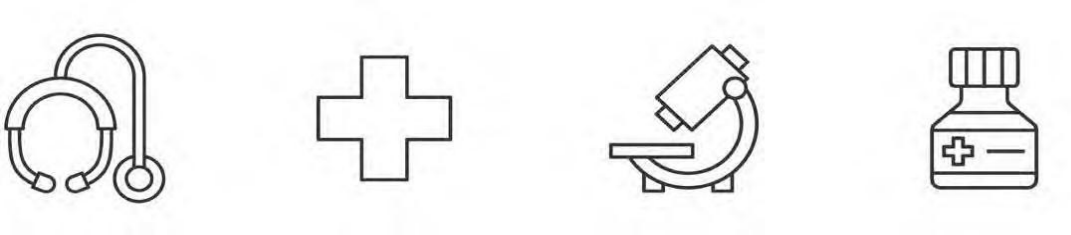
Arizona Department of Administration | ADOA

Benefit Options
Benefit Guide 2023
Active Employees



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ARIZONA
DEPARTMENT OF ADMINISTRATION
BENEFITS

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Introduction

This guide describes the comprehensive benefits package “Benefit Options” offered by the State of Arizona, Department of Administration -Benefit Services effective January 1, 2023. Included in this reference guide are explanations of the benefits programs, important plan information, contact addresses, phone numbers, web addresses, and comparison charts.

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

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

For more detailed information, please refer to your plan descriptions. If you need additional information, please visit our website at benefitoptions.az.gov or call us at 602-542-5008 or toll free at 1-800-304-3687.

Benefit Plan Changes for 2023

The 2023 Benefits Plan Year is January 1 - December 31, 2023.

- **Dental Plan**
    - The Cigna Dental Health Maintenance Organization (DHMO) plan is changing to the UHC Solstice S800B DHMO.
    - The premiums remain the same.
- **Flexible Spending Account (FSA) Maximum Contributions - TASC Card**
    - Healthcare: $2,850 ($100 increase)
    - Daycare/Eldercare: $5,000 (no change)
- **Health Savings Account (HSA) Maximum Contributions - Optum Card**
    - Individual: $3,850 ($200 increase)
    - Family: $7,750 ($450 increase)
    - Age 55 catch-up: $1,000 (no change)

Eligibility

Active Employees

- You and your eligible dependents are eligible for the Benefit Options program if you are hired by the State, including a state university and meet the required hours.
- Regularly scheduled employee: paid for at least 20 hours per week for at least 90 days.
- Seasonal, temporary or variable hour employee: paid for an average of 30 hours per week (1,560 per year) using an initial 12-month measurement period which starts on the first of the month after the hire date.
- To maintain eligibility through the annual standard measurement period of October 10th each year through October 9th of the following year, regularly scheduled employees must be paid for a minimum of 1,040 hours per year; seasonal, temporary or variable hour employees must be paid for a minimum of 1,560 hours per year.

  Does not include:

  A. A patient or inmate employed at a state institution;
  B. A non-state employee, officer, or re-enlisted personnel of the National Guard of Arizona;
  C. An individual who fills a position designed primarily to provide rehabilitation to the individual;
  D. An individual hired by a state university or college for whom the state university or college does not contribute to a state-sponsored retirement plan unless the individual is:
     a. A non-immigrant alien employee;
     b. Participating in a medical residency or post-doctoral training program;
     c. On federal appointment with cooperative extension;
     d. A retiree who has returned to work under A.R.S. § 38-766.01.

Dependents

The following dependents may be added to your plans:

A. Your legal spouse
B. Your child defined as:
   a. A natural child, adopted child, step child, foster child, a child whom there is court-ordered guardianship or a child with a court order pending adoption who is younger than age 26.
   b. Your child who is disabled and continues to be disabled as defined by 42 U.S.C. 1382c before the age of 26.

If you have a qualified dependent that is not currently enrolled in the Benefit Options Plan, he or she may be added during a future 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 date of the QLE to change your enrollment through ADOA Benefit Services Division. The change must be consistent with the event. Please refer to the Benefit Services website, benefitoptions.az.gov/qle, for more information about QLEs.

Qualified Medical Child Support Order (QMCSO)

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

Dependent Documentation Requirements

- Your dependent's coverage will not be processed until you have submitted doucmentation from the **Supporting Documentation for Qualified Life Events & New Hire/Rehire Enrollment** list as found on **benefitoptions.az.gov/QLE**.
- Your dependent child is approaching age 26 and has a disability. Application for continuation of dependent status must be made to your medical network within 31 days of the child's 26th birthday. You

will need to provide verification that your dependent child has a qualifying permanent disability, which occurred prior to his or her 26th birthday, in accordance with 42 U.S.C. 1382c.
- Employees are required to provide Social Security Numbers (SSN) for all dependents enrolled in the Benefit Options medical plans. This requirement is in accordance with the Mandatory Insurer Reporting Law (Section 111 of Public Law 110-173) which was effective January 1, 2009.

Rehires
For the purposes of benefits, you are considered a new hire. Please submit all required documentation as specified above under "Dependent Documentation Requirements."

Qualified Life Events
You may only change your benefit elections when you experience a Qualified Life Event (QLE). If you have not experienced a QLE, you must wait until the next open enrollment period to make benefit changes. Members have 31 days to enroll or change coverage options if a qualified life event occurs. Events that may be considered include but are not limited to:

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

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

Effective Date of the Change
The effective date of coverage beginning or ending depends on the type of event following the date the requested change and required documentation is submitted to ADOA-Benefit Services Division. For more information, refer to the "Qualified Life Event and Mid-Year Changes Chart" on benefitoptions.az.gov/QLEchart.

Section 125
Please consult with the Benefit Services Division to determine if the life event you are experiencing qualifies under the Section 125 regulations.

Divorce and Ex-Spouse Coverage
Divorce is a QLE. You are required to drop coverage for an ex-spouse within 31 days of your divorce decree. For court orders to provide insurance for an ex-spouse, obtain it elsewhere.

Newborn Coverage
Your newborn is ONLY covered under your insurance for the first 31 days after birth. By the 31st day, you must ENROLL your newborn as a dependent or the baby will not be covered. Miss the deadline, and you must wait until the next QLE or Open Enrollment. To enroll your child, submit a Declaration for Change form found on benefitoptionsaz.gov/forms with a crib card, birth certificate or hospital verification letter.

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

You cannot enroll as a single subscriber and be enrolled as a dependent on your spouse's or parent's policy simultaneously. If an individual is enrolled in this manner, the dual coverage will be terminated and 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. Per Arizona Administrative Code 2 A.A.C. 6, Article 3, R2-6-303, this audit may occur either randomly or in response to uncertainty concerning dependent eligibility. Should you have questions after receiving a request to provide proof of dependent eligibility, please contact the Audit Services Unit within the ADOA Benefit Services Division.

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

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

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

End-Stage Renal Disease
If you are eligible to enroll in Medicare as an active employee or retiree because of End-Stage Renal Disease (ESRD), 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. If you choose a doctor that does not accept assignment from Medicare, your doctor may be allowed to bill you for additional costs up to the Medicare limiting charge.

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

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

1. An employee who had coverage through Benefit Options and lost the coverage because of a reduction in hours of employment or a termination of employment for a reason other than gross misconduct.
2. An employee's legal spouse, as defined by Arizona Statute, who had coverage through Benefit Options and lost the coverage for any of the following reasons:
    a. Death of the employee;
    b. Termination of the employee's employment for a reason other than gross misconduct;
    c. Reduction in the employee's hours of employment resulting in a loss of eligibility for coverage;
    d. Divorce or legal separation from the employee;
    e. The employee becomes eligible for Medicare.
3. An employee's dependent child who had coverage through Benefit Options and lost the coverage for any of the following reasons:
    a. Death of the employee (parent);

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

The ADOA Benefit Services Division will determine final eligibility for COBRA coverage. The ADOA Benefit Services Division will determine whether the life event you are experiencing qualifies under the Section 125 regulations. Please see p.9 for more information regarding COBRA coverage, or visit benefitoptions.az.gov/cobra.

