Assuming joint liabilities;

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

ELIGIBILITY
Continued

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

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

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

C. Your child defined as:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dependent Documentation Requirements

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, that occurred prior to his or her 26th birthday, in accordance with 42 U.S.C. 1382c.

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

ELIGIBILITY
Continued

Qualified Medical Child Support Order (QMCSO)

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

If You and Your Spouse are both State Retirees

Dual coverage is not permitted under this Plan. An employee may elect coverage for their entire family, including the State employee spouse, or each State employee spouse may elect their own coverage.

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

Eligibility Audit

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

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 the during 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 Health 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 service is considered a Qualified Life Event (QLE). The QLE then allows them to enroll in retiree benefits again.

End-Stage Renal Disease

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

WHERE TO ENROLL ONLINE

During Open Enrollment, October 27 through November 21, 2014, benefit elections must be made using the Y.E.S. system online 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
3. a. In the Login window, enter your Employee Identification Number (EIN) as your Username, which is the 5 or 6 digit number given to you by your Human Resources Office (your EIN is also printed on the back of this guide)

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

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**

CHANGING YOUR BENEFITS

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

Qualifying Life Events

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

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

Submitting a Change Request

Requested benefit changes must be submitted in writing to ADOA Human Resources Division, Benefit Services within 31 calendar days of the event.

Effective Date of the Change

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

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

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

Premium Changes Due to QLEs

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

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

New Retiree's Option of Life Insurance Continuation

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

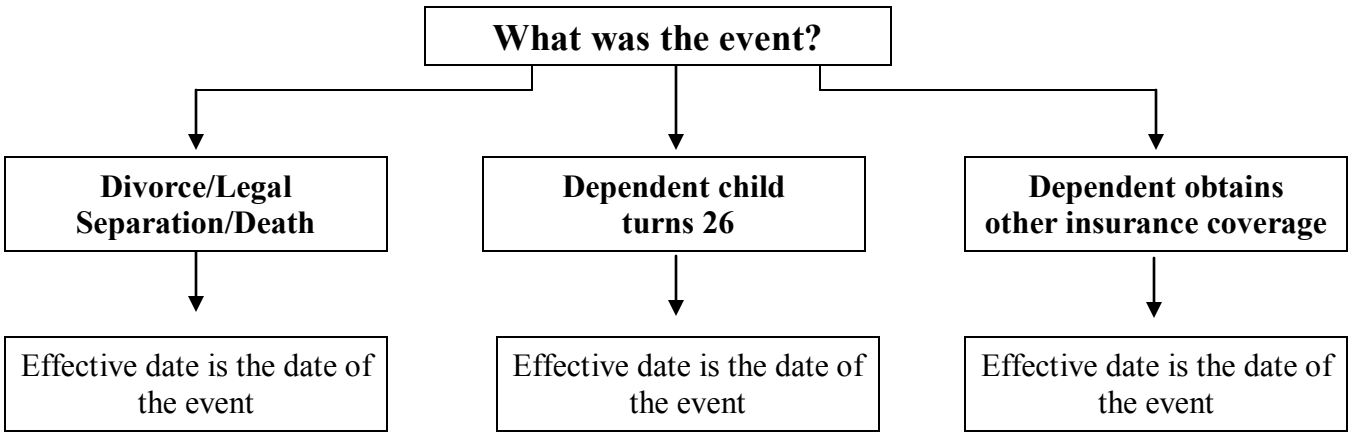
- Converting your group Life coverage to your own individual policy.
- Porting your Life coverage which continues as a term life policy. To be eligible for portability, you must terminate employment prior to Social Security Normal Retirement Age.