How to Enroll

STEP 1 – MAKE AN INFORMED CHOICE

- Visit PicWell - This decision tool will help you explore your options, and determine the most appropriate and cost-effective plans for you. Visit **adoa.picwell.com**.
- Guides - Read through this guide.
- Carrier Websites - Visit BlueCross BlueShield of AZ at azblue.com/stateofaz and UnitedHealthcare at uhcvirtual.com/stateofaz

STEP 2 – UPDATE YOUR WEB BROWSER

- The supported web browsers for enrollment are: Google Chrome, Microsoft Edge Chromium, Apple Safari, Mozilla Firefox. Using other web browsers will create enrollment issues.
- If it is necessary to install a browser, search for it online and follow the download instructions.
- Use a computer, not a phone or tablet.

STEP 3 - ACCESSING Y.E.S. PORTAL

- To set your password for the Y.E.S. Portal, visit hr.az.gov/first-time-user/yes
- Follow the instructions under "Accessing Y.E.S. for New Employees" Y.E.S. stands for "Your Employee Services."
- Password Reset
    - Visit hrsystems.azdoa.gov > Y.E.S. Portal. On the login page, click "Forgot / Reset Password"

STEP 4 – ENROLL

- Login to hrsystems.azdoa.gov > Y.E.S. Portal.
- On the left side, click BOOKMARKS > NEW HIRE ENROLLMENT.
- Then follow the steps to enroll.
- After completing each screen, click the blue CONTINUE button in the right hand corner.
    - Hint: Scroll down to find the button.
- Problems with accessing the Y.E.S. website? Contact the HRIS Help Desk at 602-542-4700.
- Benefit questions? Contact Benefit Services at 602-542-5008 or toll-free 1-800-304-3687.

STEP 5 – CONFIRMATION EMAIL

- Immediately after enrolling, a confirmation email titled "Annual Benefits Enrollment Summary" will be sent to your work and personal emails on file.
- Please review this email to ensure your elections are correct.
- Save the email for future reference.

Contact Information Requirement

You are required to validate and update your personal contact information, such as mailing address, email and phone number, so we can communicate efficiently with you about your benefits. To change your contact information at any time, visit hrsystems.azdoa.gov > Y.E.S. Portal, call 602-542-5008, or 800-304-3687. ADOA is not responsible for lost or misdirected communications.

Beneficiaries

If you elect Supplemental Life insurance, you will be unable to designate a beneficiary at the time of election. You must log in to hrsystems.azdoa.gov > Y.E.S. Portal after the benefit becomes effective, the pay period following enrollment, to designate a beneficiary.

University Faculty and Staff - *Please refer to your Human Resources website to compare both the state-sponsored and university-sponsored plans.*

Benefits Decision Tool | PicWell

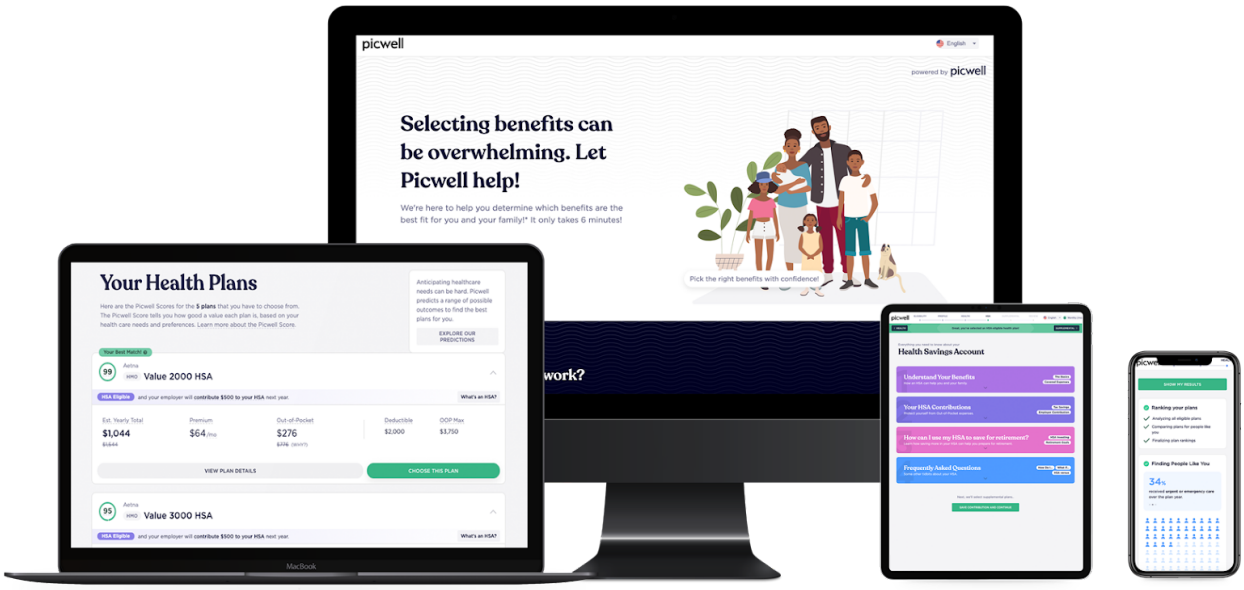
Personalized Benefits Guidance
When it comes to selecting the right benefits for you and your family, preferences matter. Picwell crunches the numbers for you based on your unique health risk and preferences and then delivers a personalized health cost prediction and ranking for each health plan we offer.

Make an Informed Decision
Picwell predicts your potential healthcare costs so you know what to expect.

How Picwell Works
Picwell combines big data, artificial intelligence and economic models to help you find the health insurance plan that's right for you.

The Process
To get the most personalized and accurate results, Picwell will ask you a handful of key questions -- some requiring personal information. Your experience is totally private. Personal information is not maintained or sent to your employer. It is completely anonymous.

Getting Started
- Visit adoa.picwell.com
- Using Picwell is fast and simple! The whole process takes less than five minutes.
- Please note, after using PicWell, you must log into hrsystems.azdoa.gov > Y.E.S. Portal to elect benefits.



Premiums Summary

Medical Plan Premiums Per Pay Period

Network Carriers: Blue Cross Blue Shield of Arizona and UnitedHealthcare (rates apply to both)

	Triple Choice Plan (TCP)		High Deductible Health Plan + HSA (HDHP)		
	Employee	State	Employee	State	Agency HSA Contribution
Employee Only	$26.17	$351.96	$10.15	$237.66	$27.69
Employee + Spouse	$71.49	$724.82	$30.46	$492.59	$55.38
Employee + 1 Child	$57.30	$471.40	$25.89	$321.99	$55.38
Family	$121.61	$820.71	$56.35	$548.80	$55.38

Dental Plan Premiums Per Pay Period

Plan Type	DHMO - UHC Solstice S800B[1]	Delta PPO Plus Premier
Employee Only	$1.64	$14.30
Employee + Adult	$3.29	$30.33
Employee + Child	$3.08	$23.34
Employee + Family	$5.46	$48.26

[1]Coverage is not available in these states/territories: AK, AL, AR, DE, HI, IA, ID, LA, ME, MS, MT, ND, NE, NH, OK, RI, SD, VT, WV, WY, GU, USVI, and PR. Check to see if your provider is on the plan and see the plan coverage by visiting smilestateofaz.com. Use plan code S800B.

Vision Plan Premiums Per Pay Period	Avesis Advantage Program
Employee Only	$1.72
Employee + Spouse	$5.70
Employee + 1 Child	$5.65
Employee + Family	$7.11

Supplemental Life And AD&D Insurance

Premiums Per Pay Period[1]

Your Age	Cost per $5,000
29 and under	$0.14
30-34	$0.16
35-39	$0.17
40-44	$0.28
45-49	$0.36
50-54	$0.57
55-59	$0.82
60-64	$1.44
65-69	$1.44
70+	$2.26

[1] The total calculated premium may vary due to payroll rounding.

Dependent Life And AD&D Insurance

Premiums Per Pay Period[1]

Coverage Amount	Cost Per Pay Period
$2,000	$0.43
$4,000	$0.87
$6,000	$1.30
$10,000	$2.17
$12,000	$2.60
$15,000	$3.25
$50,000[2]	$10.85

[1]The total calculated premium may vary due to payroll rounding.
[2]You must have combined basic & supplemental coverage of at least $50,000; supplemental life elections must be at least $35,000.

STD Premiums	STD Payable Benefit[2]	
Employee Cost Per Pay Period[1]	**Weekly Minimum**	**Weekly Maximum**
Monthly premiums are $0.316 for every $100 of your annual base pay, up to the first $70,000, if applicable. You pay premiums each bi-weekly pay period. **Calculate Per Pay Period Premium:** ● Step 1: (Annual Salary ÷ 100) x $0.316 = Annual Premium ● Step 2: Annual Premium ÷ 26 Pay Periods = Pay Period Premium[1] **Example:** ● Step 1: ($45,000 ÷ 100) = 450 x $0.316 = $142.20 ● Step 2: $142.20 ÷ 26 = $5.47 Pay Period Premium[1]	$67.31 or 10% of the Weekly Benefit before reductions for Other income Benefits, which is greater	$897.43

[1] The total calculated premium may vary due to payroll rounding.
[2] Payable Benefit is reduced by 100% of any sick and annual leave paid on your paycheck after the benefit waiting period.

Medical Plan Information

Two Medical Plans

- There are two medical plans offered by Benefit Options.
    - Triple Option Plan (TCP)
    - High Deductible Health Plan with Health Savings Account (HDHP with HSA)

Two Medical Networks

- Both carries offer the TCP and HDHP with HSA
- Blue Cross Blue Shield of Arizona
    - 866-287-1980
    - Preview Site, including doctors and facilities - azblue.com/stateofaz
    - members - azblue.com
    - Group: 30855
- UnitedHealthcare
    - 800-896-1067
    - Preview Site, including doctors and facilities - uhcvirtual.com/stateofaz
    - members - myuhc.com
    - Group: 705963

Definition of Terms

For the plan year of January 1 - December 31, 2023, employees have the option of choosing from two plans, two Networks with nationwide coverage, and four coverage tiers.

- “Network” describes the company contracted with the State to provide access to a group of providers (doctors, hospitals, etc.) Certain providers may belong to one Network but not another. OUr Networks are BlueCross BlueShield of Arizona (BCBSAZ) and UnitedHealthcare (UHC).
- “Plans” are loosely defined as the structure of your insurance policy: the premium, deductibles, copays, and out- of-Network coverage. OUr plans are the Triple Choice Plan (TCP) and the High Deductible Health Plan (HDHP).
- “Tier” describes the number of persons covered by the medical plan. Our coverage tiers are employee, employee plus spouse, employee plus child and family.
- “Tier 1, Tier 2, and Tier 3” are used to describe the provider networks for the Triple Choice Plan. (See p. 17.)

Choosing the Right Plan

- Assess the costs you expect in the coming year, including employee premiums, copays, and coinsurance. To help determine costs, see the plan comparisons. (Medical, p. 22. Dental, p. 41. FSA, p. 51.)
- Visit our virtual benefits assistant, Picwell, to select the most appropriate benefit plan for you and your family. See p. 13 for more information, then visit adoa.picwell.com.
- Determine if your doctors are contracted with the Network you are considering. Each medical Network has a website to help you determine if your doctor is contracted with the Network.
    - BlueCross BlueShield of AZ at azblue.com/stateofaz
    - UnitedHealthcare at uhcvirtual.com/stateofaz
- Once you have selected which plan best suits your needs and your budget, make your benefit elections online at hrsystems.azdoa.gov > Y.E.S Portal.

Transition of Care (TOC)

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

If approved, you will receive in-Network benefits for your current doctor during a transitional period after January 1. The transition of care is typically approved if one of the following applies:

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

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

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

Network Options Outside Arizona
Both medical plans and medical carrier 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 essential to check with your current provider to determine if they are contracted with your selected Medical Network.

Triple Choice Plan | TCP

Overview

- If you choose the Triple Choice Plan (TCP) under Benefit Options, you can see providers in-Network or out-of-Network but will have higher costs for out-of-Network services.
- Additionally, there are in-Network and out-of-Network deductibles that must be met before the copay or coinsurance applies.
- Under the TCP, you will pay the monthly premium and the plan deductible or any required copay or coinsurance (percent of the cost) at the time of service.
- The plan is available with BlueCross BlueShield of Arizona and UnitedHealthcare.
- It is important to ensure that your preferred physician is contracted with the Network you select.
    - BlueCross BlueShield of AZ at azblue.com/stateofaz
    - UnitedHealthcare at uhcvirtual.com/stateofaz
- The benefit is the same among the Networks.
- In-Network preventive services are covered at 100%.

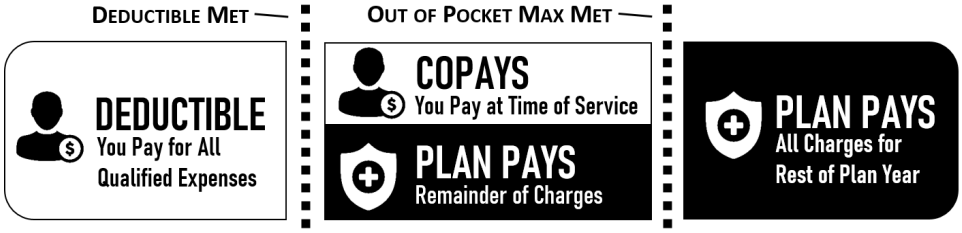
Understanding the TCP

- **Network Carriers:** Blue Cross Blue Shield of Arizona and UnitedHealthcare.
- **One Plan: The TCP is a single plan; you do not sign up for a specific tier.**
- **One Premium:** You pay a single premium to access the plan.
- **Tier Access:** You can access all three tiers of providers and facilities. You control costs by choosing providers and facilities in the lowest tiers. See the chart below on this page.
- **No Referrals:** You can still see the providers you know and trust—even if they aren't in Tier 1.
- **Preventive Care:** In-Network preventive services are covered at 100%.
- **Deductibles:** The deductible for Tier 1 counts toward Tier 2 and vice versa. Prescription drug copays are not subject to medical deductibles. These copays do count toward the annual out-of-pocket maximums. See the deductibles and how they work on p. 18.

Triple Choice Plan Tiers		
Tier 1	In-Network Providers	Providers have been evaluated and nationally accepted based on quality and efficiency standards. These are your lowest-cost in-network provider options.
Tier 2	In-Network Providers	Providers are part of a broader PPO program. For some services, you'll pay a higher out-of-pocket cost with a Tier 2 provider vs. a Tier 1 provider.
Tier 3	Out-of-Network Providers	Providers are not in the network. You will pay the highest cost for using out-of-network providers and may be responsible for paying the full provider billed charges.

Triple Choice Plan, cont.

Deductible Structure



Tier 1 Deductibles (also apply to Tier 2)*			Tier 2 Deductibles (also apply to Tier 1)*		
Individual $200	**Family $400**		**Individual $1,000**	**Family $2,000**	
Member meets **$200** in expenses member begins paying copays	Any 1 Member meets **$200** in expenses **ALONE** member begins paying copays	Other Members meet **$200** in expenses **COMBINED** other members begin paying copays	Member meets **$1,000** in expenses member begins paying copays	Any 1 Member meets **$1,000** in expenses **ALONE** member begins paying copays	Other Members meet **$1,000** in expenses **COMBINED** other members begin paying copays

**Only qualified expenses apply. Visit irs.gov for a complete list of qualified expenses.*

Using The Triple Choice Plan - Individual Coverage Example

Using ONLY Tier 1 Providers

Tier 1 Deductible Met ($200) →

Tier 1	Tier 1		Tier 1	Tier 1	Tier 1
Office Visit	**Specialist Visit**		**Imaging**	**Surgery**	**Rehab**
January	February/March			April / May	

Save! The more **Tier 1** providers you use, the lower your deductible.

Using Tier 1 and Tier 2 Providers

Tier 2 Deductible Met ($1,000) →

Tier 1	Tier 2	Tier 1	Tier 1	Tier 2
Office Visit	**Specialist Visit**	**Imaging**	**Surgery**	**Rehab**
January	February/March		April / May	

How To Find Doctors and Facilities on The Triple Choice Plan

Blue Cross Blue Shield of Arizona - Tier 1

- Visit azblue.com/stateofaz.
- Click the "Find A Doctor" tab.
- Choose the Triple Choice Plan.
- Type in the doctor or facility name.
- Look for results with the Tier 1 ribbon.

Tier 1

UnitedHealthcare - Tier 1

- Visit uhcvirtual.com/stateofaz
- Click the "Providers" tab.
- Choose the Triple Choice Plan.
- Type in the doctor or facility name.
- Look for results with the Tier 1 dot.