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

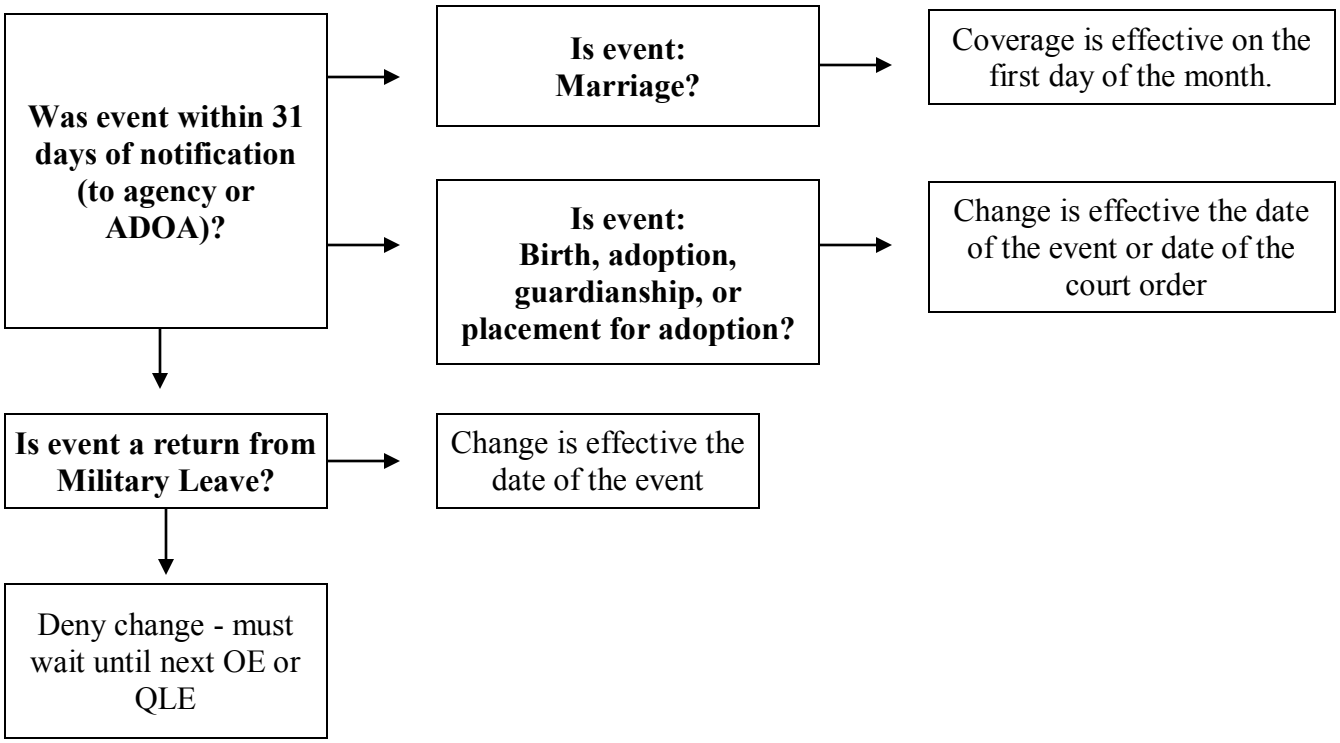
CHANGING YOUR BENEFITS FLOW CHART

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



SUMMARY OF MONTHLY INSURANCE PREMIUMS

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	$943
	Retiree + One	$2,219
	Family	$3,074

Monthly Medical Premiums (With Medicare)

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

For the NAU Blue Cross Blue Shield plan rates visit:
http://nau.edu/Human-Resources/Benefits/

SUMMARY OF MONTHLY INSURANCE PREMIUMS Continued

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 16			**A**
	+		
Your monthly dental plan premium from page 17			**B**
Total Premium	**(A plus B)**		**C**
Your Basic Premium Benefit Subsidy (See chart on page 20)	-		**D**
Your Net Premium	**(C minus D)**	=	**E**

UNDERSTANDING YOUR INSURANCE COST Continued

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 Human Resources Division, Benefit Services will mail a bill to you. It will be your responsibility to pay any outstanding premiums to ADOA Human Resources Division, Benefit Services. If you do not receive a bill by the twenty-fifth day of the month, you must contact ADOA Human Resources Division, 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 ADOA Human Resources Division, 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 Human Resources Division, Benefit Services 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 Human Resources Division, Benefit Services at 602.542.5008.

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.

UNDERSTANDING YOUR INSURANCE COST Continued

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 Human Resources Division, Benefit Services. 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

UNDERSTANDING YOUR INSURANCE COST Continued

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 18). Once the premium subsidy is added into your pension, the retirement system pays for your dental premium first. ASRS or PSPRS will apply remaining money to pay for your medical premium.

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

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

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

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

IMPORTANT NOTICE

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

RETAIN FOR YOUR RECORDS THIS IS NOT A CHECK

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

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

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

CRP16 AQ001 MNT

DIRECT DEPOSIT SUMMARY

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

PAYMENT DETAIL

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

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

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

YOUR PAYMENT HAS BEEN ELECTRONICALLY TRANSMITTED:

Deposit Account 00000000000000 Bank TR# 000000000000

09

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

NON - NEGOTIABLE

MEDICARE PART A & B

To help you calculate, use the three step worksheet on page 18. 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 3 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 ADOA Human Resources Division, Benefit Services with this information.