TIER 1

High Deductible Health Plan (HDHP) with Health Savings Account (HSA)

Overview

- This option is a High Deductible Health Plan (HDHP) for active employees and COBRA participants who are not eligible for Medicare.
- The Plan allows you to open a Health Savings Account (HSA) to use for qualified medical expenses with investment options available.
- Services can be obtained in- Network or out-of-Network, but will have higher costs for out-of-Network services.
- Additionally, there are in- Network and out-of-Network deductibles that must be met. It is important to ensure that your preferred physician is contracted with the Network you select.
    - BlueCrossBlueShield of AZ at azblue.com/stateofaz
    - UnitedHealthcare at uhcvirtual.com/stateofaz
- The benefit is the same among the Networks.
- In-Network preventive services are covered at 100%.

Understanding the HDHP with HSA Plan

- The High Deductible Health Plan (HDHP) works in conjunction with a Health Savings Account (HSA):
    - You will be automatically enrolled in a Health Savings Account. However, to establish this account, members must complete the Customer Identification Process. (See p. 23.)
    - HSA is a special savings account that allows tax-free contributions, earnings, and healthcare-related withdrawals.
- The HSA offers financial advantages in that an HSA member:
    - Pays lower employee premiums (paycheck deductions).
    - Receives qualified preventive services at no cost.
    - May have lower out-of-pocket costs.
    - Is eligible to open and contribute to a Health Savings Account.
    - Receives a State contribution into the Health Savings Account each pay period.
- The HSA presents financial considerations:
    - HSA members pay copays and/or coinsurance after the deductible is met (qualified preventive services are covered at 100%).
- The HSA might be a good choice for you if:
    - You want to open a tax-advantaged HSA and save for future healthcare costs.
    - You are willing to accept some degree of financial risk.
    - You can afford to pay a high deductible if necessary.
- The HSA may not be a good choice for you if:
    - You prefer copays because they are simple and predictable.
    - You are not willing to accept some degree of financial risk.
    - You cannot afford to pay a high deductible.
    - You are entitled to benefits under Medicare.

Qualified Preventive Services

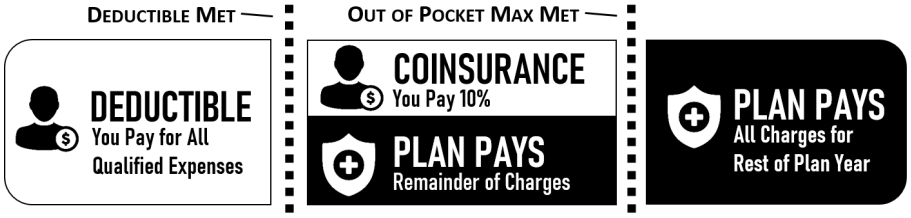
Preventive service is defined as

- Periodic health evaluations, including tests and diagnostic procedures, ordered relating to routine examinations (i.e., annual physicals)
- Routine prenatal and well-child care
- Child and adult immunizations
- Tobacco cessation programs
- Certain screening services
- Prescriptions that are preventive

Non-Permitted Coverage

1. Members and dependents (including spouses) enrolled in an HSA do not qualify for a traditional Medical Flexible Spending Account; instead, they qualify for a Limited Flexible Spending Account. The only qualifying expenses for this Limited Flexible Spending Account are dental and vision care expenses.
2. You cannot have a regular Flexible Spending Account or Health Reimbursement Account. If you or your spouse has one of these, you are not eligible to contribute to an HSA.
3. If you are enrolled in Medicare or Medicaid, or an enrolled dependent, you are not eligible for an HSA. If you had an HSA when you enrolled in Medicare or Medicaid, you could still use the funds. You just cannot contribute to the account. Note: If you are eligible for Medicare but not yet enrolled, you can still contribute to the HSA.
4. If you are enrolled in Tricare, you are not eligible for an HSA. (Tricare is health coverage for people in the military.) You can still use the funds if you had an HSA when you started on Tricare. You just cannot contribute to the account.
5. If you receive care from the Veterans Administration (VA), that may affect your HSA eligibility. Generally, when you receive VA care, you are not eligible for an HSA for the next three months. This means that you cannot contribute for the next three months after having VA care.

Deductible Structure*



*Only qualified expenses apply. Visit irs.gov for a complete list of qualified expenses.

Individual $1,500	Family $3,000
Member meets **$1,500** in expenses member begins paying coinsurance	Members meet **$3,000** in expenses **COMBINED** all members begin paying coinsurance

Using The HDHP w/HSA - Individual Plan Example

Using Total Care or Premium Care Providers	Deductible Met ($1,500) →				Coinsurance →		
	Total Care				Total Care		
	Office Visits	Specialists	Imaging	Surgery	Rehab	Rehab	Office Visit
	January	February	March	April	May	June	July
Your HSA Contribution Per Paycheck (2/mo)	$ $	$ $	$ $	$ $	$ $	$ $	$ $
State HSA Contribution Per Paycheck** (2/mo)	$ $	$ $	$ $	$ $	$ $	$ $	$ $

**$27.29 Individual, $55.38 Family, see p. 14

How To Find Doctors and Facilities On the High Deductible Plan for the Best Value and Quality Care

Blue Cross Blue Shield of Arizona - Total Care

- Visit azblue.com/stateofaz.
- Click the "Find A Doctor" tab.
- Choose the HDHP w/HSA plan.
- Type in the doctor or facility name.
- Look for results with the Total Care icon.

Total Care

UnitedHealthcare - Premium Care

- Visit uhcvirtual.com/stateofaz.
- Click the "Providers" tab.
- Choose the HDHP w/HSA plan.
- Type in the doctor or facility name.
- Look for results with the double heart icon.

Medical Plan Comparison Chart

The chart below compares in-network and out-of-Network services. For a complete list of benefits coverage, view the Summary Plan Descriptions on benefitoptions.az.gov.

Network Carriers BlueCross BlueShield of Arizona | United Healthcare

Coverage		Triple Choice Plan			High Deductible Health Plan	
		Tier 1 In-Network	Tier 2 In-Network	Tier 3 Out-of-Network	In-Network	Out-of-Network
Deductible	**EE Only**	$200	$1,000	$5,000	$1,500	$5,000
	EE + Spouse EE + 1 Child Family	$400	$2,000	$10,000	$3,000	$10,000
Out-of-Pocket Maximum[3,4]	**EE Only**	$7,350 - Tier 1 & Tier 2 Combined		$8,700	$3,500	$8,700
	EE + Spouse EE + 1 Child Family	$14,700 - Tier 1 & Tier 2 Combined		$17,400	$7,000	$17,400
Lifetime Maximum		Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Routine Preventive Services		$0	$0	50%	$0	50%
Copayment / Coinsurance[2,3] After Applicable Deductibles Are Met						
Office Visits (Including Mental & Behavioral Health)						
Primary Care Physician (PCP)		$20	$20	50%	10%	50%
Specialist[4]		$40	$40	50%	10%	50%
OB/GYN		$20	$20	50%	10%	50%
Telehealth Services		$20	$20	50%	10%	50%
Durable Medical Equipment		$0	$0	50%	10%	50%
Emergency Services						
Ambulance		$0	$0	$0	10%	50%
Emergency Room		$200[5]	$200[5]	$200[5]	10%	10%
Urgent Care		$75	$75	50%	10%	50%
Inpatient Hospital Admission		$250	$250	50%	10%	50%
Outpatient Facility		$100	$100	50%	10%	50%
Laboratory and X-Ray Services[6]		$0	$0	50%	10%	50%
Major Radiology Services[7]		$100	$100	50%	10%	50%

1 For the NAU-only BCBS PPO Plan information, visit nau.edu/human-resources/benefits/benefit-plan-document/
2 Copayments apply after the Plan deductible is met. Copayments and deductibles apply to the Out-of-Pocket Maximum.
3 The Plan pays 100% after the out-of-pocket maximum is met.
4 Includes Chiropractor and Therapy services.
5 Emergency Room copayment waived if admitted, but subject to hospital admission copayment.
6 See summary plan document for more information on covered services.
7 Includes CAT scans, MRI/MRA, PET scans, etc. See the summary plan document for more information.

Protect Your Health & Your Wallet

Choose the Right Care for Your Needs

	Nurseline	Telemedicine	Walk-In Clinic	Doctor's Office	Urgent Care	Emergency Room
CONDITIONS TREATED & SERVICES AVAILABLE	• Headache • Cold/Flu/Fever • Acne • Allergies • Rash • Sore Throat • Stomach Ache • Questions • Treatment Referrals ***Nurseline Number*** Printed on the back of your insurance card.	• Headache • Cold/Flu/Fever • Sore Throat • Vomiting & Diarrhea • Rash • Screenings • Prescriptions ***Choose Your App*** • Doctor on Demand App • Medical Carrier's App	• Cold/Flu/Fever • Sore Throat • Sinus • Earache • Minor Cut/Burn/Rash • Immunizations • Prescriptions • Drug Store Locations	• Preventive Care • Routine Check-up • Annual Physical • Medication Tracking • Immunizations • Screenings • General Health Issues • Referrals ***Choose a Primary Care Physician (PCP)*** Establish a relationship for consistent, quality care.	• Headache • Cold/Flu/Fever • Minor Cut/Burn/ Rash/Bite • Lower Back Pain • Joint Pain • Sprain • X-Rays (varies)	• Chest Pain • Head Injury • Short of Breath • Suddenly Numb/Weak • Uncontrolled Bleeding • Severe Cut/Burn/Bite • Overdose • Broken Bone • Seizure/Unconscious • Vision Blurred
HOURS	24 Hours via Phone	24 Hours via Smart Device	Retail Hours	Office Hours	8 am - 9 pm Typically	24 Hours
WAIT TIME	2-3 Minutes Avg	5-10 Minutes Avg	15 Minutes Avg	By Appointment	20 Minutes Avg	2-4 Hours Avg
LOCATION	Your Home or Office	Your Home or Office	Drive to Location	Drive to Office	Drive to Facility	Drive to Facility
COST	$0	TCP $49 fee* | $20 copay** HDHP $49* fee | 10% co-ins**	TCP $75 avg* | $20 copay** HDHP $75 avg* | 10% co-ins**	TCP $150 avg* | $20 copay** HDHP $150 avg* | 10% co-ins**	TCP $150 avg* | $75 copay** HDHP $150 avg* | 10% co-ins**	TCP $1,600 avg* | $200 copay** HDHP $1,600 avg* | 10% co-ins**

*Before deductible met. **After deductible met, copay/coinsurance applies. Prices and services subject to change.

Note: This information is for guidance only. If you are experiencing an emergency, call 911.

Active | Rev. 12-2021

ARIZONA DEPARTMENT OF ADMINISTRATION HUMAN RESOURCES

benefits@azdoa.gov
602-542-5008 | 800-304-3687
benefitoptions.az.gov

Health Savings Account

HSA Administrator - Optum Bank
866-610-4839 | optumbank.com/arizona

Overview
An HSA is a special savings account that allows individuals to pay for current health expenses and save for future qualified medical expenses on a tax-free basis. You can use this account even after you retire.
An HSA is used with a High Deductible Health Plan (HDHP).

Advantages
- Contributions: The State makes biweekly contributions to your HSA for qualified medical expenses. You can contribute on a pre-tax basis and use the funds for qualified expenses, including medical, dental, and vision costs.
- Triple Tax Advantage: Contributions are tax-free. Withdrawals to pay for expenses are tax-free. Interest earnings and investment growth are tax-free.
- Unused Funds Remain: There is no “use it or lose it” rule. Any unused funds remain in your account for future use.
- Money Stays With You: Funds in the HSA are yours and remain available for future medical expenses, even after you retire.
- Investment: Funds may also be invested with tax-free growth.

How to Open Your HSA
Your HSA will be established in your name when you enroll in the High Deductible Health Plan and complete the Customer Identification Process (see below for additional information). You will receive a welcome kit by mail within 7-10 business days after the account is opened. To avoid a delay in opening your account, please promptly provide any information Optum Bank requests to establish your HSA.

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

Annual Contribution Limits for 2023: Individual: $3,850 Family: $7,750
Catch-Up Contribution: $1,000 for age 55+, in addition to the Employee or Family contribution.

Using Your HSA
- Use the HSA Debit Card to pay for qualified medical expenses or to reimburse yourself for expenses paid out-of-pocket.
- Invest your HSA funds in various investment options once the funds reach $1,000.
- You can contribute to the HSA as long as you are enrolled in a qualified high-deductible health plan (such as the HSA). You may use the HSA funds anytime.

Customer Identification Process
Optum Bank must confirm some of your personal information before establishing your HSA. This includes your correct name, address, date of birth, and Social Security Number. Doing so is required by Section 326 of the USA Patriot Act. It is a process known as the “Customer Identification Process.” You will receive a notification through mail and/or email from Optum Bank requesting additional information if the Customer Identification Process fails. Until you pass the verification process, all HSA contributions to your account will be held. You will still have health insurance, but you will not have an HSA. If you do not pass the Customer Identification Process within 60 days of your first notification, your contributions, if applicable, will be refunded to you. The State will stop its contributions and will not be refunded to you.

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

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

Be sure we have your correct mailing address (no P.O. Boxes allowed), and that your name in our system matches the full legal name on your Social Security card.

HSA Debit Card

- You access your HSA funds with a debit card to pay for qualified medical expenses.
- You will receive an Optum Bank mailing with account activation instructions.
- Access account information on optumbank.com/arizona or download the Optum Bank app.
- To order additional cards for your spouse and eligible dependents over the age of 18, sign in to your Optum Bank account. In the "I want to" section, click "Manage debit cards."
- If you're a new account holder, you'll be able to choose a PIN when you first activate your debit card. If you've forgotten your PIN or need to change it, call the customer service phone number on the back of your debit card.

How to Calculate Your Contributions

Every year, the Internal Revenue Service (IRS) sets maximum contribution limits for health savings accounts (HSAs). Failure to observe these limits may result in tax penalties as outlined in IRS Publication 969. Optum is required to report HSA contribution information to the IRS.

The chart below outlines the contribution amounts provided by the State, the employee annual maximum contribution to avoid tax penalties, and the 2023 IRS annual maximum contribution limit.

HSA CONTRIBUTIONS - 2023

Coverage Type	State Contribution	Employee Annual Contribution Maximum	Annual IRS Contribution Maximum
Employee	$27.69 per pay period Up to $719.94 annually[1]	$3,130.06	$3,850.00
Employee + Adult	$55.38 per pay period Up to $1,439.88 annually[1]	$6,310.12	$7,750.00
Employee + Child			
Family			
Catch Up Contribution	$1,000 for age 55+, in addition to the Employee or Family contribution. Include in your Max Limit if applicable.		

Eligibility to Contribute

Employees and enrolled dependents are not eligible to contribute or receive contributions to the HSA if:

- You or your spouse has a regular Healthcare Flexible Spending Account (FSA) or Health Reimbursement Account (HRA).
- You or a dependent are enrolled in Medicare or Medicaid.
- You or a dependent are enrolled in TriCare.

- You or a dependent receive care from the Veterans Administration (VA). Contributions to an HSA cannot be made for three months after care is received.
- Your eligibility to contribute to an HSA for each month is generally determined by whether you have High Deductible Health Plan (HDHP) coverage on the first day of the month. If you are enrolled in Medicare or Medicaid, you are not eligible for an HSA Plan. If you had HSA when you enrolled in Medicare or Medicaid, you could still use the funds. You just cannot contribute to the account. Medicare members are not eligible to contribute to an HSA account effective the month of Medicare entitlement (the effective date of Medicare Parts A and/or B).

Contribution Options
All contributions made to the Health Savings Account are subject to the annual IRS maximum amount as indicated in the chart above.

Use the chart on the previous page to calculate the number of contributions you can elect using the following methods:

- Pre-tax Payroll deductions up to 26 pay periods annually
- Checks or money orders
- Electronic funds transfer from personal bank account
- Rollover from IRA (one-time transfer from IRA up to permitted annual HSA contribution limit)
- Trustee to Trustee transfer from Archer MSA or other HSA

Additional Contribution for 55+
If you are an eligible individual who is age 55 or older, your contribution limit may be increased by $1,000.

Reduction of Contribution Limit
You must reduce the amount that can be contributed (including any additional contribution) to your HSA by the amount of any contribution made to your Archer MSA for the year. A special rule applies to married people if each spouse has family coverage under separate HDHPs.

When You Can Contribute
We report your annual contributions to your HSA from your paycheck. You can directly contribute to your HSA designated for 2023 until April 15, 2024. Contact Optum Bank to find out how.