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

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 24)

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 plan 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 with any of the ADOA Medical Plans.)

MEDICARE PART A & B Continued

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 claims. If you decline or disenroll from Medicare Part B, you will be financially responsible for ALL Part B claims.

Medicare and ADOA

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

Medicare Primary

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

- Medicare is primary coverage
- Benefit Options is secondary coverage

How it Works

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

Copays

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

Medicare Crossover Program

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

MEDICARE PART A & B
Continued

Preventive Services Checklist

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

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

MEDICARE PART D

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

All Medicare-eligible participants covered under the State of Arizona Benefit Options Program will be enrolled in a 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 per day, 7 days per 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 *www.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 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 42.

MEDICAL PLAN INFORMATION

Understanding Your Options

For the plan year beginning January 1, 2015 retirees have the option of two plans and four networks. The word "Network" describes the company contracted with the State to provide access to a group of providers (e.g., doctors, hospitals). Certain providers may belong to one network but not another. Plans are loosely defined as the structure of your insurance policy: the premium, deductibles, copays, and out-of-network coverage associated with your medical benefit.

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

How the Plans Work

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

The EPO Plan

If you choose the EPO plan under Benefit Options you must obtain services from a network provider. Out-of-network services are only covered in emergency situations.

Under the EPO plan, you will pay the monthly premium and any required copay at the time of service. The EPO plan is available with all four networks: Aetna, BlueCross Blue Shield of Arizona, Cigna and UnitedHealthcare.

The PPO Plan

If you choose the PPO plan under Benefit Options you can see providers in-Network or out-of-Network, but will have higher costs for out-of-Network services. Additionally, there are in-Network and out-of-Network deductibles that must be met. Under the PPO plan, you will pay the monthly premium and any required copay or coinsurance (percent of the cost) at the time of service. The PPO plan is available with Aetna, Blue Cross Blue Shield of Arizona, and UnitedHealthcare.

Choosing the Best Plan for You and Your Family

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

1. Assess the costs you expect in the coming year including: monthly premiums, copays, and out-of pocket. Refer to pages 16-17 for monthly premiums and page 28 for the plan comparisons to help determine cost.

2. Determine if your doctors and specialists are contracted with the network you are considering. Each medical network has a website or phone number (under Contacts) for you to determine if your doctor is contracted.

MEDICAL PLAN INFORMATION
Continued

3. Once you have selected which plan best suits your needs and your budget, make any changes to your benefit by completing your benefit elections online or 2015 Enrollment Form.

Transition of Care (TOC)

If you are undergoing an active course of treatment with a provider who is not contracted with one of the new networks, you can apply for transition of care. If you are approved, you will receive in-network benefits for your current provider during a transitional period after January 1, 2015. Transition of care is typically approved if one of the following applies:

1. You have a life threatening disease or condition;
2. You have been receiving care and a continued course of treatment is medically necessary;
3. You are in the third trimester of pregnancy; or
4. You are in the second trimester of pregnancy and your doctor agrees to accept our reimbursement rate and to abide by the Plan's policies, procedures, and quality assurance requirements.

TOC forms are available on the Benefit Options website *benefitoptions.az.gov.*

ID Cards

Your personal insurance cards typically arrive 7-14 business days after your benefits become effective.

If you are an existing member of Aetna or Cigna and you re-elect the same network, you can continue to use your current ID card for 2015.

If you elect Blue Cross Blue Shield of Arizona or UnitedHealthcare, new ID cards will be issued effective January 1, 2015.

Contacts

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

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

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

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

MEDICAL PLANS COMPARISON CHART

		EPO	PPO	PPO
Available Plans		☑*Aetna* ☑*BCBSAZ* ☑*Cigna* ☑*UnitedHealthcare*	☑*Aetna* ☑*BCBSAZ* ☑*UnitedHealthcare*	☑*Aetna* ☑*BCBSAZ* ☑*UnitedHealthcare*
		IN-NETWORK	**IN-NETWORK**	**OUT-OF-NETWORK**
Plan year deductible	Retiree only	none	$500*	$1,000*
	Ret+adult, ret+child, family	none	$1,000*	$2,000*
Out-of-pocket max	Retiree only	none	$1,000*+	$4,000*
	Ret+adult, ret+child, family	none	$2,000*+	$8,000*
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	Ambulance	$0	$0	10% after deductible
ER copay waived if admitted	ER	$125	$125	$125
	Urgent care	$40	$40	50% after deductible
Home health services Maximum visits per year		42	42	
Hospital admission (Room and Board)		$150	$150	50% after deductible
Mammography		$0	$0	50% after deductible
Office visits	PCP	$15	$15	50% after deductible
Max of 1 copay/day/ provider	**Specialist	$30	$30	50% after deductible
	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

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

For the NAU only BCBS PPO plan details, go to http://hr.nau.edu and choose Benefits, Heath Insurances, Medical, BCBS Plan Book.