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 its specific members.

Professional, experienced staff work on your behalf to make sure you are getting the best possible care and that you are properly educated on all aspects of your treatment.

Utilization Management & Authorization
Each Medical network provides prior authorization and utilization review for the ADOA Benefit Options plans when members require non-primary care services. Before 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:

- BlueCross BlueShield of Arizona 1-800-232-2345 ext. 4320
- 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 the member and the State of Arizona.

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

- BlueCross BlueShield of Arizona 1-866-422-2729, Option 9
- UnitedHealthcare 1-800-896-1067

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:

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

If you are eligible or become eligible for one of the programs above, a disease manager from your selected Network will assess your needs and work with your physicians to develop a personalized plan. Your personalized plan will establish goals and steps to help you to 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 and control stress along with the associated symptoms.
- 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. Participants learn to incorporate healthy habits throughout the program and improve their overall health.

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

The medical Networks work with the Benefit Options plan to provide this additional service. Participation is optional, private, and tailored to your specific needs. Also, members of the Benefit Options plan who are concerned about a health condition and would like to enroll in one of the covered programs can contact their medical Networks directly to self-enroll.

Please contact your medical Network's disease management program if you or your dependent are interested.

- BlueCross BlueShield of Arizona – 1-866-287-1980
- UnitedHealthcare – 1-800-896-1067

Telehealth

All Benefit Options plans include coverage for telehealth visits. You may use your medical network carrier's app or our Doctor on Demand app, which works with both medical network carriers.

What is Telehealth?

- Why wait for an appointment, drive to the doctor's office, and sit in a crowded waiting room? You can now connect with a doctor on your mobile device from home or when you're traveling the United States.
- Services are available 24/7 so you and your family can get care quickly, often within minutes.
- Through live video, doctors review symptoms and medications, perform an exam, and may recommend treatment, including prescriptions and lab work, if needed.
- All doctors are board-certified and extensively trained in telehealth.

Conditions Treated

- allergies, bronchitis; coughs/colds; diarrhea; fevers; migraines/headaches; pinkeye; rashes; seasonal flu; sinus problems; sore throats; stomachaches
- Mental health services are also available so you can speak to a counselor in privacy and at your convenience.
- If you are experiencing an emergency, please call 911.

Cost
Medical Visit

- Before Deductible is Met
    - TCP & HDHP: Negotiated rates differ among network carriers.
- After Deductible is Met
    - TCP: $20 copay. The copay is the same as for an office visit.
    - HDHP: 10% coinsurance. The coinsurance is the same as for an office visit.

Mental Health Visit

- Before Deductible is Met
    - TCP & HDHP: Psychology and Psychiatry visits can range from $80-$300. Negotiated rates differ among network carriers.
- After Deductible is Met
    - TCP: $20 copay. The copay is the same as for an office visit.
    - HDHP: 10% coinsurance. The coinsurance is the same as for an office visit.

Sign Up Before You Need It

- Get your insurance card to register you and your covered dependents on the app in a few taps.
- Consider setting up your account before you need it so you can get care quickly.

Telehealth Services available - See the next three pages

- BlueCare Anywhere - BlueCross BlueShield of Arizona
- UnitedHealthcare - UnitedHealthcare
- Doctor on Demand - works with both BlueCross and UnitedHealthcare

Telehealth | BlueCare Anywhere

To register, visit bluecareanywhereaz.com or download the app

BlueCross BlueShield members have the advantage of flexible, affordable, and immediate healthcare with BlueCare Anywhere telehealth. Employees can visit with a doctor, counselor, or psychiatrist anytime – from their smartphone, computer, or tablet.

How to Use BlueCare Anywhere
All you need is high-speed internet access, a smartphone, tablet, or computer, and a webcam or a built-in camera and audio capability. It's this simple:

1. Sign up/Login – Just provide your name, email address, and password.
2. Fill out a brief questionnaire about your insurance, symptoms, medications, and health history. (First visit only.)
3. Select the type of provider that you want to see.
4. Choose an available doctor.
5. Pay your cost share. You can use your credit card, a flexible spending account, or a health savings account.
6. If medication is required, choose a pharmacy near you.
7. See the doctor, or schedule an appointment. Typical wait times are less than 2 minutes!
8. Receive a summary of your visit, which you can share with your primary care provider.

Types of Care

- **Medical**
  Board-certified doctors provide immediate care for various common illnesses, aches, and pains and can prescribe medications.

- **Mental Health**

  - **Counseling -** A certified psychologist or counselor is available to treat issues affecting emotional, psychological, and social well-being.

  - **Psychiatry -** On demand or by appointment, board-certified psychiatrists are available for assessments, evaluation, and treatment, including prescription support.

    - **Counseling and Psychiatric Care Provided:**
      - Anxiety
      - Depression
      - Divorce or Grief Counseling
      - Stress from Parenting or a Major Life Change
      - Smoking Cessation
      - Weight Concerns
      - And More…

Telehealth | Doctor on Demand

To register, visit patient.doctorondemand.com/register/ or download the app

Members of all medical carrier Networks have access to Doctor on Demand as a telemedicine service.

Register

- It takes just a few minutes to fill out the brief registration form.
- For the employer name, use: State of Arizona.
- Then, you will be ready to choose the correct doctor for your care needs.

Types of Care

- **Urgent Care**
  When you are sick and need to see a doctor, Doctor on Demand has a team standing by for you around the clock. Their providers can help get you on track and order prescriptions if needed.

- **Behavioral Health**
  Doctor on Demand has a diverse team of licensed psychiatrists and psychologists that can provide the emotional support you need from the privacy and ease of home. Their team supports your mental well-being, from talk therapy to medication management. To get started, you can access a free mental health assessment on their webpage.

- **Preventive Health**
  Doctor on Demand has an attentive care team that partners with you to support your day-to-day health and self-care routines. From healthy eating to preventive lab screenings, they bring together trusted providers with solutions that work in the real world.

- **Chronic Care**
  This approach to care gives you the flexibility to focus on your health when it works best for you. When you need to manage ongoing or chronic health conditions, Doctor on Demand makes it easy and convenient by being there at the touch of a button.

Telehealth | UnitedHealthcare

To register, visit myuhc.com or download the UnitedHealthcare app

Visit with a doctor 24/7 – whenever, wherever.
Virtual Visits make it easier than ever to get treated by a doctor. You can get care in minutes when you or your family members aren't well. Doctors can diagnose and treat common conditions like the flu, sinus infections, sore throats, allergies, and more. You can even get a prescription if needed.

Whether using myuhc.com or the UnitedHealthcare app, Virtual Visits let you video chat with a doctor 24/7 — without setting up additional accounts or apps. But, if you'd rather just speak with a doctor, you can do a Virtual Visit over the phone.

Activate your Virtual Visits benefit

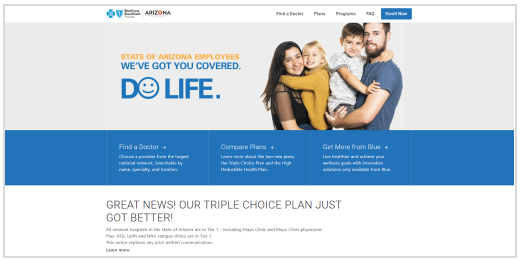
- Go online to myuhc.com, download the UnitedHealthcare app or call to register
- myuhc.com: Go to Find Care & Costs > Medical Directory > People > Provider Type > Virtual Visits
- UnitedHealthcare app: Select Virtual Visits from your dashboard
- Complete a brief Medical History
- Request a visit 24/7

Stressed? Anxious? With virtual therapy, getting help may now be more accessible than ever.
Reaching out may be complicated —especially if you might not want anyone to know you're hurting. From the privacy of home and the convenience of your mobile device or computer, you can receive caring support from a licensed behavioral health virtual therapist. Get 1-on-1 support — in your home and at a time that's convenient for you. Virtual therapy is designed to help treat conditions like:

- ADD/ADHD
- Depression
- Addiction
- Anxiety

Sign in or register on myuhc.com. Then, go to Find Care & Costs > Behavioral Health Directory > People > Provider Type > Telehealth.

Medical Website | BlueCross BlueShield of Arizona



Preview site with doctors and facilities - azblue.com/stateofaz
Members - azblue.com

App: Download from your app store

Site Features

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

ID Card
Order a new ID card or print a temporary one. You may also view the card on our mobile app.