MEDICAL ONLINE FEATURES

You can review your personal profiles, view the status of medical claims, obtain general medical information, and learn how to manage your own healthcare through the available health plan websites.

Aetna

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

During Open Enrollment visit:
DocFind
To find out if your physician or hospital is contracted with Aetna use this online directory.

Aetna members can create a user name and password and have access to:
Aetna Navigator—Review Your Plan and Benefits Information
You can verify your benefits and eligibility. You will also have access to a detailed claims status and claim Explanation of Benefits (EOB) statements.

ID Card
Print a temporary or order a replacement ID card.

Contact and E-mail
Access contact information for Aetna Member Services as well as Aetna's 24/7/365 NurseLine. Chat live with member service representatives for quick, easy and secure assistance by using the Live Help feature within your Aetna Navigator homepage.

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

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

Personal Health Record
Access and print historical claims information that may be useful to you and your healthcare professional.

Aetna Mobile
Simply type aetna.com in your smart phone to access doctors, Aetna Navigator, and much more. There is an I-Phone application available for downloading.

MEDICAL ONLINE FEATURES Continued

Blue Cross Blue Shield of Arizona

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

Lookup Provider
To find out if your doctor, hospital, retail clinic, or urgent care provider is contracted with BCBSAZ use this tool.

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

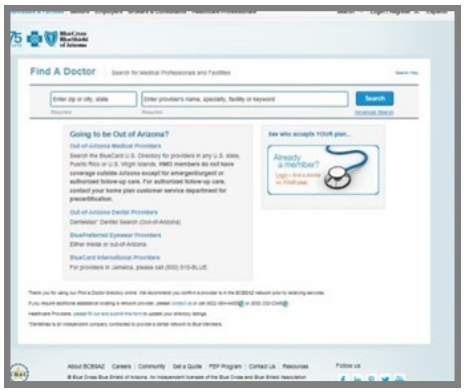
ID Card
Order a new ID card or print a temporary one.

Care Comparison
This simple online tool gives you access to price ranges for many common health care services right down to the procedure and the facility in your area.

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.

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

Coverage Inquiry
Verify eligibility for you and your dependents.



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.

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

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

MEDICAL ONLINE FEATURES
Continued

Cigna

Non-member: *cigna.com/stateofaz*
Existing member: *mycigna.com*

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

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

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

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

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

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

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

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

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

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

You can download a free, personalized smartphone 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.

MEDICAL ONLINE FEATURES Continued

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?
Click *"Find a doctor"* to search for doctors near you. You can even see which physicians have been recognized by the UnitedHealth Premium program® for having met national quality standards and local benchmarks for 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?
The health care cost estimator tool may help you get the best care for the best cost. Click on *"Estimate Health Care Costs"* to get started. It will guide you through the steps to get your estimate and provide you information about the procedure, risks, and benefits along the way.

Looking for an easier way to manage claims?
Click on *"Manage My Claims"* to easily search for claims, track claims you want to watch and subscribers can pay their health care providers online for any claim that has a 'You Owe' amount using the 'Make Payment' feature. All payment methods may not be available for all providers.

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
The UnitedHealthcare Health4Me™ mobile app helps put your insurance information in the palm of your hand.

MEDICAL MANAGEMENT

Services Available

When you choose Benefit Options medical insurance you get more than basic healthcare coverage. **You get personalized medical management programs at no additional cost**. Under the Benefit Options health plan, 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 Benefit Options Plan.

Disease Management

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

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

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

If you are eligible or become eligible for one of the programs above, a disease manager from your selected Network will assess your needs and work with your physicians to develop a personalized plan. Your personalized plan will establish goals and

MEDICAL MANAGEMENT Continued

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 Aetna, Blue Cross Blue Shield of Arizona, Cigna, and UnitedHealthcare identify and reach out through phone calls and/or mail to members who may need help managing their health conditions. The disease management companies work with the Benefit Options plan to provide this additional service.

Participation is optional, private, and tailored to your specific needs. Also, members of the Benefit Options plan who are concerned about a health condition and would like to enroll in one of the covered programs can contact their respective disease management vendors directly to self enroll. Please refer to the your medical management vendor's phone number on page 33 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

Cigna 1.800.968.7366

UnitedHealthcare 1.800.401.7396

NETWORK OPTIONS OUTSIDE OF ARIZONA

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

PRE-MEDICARE PHARMACY PLAN INFORMATION

MedImpact

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

MedImpact currently services 47 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 41. The copays listed in the chart are for a 30-day supply of medication bought at a retail pharmacy.

Formulary

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

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

Finding a Pharmacy

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

The 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.

PRE-MEDICARE PHARMACY PLAN INFORMATION Continued

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

- Submit a 90-day written prescription from your physician.
- Request up to a 90-day supply of medication for **two copays** (offer available to HSA Option members only when copays apply).
- Payments can be made by check or credit card: Visa, MasterCard, American Express, or Discover.
- Register your e-mail address to receive information on your orders.
- Order refills online at *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 Walgreens Specialty Pharmacy Program includes monitoring of specific injection drugs and other therapies requiring complex administration methods and special storage, handling, and delivery.

Specialty medications are limited to a 30-day supply and may be obtained only at a Walgreens retail pharmacy or 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.

PRE-MEDICARE PHARMACY PLAN INFORMATION Continued

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 an extra medication you will need *providing you have the appropriate number of refills remaining.*

Order refills at least two weeks in advance of your departure. If there is a problem, such as, *not enough refills*, you will have enough time to phone your physician. If you're using Mail Order, contact MedImpact at least three weeks in advance.

If you are already out of town and need a prescription call MedImpact. Tell the representative you are out of town and need to find a participating pharmacy in the area where you are. You will need the zip code where you are visiting. In most cases you will have several choices.

If your medication is lost, stolen, or damaged, replacement medication is not covered.

Contacts

MedImpact

Customer Care Center and Prior Authorization	1.888.648.6769

Walgreens

Mail Order	1.866.304.2846
Specialty Pharmacy	1.888.782.8443

PRE-MEDICARE PHARMACY PLAN INFORMATION Continued

NAU Retiree BCBS Member 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 *www.bcbsaz.com.* Go to 4 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.

PRE-MEDICARE PHARMACY ONLINE FEATURES

Pre-Medicare members can view pharmacy information located at *benefitoptions.az.gov*. Click on the pharmacy link and go to the Retired State Employees, Pre-Medicare Pharmacy Benefits, and click on 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.

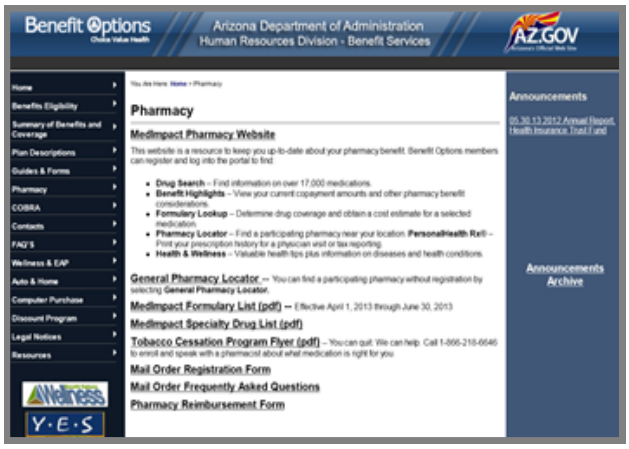
Health & Wellness
Learn valuable tips and information on diseases and health conditions.

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 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 only Blue Cross/Blue Shield Members

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

PRE-MEDICARE PHARMACY BENEFITS SUMMARY

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

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

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

MEDICARE ELIGIBLE PHARMACY PLAN INFORMATION

Medicare GenerationRx

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

Effective January 1, 2015, if you elect any Benefit Options medical plan, you will be automatically enrolled in the Medicare GenerationRx for Benefit Options.

Medicare GenerationRx is sponsored by Stonebridge Life Insurance Company, a Medicare approved Part D sponsor. 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 ($4,700 in total out-of-pocket costs for 2015), 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.

The benefit information provided is a brief summary, not a complete description of benefits.

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.

MEDICARE ELIGIBLE PHARMACY PLAN INFORMATION Continued

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

** Total medication cost.*

Members will use Medicare GenerationRx's 4 tier formulary. Generic and brand name medications are available at a lower 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 open 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.

MEDICARE ELIGIBLE PHARMACY PLAN INFORMATION Continued

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 will receive a pharmacy directory based on their permanent address as part of the Welcome Kit.

Members may request additional directories from Member Services or use the online Pharmacy Locator at *medicaregenerationrx.com/stateofaz*.