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

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

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

Optional Electronic Paperless EOB
Reduce mail, eliminate filing and help the planet by going green.

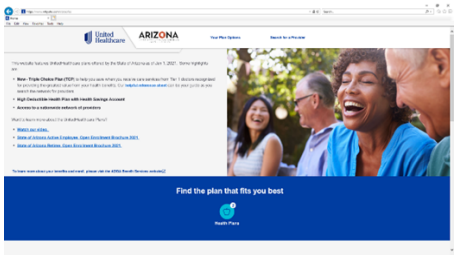
Coverage Inquiry
Verify eligibility for you and your dependents.

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

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

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

Medical Website | UnitedHealthcare



Preview site with doctors and facilities: uhcvirtual.com/stateofaz
Existing member: myuhc.com

App: Download from your app store

- Find care and compare costs for providers and services in your network
- Access benefit information, learn about available tools, resources, and programs, view open enrollment materials and more.
- View and compare benefit plan options
- Learn more about wellness programs, specialized benefits, and online tools
- Search for physicians and facilities, and access our site for members, myuhc.com.

Need a new doctor or a specialist?

- You can search for doctors near you and see which doctors have been recognized by the UnitedHealth Premium program for quality and cost-efficiency. Your health, your questions, your myuhc.com.

ID Card

Order a new ID card or print a temporary one on myuhc.com. You may also view and share your health plan ID card on the UnitedHealthcare app.

Are you worried about the cost of getting rid of that nagging pain?

You can see what a treatment or procedure typically costs and see what your share of expenses may be.

Looking for an easier way to manage claims?

You can track claims, mark claims you've already paid, and review graphs to understand better what you owe. You can even make claim payments online.

Stay healthy with innovative health and wellness tools

- Wellness tools and checklists give tips on living healthy and using health plan benefits.
- Get reminders when it's time for checkups. Plus, get suggestions for other covered services, like immunizations, well-visits, routine tests, or lab work.
- Pursue your health goals. You can participate in missions and have fun while focusing on wellness through exciting interactive tools.
- Sync your wearable devices- like Fitbit or Apple Watch –for accurate reporting and results. You can even earn coins to enter for a chance to win a prize!

Always on the go? We can help you there too.

Whether you need to find urgent care, you forget your health plan ID card, or need to call customer service, the UnitedHealthcare Health4Me mobile app helps put your insurance information in the palm of your hand.

Pharmacy Plan | MedImpact

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

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

Contact
- 888-648-6769 | Available 24 hours a day, seven days a week.
- Member Login, to view member-specific claims and benefit information: medimpact.com/plan/adoa
- Preview for BCBS members: bit.ly/MedImpactBCBS
- Preview for UHC members: bit.ly/MedImpactUHC
- Rx BIN: 003585 | Rx PCN: 28914

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

How The Plan 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 p.36. The copays listed in the chart are for a 31-day supply of medication bought at a retail pharmacy.

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

To see the formulary, go to benefitoptions.az.gov > employees > insurance > pharmacy 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 get the best value, saving money for you and your plan.

Pharmacy Mail Order Service
A convenient and less expensive mail order service is available for employees who require medications for ongoing health conditions or will be in an area with no participating retail pharmacies for an extended period. MedImpact Direct Mail®, serviced by Birdi pharmacy, is ADOA's mail order program. Mail-order prescriptions are available for two 30-day copays.

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 and a half copays (offer available to HSA members only when copays apply).
- Payments can be made by check or credit card: VISA, MasterCard, American Express, or Discover.
- Register your email address to receive information on your orders.

Choice90
With this program, employees who require medications for an ongoing health condition can obtain a 90-day supply 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, and dosage or may have age restrictions. You, your local pharmacy, or your physician may initiate the authorization process by calling MedImpact at 1-888-648-6769.

Step Therapy Program
Step Therapy is a program that 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 MedImpact Direct Specialty Pharmacy Program. This program assists you with monitoring your medication needs and provides patient education.

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

Specialty medications are limited to a 31-day supply and may be obtained only through the MedImpact Direct Specialty Pharmacy program. You may need to change pharmacies for plan design or medication reasons. MedImpact can direct you to the right pharmacy.

The MedImpact Direct Specialty Program network includes Ardon Health, Biologics Specialty Pharmacy, Humana Specialty Pharmacy, Kroger Specialty Pharmacy, and US Bioservices. Your prescription may be filled by one of these partners, so you may see their labels.

A Specialty Care Representative may contact you to facilitate your enrollment in the Specialty Pharmacy Program.

Contact Information: MedImpact Direct Specialty Pharmacy, Toll-free 1-877-391-1103 (TTY dial 711) 8 am to 8 pm Eastern Time, Monday-Friday, specialtyservicecenter@medimpactdirect.com. For security reasons, do not include any personal health or payment information in your email.

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

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

Extended Vacation or Travel Abroad

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

Order refills at least two weeks in advance of your departure. If there is a problem, such as insufficient refills, you will have enough time to phone your physician. Contact MedImpact at least three weeks in advance if you are using Mail Order.

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

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

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

Pharmacy Copays			
	Generic	**Preferred Brand Name**	**Non-Preferred Brand Name**
Retail 31 Days	$15	$40	$60
Retail 90 Days	$37.50	$100	$150
Mail Order 90 Days	$30	$80	$120

Tobacco Cessation

Services are provided by MedImpact, our pharmacy benefit manager.

- As an employee of the State of Arizona, smoking cessation help is available through this pharmacy-based program at no cost to you.
- All help services are free and available in English and Spanish.
- To take the first step toward quitting, call 844-866-3727.

What to expect when you enroll in the program:

1. **Enrollment**
    - When you're ready to enroll, call 844-866-3727 and select the option for the State Employee Tobacco Cessation Program. You will need to provide the following information:
        - Phone Number
        - Pharmacy Information
        - Primary Care Provider Information
        - Medical History
            - Food/Drug Allergies
            - Conditions
            - Current Medications
            - Use of Tobacco Cessation Products
            - Smoking History

2. **Connect with Your Clinician**
    - During your one-on-one consultations, your clinical pharmacist will:
        - Answer any questions or concerns regarding smoking cessation therapies
        - Help you set goals regardless of your quiting stage
        - Discuss therapies available for tobacco cessation
        - Provide ongoing support through your quit journey

3. **Select a Tobacco Cessation Therapy**
    - Your clinical pharmacist will work closely with you when determining an appropriate tobacco cessation therapy.
    - Once selected, a prescription request will be sent to your primary care provider for approval. Approved therapies will be faxed to your preferred pharmacy, and we will notify you when the prescription will be ready.

4. **Follow Up**
    - Members of the clinical team will be available to help you with any questions or concerns you have along the way and will provide you with regularly scheduled follow-up appointments based on any tobacco cessation therapies selected.

Dental Plans

In this section:

- Dental Plans Overview
- Plan Comparison Chart
- UHC and Delta Website Overviews

Dental Plans Overview

ADOA offers two dental plans:

- UnitedHealthcare Solstice S800B - (Dental Health Maintenance Organization - DHMO)
  844-208-0223 | smilestateofaz.com | Group/Plan Code: S800B

- Delta Dental PPO Plus Premier - (Preferred Provider Organization- PPO)
  602-588-3620 | 866-978-2839 | deltadentalaz.com/adoa/ | Group: 77777

How to Choose the Best Dental Plan for You
When choosing between a Prepaid/DHMO plan and an PPO plan, you should consider the following: dental history, level of dental care required, costs/budget and provider in the Network. If you have a dentist, make sure he/she participates on the plan you are considering.

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

ID Card
New enrollees should receive a card within 10-14 business days after the benefits become effective. ID cards can also be printed from the network carrier websites or apps..

DHMO Plan: UnitedHealthcare Solstice S800B
844-208-0223 | smilestateofaz.com | Group/Plan Code: S800B

Overview

- Open Access plan grants you access to the greater network with no assignment to provider so long you remain In-Network
- You MUST use a DHMO Participating Dental Provider to provide and coordinate all of your dental care
- Access to specialty care: Endodontist, Periodontist, Oral Surgeon)
- No annual deductible or maximums
- No waiting periods
- Pre-existing conditions are covered
- Specific copays for services
- Specific lab fees for prosthodontic materials
- Out-of-Network services are only covered in emergency situations

Each family member may choose a different general dentist from the DHMO provider network.Members may self-refer to dental specialists within the Network. Specialty care copays are listed in the Patient Charge

Schedule. Specialty services not listed are provided at a discounted rate. This discount includes services at a Periodontist, Prosthodontist, and TMJ care.