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.*

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*.

MEDICARE ELIGIBLE PHARMACY PLAN INFORMATION Continued

Specialty medications are limited to a 31-day supply.

*Other pharmacies are available in our network.

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 per week. TTY/TDD users should call 1.877.486.2048, or visit *medicare.gov*.

Part D Income Related 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 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 2015*** gives information about the Medicare premiums in the section called "2015 Medicare Costs." This explains how the Medicare Part B and Part D premiums differ for Medicare eligible members and their dependents with different incomes.

MEDICARE ELIGIBLE PHARMACY PLAN INFORMATION Continued

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 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 *providing you have the appropriate number of refills remaining.*

Order refills at least two weeks in advance of your departure. If there is a problem, such as, *not enough refills*, you will have enough time to phone your physician.

MEDICARE ELIGIBLE PHARMACY PLAN INFORMATION Continued

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 & 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.*

MEDICARE ELIGIBLE PHARMACY ONLINE FEATURES

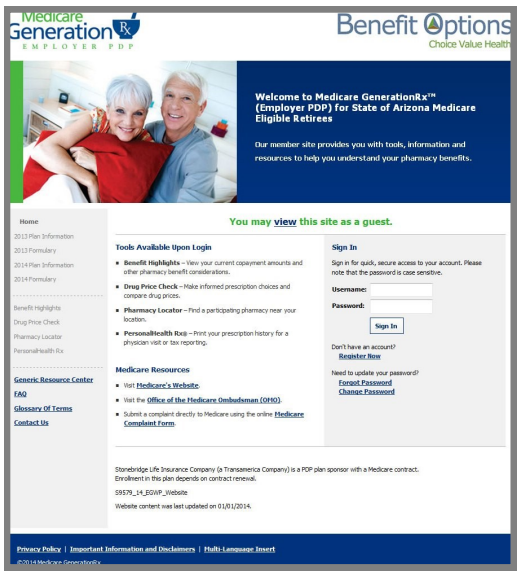
Members can view pharmacy information at *medicaregenerationrx.com/stateofaz.*

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.

DENTAL PLAN INFORMATION

Dental Plan Options

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

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

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

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

Indemnity/PPO Plan – Delta Dental PPO plus Premier

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

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

To find a Delta Dental dentist near you, 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

DENTAL PLAN INFORMATION Continued & ONLINE FEATURES

dentist, make sure he/she participates on the plan (prepaid/DHMO plan -TDAHP or indemnity/PPO - Delta Dental PPO plus Premier) you are considering.

ID Card

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

Total Dental Administrators Health Plan (TDAHP), Inc.

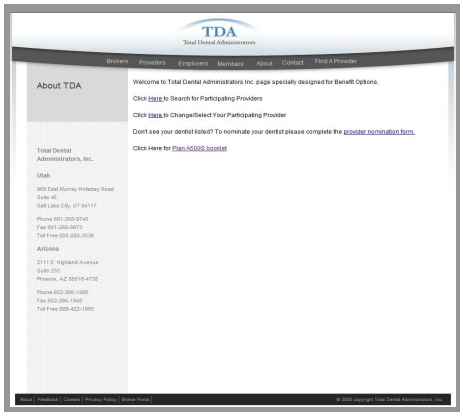
If you are enrolling with TDAHP go to *TDAdental.com/adoa* to access the following online features:

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

Select or Change Participating Provider
You can select or change your specific participating provider.

Nominate a Dentist
If you have a preferred dentist that is not a participating provider, you can nominate your dentist to be included in the plan.

Plan A500AZ
Learn about the plan by clicking on this option.



Delta Dental PPO plus Premier

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

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

Plus:

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

DENTAL PLANS COMPARISON CHART

	TDAHP Total Dental Administrators	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*
Prophylaxis/Cleaning	$0	$0 - Deductible Waived*
Fluoride Treatment	$0 (to age 15)**	$0 - Deductible Waived* (to age 18)
X-Rays	$0	$0 - Deductible Waived*
BASIC CLASS II SERVICES		
Office Visit	$0	$0*
Sealants	$10 per tooth (to age 17)	20% (to age 19)
Fillings	Amalgam: $10-$37	20%
	Resin: $26-$76	
Extractions	Simple: $30 Surgical $60	20%
Periodontal Gingivectomy	$225	20%
Oral Surgery	$30 - $145	20%
BASIC CLASS III SERVICES		
Office Visit	$0	$0*
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%
ORTHODONTIA		
Child	$2,800 - $3,400	See lifetime
Adult	$3,200 - $3,700	
TMJ SERVICES		
Exam, services, etc.	20% Discount	100%

**Routine visits, exams, cleanings, x-rays (Bitewing, Periapicals), and fluoride treatments are covered two times per plan year at 100%.*
***Fluoride treatment covered 100% once per plan year up to age 15. Additional treatment subject to applicable copayments.*
This is a summary only; please see plan descriptions for detailed provisions.

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.

Benefit Changes for 2015

- Four tier options and lower premiums
- Increased allowance for LASIK surgery - now at $600
- Hearing Discount 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 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.

VISION PLAN INFORMATION Continued & VISION ONLINE FEATURES

Refractive Surgery Benefit

LASIK surgery benefits are available to Advantage Program or Discount Program members. To find a LASIK provider - visit *www.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.*

Online Features

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

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

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

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

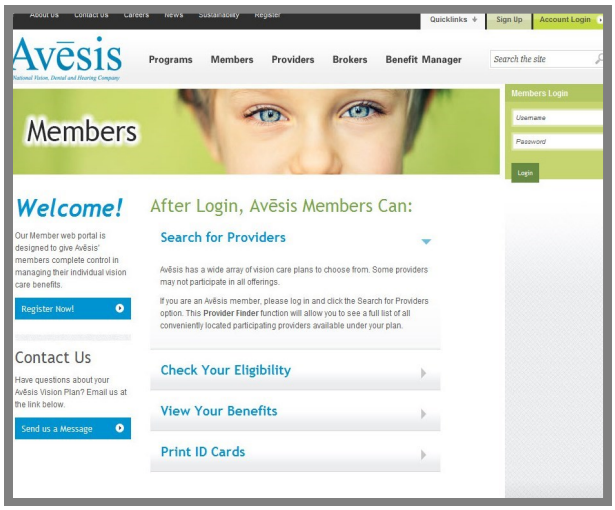
Print an ID Card
If you lose or misplace your ID card, you can print a new one.

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

Glossary
You can learn about vision terminology.

Facts on Vision
Learn about different vision facts.

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



VISION PLANS COMPARISON CHART

IN-NETWORK BENEFITS		
	Advantage Vision Care Program	**Discount Vision Care Program***
Examination Frequency	Once every 12 months	Once per 12 months
Lenses Frequency	Once every 12 months	Once per 12 months
Frame Frequency	Once every 12 months	Once per 12 months
Examination Copay	$10 copay	20% discount
Optical Materials Copay (Lenses & Frame Combined)	$0 copay	Refer to schedule below
Standard Spectacle Lenses		
Single Vision Lenses	Covered-in-full	20% discount
Bifocal Lenses	Covered-in-full	20% discount
Trifocal Lenses	Covered-in-full	20% discount
Lenticular Lenses	Covered-in-full	20% discount
Progressive Lenses	Uniform discounted fee schedule	20% discount
Selected Lens Tints & Coatings	Uniform discounted fee schedule	20% discount
Frame		
Frame	Covered up to $100-$150 retail value ($50 wholesale cost allowance)	20% discount
Contact Lenses (in lieu of frame/spectacle lenses)		
Elective	10-20% discount & $150 allowance	10-20% discount
Medically Necessary	Covered-in-full	10-20% discount
LASIK/PRK		
LASIK/PRK	Up to $600	10-20% discount

**Members that choose not to enroll in the Advantage Vision Care Program will automatically be enrolled in the Discount Plan at no cost.*

VISION PLANS COMPARISON CHART

OUT-OF-NETWORK BENEFITS		
	Advantage Vision Care Program	**Discount Vision Care Program***
Examination Frequency	Once every 12 months	No benefit
Lenses Frequency	Once every 12 months	No benefit
Frame Frequency	Once every 12 months	No benefit
Examination	Up to $50 reimbursement	No benefit
Standard Spectacle Lenses		
Single Vision Lenses	Up to $33 reimbursement	No benefit
Bifocal Lenses	Up to $50 reimbursement	No benefit
Trifocal Lenses	Up to $60 reimbursement	No benefit
Lenticular Lenses	Up to $110 reimbursement	No benefit
Progressive Lenses	Up to $60 reimbursement	No benefit
Lens Tints & Coatings	No benefit	No benefit
Frame		
Frame	Up to $50 reimbursement	No benefit
Contact Lenses (in lieu of frame/spectacle lenses)		
Elective	Up to $150 reimbursement	No benefit
Medically Necessary	Up to $300 reimbursement	No benefit
LASIK/PRK		
LASIK/PRK	Up to $600 reimbursement	No benefit

**Members that choose not to enroll in the Advantage Vision Care Program will automatically be enrolled in the Discount Plan at no cost.*

INTERNATIONAL COVERAGE

	INTERNATIONAL COVERAGE
MEDICAL CARE	
EPO Plans	
Aetna	Emergency & Urgent Only
BCBSAZ	Emergency & Urgent Only
Cigna	Emergency & Urgent Only
UnitedHealthcare	Emergency & Urgent Only
PPO Plans	
Aetna	Emergency & Urgent Only at In-Network Benefit Level*
BCBSAZ	Emergency & Urgent Only at In-Network Benefit Level*
UnitedHealthcare	Emergency & Urgent Only at In-Network Benefit Level*
HSA Plan	
Aetna	Emergency & Urgent Only at the In-Network Benefit Level*
NAU Only	
Blue Cross Blue Shield PPO	For assistance with locating a provider and locating a provider and submitting claims call 1.800.810.2583 or 1.804.673.1686. For an international claim form, go to *www.bcbs.com/blue cardworldwide/index*
PHARMACY	
MedImpact/Medicare GenerationRx	Not covered
DENTAL CARE	
Prepaid/DHMO Plan	
Total Dental Administrators Health Plan, Inc.	Emergency Only
PPO Plan	
Delta Dental PPO plus Premier	Coverage is available under non-participating provider benefits
VISION CARE	
Avesis	Covered as out-of-Network and will be reimbursed based on the Avesis reimbursement schedule

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

LONG-TERM DISABILITY MEMBERS

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 3 months before your Medicare entitlement date. You must mail a copy of your Medicare card to the ADOA Human Resources Division, Benefit Services 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 Human Resources Division, Benefit Services.

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 people with Medicare. It explains the options you have under Medicare prescription drug coverage (Medicare Part D) and can help you decide whether or not you want to enroll.

COBRA Coverage Notice
Notice of the Arizona Benefit Options Program COBRA Coverage.

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

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

GLOSSARY

Appeal
A request to a plan provider for review of a decision made by the plan provider.

Balance Billing
A process in which a member is billed for the amount of a provider's fee that remains unpaid by the insurance plan. You should never be balance billed for an in-network service; out-of-network services and Non-covered services are subject to balance billing.

Beneficiary
The person(s) you designate to receive your life insurance (or other benefit) in the event of your death.

Brand Name Drug
A drug sold under a specific trade name as opposed to being sold under its generic name. For example, Motrin is the brand name for ibuprofen.

Case Management
A process used to identify members who are at risk for certain conditions and to assist and coordinate care for those members.

Centers for Medicare & Medicaid Services (CMS)
The Federal agency that administers Medicare. You may contact Medicare at 1.800.MEDICARE (1.800.633.4277) or *medicare.gov.*

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

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

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

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

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

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

Creditable Coverage
Prescription drug coverage (for example, from an employer) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People

GLOSSARY

who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Deductible
Fixed dollar amount a member pays before the health plan begins paying for covered medical services. Copays and/or coinsurance amounts may or may not apply (see comparison chart on page 28).

Dependent
An individual other than a health plan subscriber who is eligible to receive healthcare services under the subscriber's contract. Refer to pages 9-12 for eligibility requirements.

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

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

Domestic Partner
Refer to pages 9-12 for eligibility requirements.

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

Emergency
A medical or behavioral condition of sudden onset that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a person who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the insured person in serious jeopardy, serious impairment to bodily functions, serious disfigurement of the insured person, serious impairment of any bodily organ or part of the insured person, or in the case of a behavioral condition, placing the health of the insured person or other persons in serious jeopardy.

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

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

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

GLOSSARY

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

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

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

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

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

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

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

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

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

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

Medicare
The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-State Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through

GLOSSARY

Original Medicare, a Medicare Cost Plan, a PACE plan, or a Medicare Advantage Plan and prescription drug coverage through a Medicare Advantage Prescription Drug plan (MA-PD) or a standalone Prescription Drug Plan (PDP) that works with Original Medicare.

Member
A person who is enrolled in the health plan.

Member Services
A group of employees whose function is to help members resolve insurance-related problems.

Network
The collection of contracted healthcare providers who provide care at a negotiated rate.

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

Out-of-Pocket Maximum
The annual amount the member will pay before the health plan pays 100% of the covered expenses. Out-of-pocket amounts do not carry over year to year.

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

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

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

Pre-Authorization
The process of becoming approved for a healthcare service prior to receiving the service.

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

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

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

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

GLOSSARY

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

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