During enrollment, confirm your identity with your Solstice unique ID number located on the front of your dental ID card, Employee ID Number (EIN), or social security number (SSN).

Plan Availability: Coverage is not available in these states/territories: AK, AL, AR, DE, HI, IA, ID, LA, ME, MS, MT, ND, NE, NH, OK, RI, SD, VT, WV, WY, GU, USVI, and PR. Check to see if your provider is on the plan and see the plan coverage by visiting smilestateofaz.com. Use plan code S800B.

PPO Plan – Delta Dental PPO Plus Premier
602-588-3620 | 866-978-2839 | deltadentalaz.com/adoa/ | Group: 77777
Overview

- 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 with certain health conditions
- A no missing tooth clause is included
- You can visit any licensed dentist but you will save the most money when you see a Delta Dental PPO dentist
- Delta Dental has the largest network in Arizona with 3,600+ participating dentists
- Delta Dental dentists have agreed to accept a negotiated fee (after deductibles and copays are met) and in most circumstances, cannot balance bill you more than the allowed fee
- Claims are filed by the network dentist and they are paid directly, making it easier for you.

Dental Plans Comparison Chart

The chart below is a comparison of in-Network services only which are subject to all provisions, terms and conditions of the Plan Description or Patient Charge Schedule. For a complete list of benefits coverage and out-of-Network services, view the Summary Plan Descriptions on benefitoptions.az.gov.

Dental Plan Premiums Per Pay Period			
Plan Type		**UHC Solstice - DHMO[1]**	**Delta PPO Plus Premier**
Employee Only		**$1.64**	**$14.30**
Employee + Adult		**$3.29**	**$30.33**
Employee + Child		**$3.08**	**$23.34**
Employee + Family		**$5.46**	**$48.26**
Employee Cost For Care			
Plan Year Deductibles		None	$50/$150
Annual Combined Basic & 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[2]
	Emergency Exam	$0, pain treatment $35, after hours office visit	$0 - Deductible Waived[2]
	Prophylaxis/ Cleaning	$0	$0 - Deductible Waived[2]
	Fluoride Treatment	Without Varnish: $0 | With Varnish $20	$0 (to age 18) - Deductible Waived[2]
	X-Rays	$0	$0 - Deductible Waived[2]
Sealants		$0 per tooth	20% (to age 19)
Fillings		Amalgam: $16 | Resin: $37	20%
Extractions		Simple: $35 Surgical $105	20%
Periodontal Gingivectomy		$119: 1-3 teeth | $180: 4 or more teeth	20%
Oral Surgery		$25-$270	20%
Crowns		$195-$290 + Lab & Material	50%
Dentures		$485 - $502	50%
Fixed Bridgework		$290 + Lab & Material per Unit	50%
Crown/Bridge Repair		$80 - $95	50%
Implant Body		$795	50%[3]
Orthodontia		$1,375-$2,875	50%[4]
Other Services	**TMJ Exam/Services**	$150 - $250	Not covered
	External Bleaching	$30 - $240	Not covered

1 Plan not available in AK, AL, AR, DE, HI, IA, ID, LA, ME, MS, MT, ND, NE, NH, OK, RI, SD, VT, WV, WY, GU, USVI, and PR
2 Routine visits, exams, cleanings and flouride treatments are covered two times per Plan Year at 100%. Emergency exams are covered once per Plan Year at 100%. X-rays (Bitewing, Periapicals) are covered once per Plan Year at 100%.
3 Subject to both the benefit year allowance and the lifetime maximum limit of $1,000 per tooth. Subject to all provisions, terms, and conditions of the Plan Description.
4 Limited to a lifetime maximum of $1,500 per member.

Dental Website | UHC Solstice

Dedicated State of Arizona Web-Site: smilestateofaz.com

Website Features

- **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. You can also view your ID card on the mobile app.

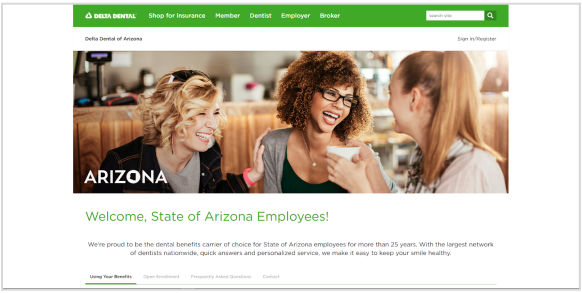
- **Find Dentists and Services**
  View office dental office features, procedures, and costs.

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

- **MySolstice Mobile App**
  Access your dental plan details, member ID card, and so much more from anywhere using our free mobile app!

Plan Availability: Coverage is not available in these states/territories: AK, AL, AR, DE, HI, IA, ID, LA, ME, MS, MT, ND, NE, NH, OK, RI, SD, VT, WV, WY, GU, USVI, and PR. Check to see if your provider is on the plan and see the plan coverage by visiting smilestateofaz.com. Use plan code S800B.

Dental Website | Delta Dental



Preview site for Non-member: deltadentalaz.com/adoa
Existing member: deltadentalaz.com/adoa

Site Features

- Member Portal: Sign into the member portal for 24/7 access to your benefits information. You can print your ID card, view your coverage, claim status, download your Explanation of Benefits (EOBs) and more.
- Find a Dentist: Use the online dentist search tool to find a Delta Dental network dentist near you.
- Benefits Resources: Learn more about your dental plan by viewing an informative webinar and other important plan documents.
- The Floss Newsletter: Sign up for a free oral health newsletter with simple tips to take care of your smile.

Other Delta Dental Resource

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

Vision Plan | Avesis

Avesis Advantage Program
888-759-9772 | avesis.com/arizona | Policy: 11001-2178

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

Program Highlights

- Yearly coverage for a routine eye exam, prescription glasses or contact lenses
- Extensive provider access throughout the state
- Unlimited discounts on additional optical purchases.

How to Use the Advantage Program

- Find a provider – You can find a provider using the Avesis website avesis.com/arizona 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.
- 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 form and itemized receipt to Avesis for reimbursement.
- The claim form and itemized receipt should be sent to Avesis within three months of the date of service to be eligible for reimbursement.
- The Avesis claim form can be obtained at the website avesis.com/arizona.
- Reimbursement will be made directly to the member.

Vision Plan Services		
	In-Network	**Out-of-Network**
Examination Frequency	Once per Plan Year	Once every 12 months
Lenses Frequency	Once per Plan Year	Once every 12 months
Frame Frequency	Once per Plan Year	Once every 12 months
Examination Copay	$10 copay	Up to $50 reimbursement
Optical Materials Copay (Lenses & Frame Combined)	$0 copay	N/A
Standard Spectacle Lenses		
Single Vision Lenses	Covered-in-full	Up to $33 reimbursement
Bifocal Lenses	Covered-in-full	Up to $50 reimbursement
Trifocal Lenses	Covered-in-full	Up to $60 reimbursement
Lenticular Lenses	Covered-in-full	Up to $110 reimbursement
Progressive Lenses	Uniform discounted fee schedule	Up to $60 reimbursement
Selected Lens Tints & Coatings	Uniform discounted fee schedule	No benefit
Frame		
Frame	Covered up to $100-$150 retail value ($50 wholesale cost allowance)	Up to $50 reimbursement
Target Optical Discount (locations inside Target Stores)	$25	N/A
Contact Lenses (in lieu of frame/spectacle lenses)		
Elective	10-20% discount and $150 allowance[3]	Up to $150 reimbursement
Medically Necessary	Covered-in-full	Up to $300 reimbursement
LASIK/PRK		
LASIK/PRK	Up to $750	Up to $750 reimbursement

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

Vision Website | Avesis

Members: avesis.com/arizona

Website Features

- **Provider Search**
  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**
  Print a new card at any time.
- **Verifying Eligibility**
  Check your eligibility status before you schedule an exam or order new materials.
- **Plan Policy**
  View your plan policy.
- **Glossary**
  Understand vision care terminology.
- **Facts on Vision**
  Learn about different aspects of vision care.
- **Claim Form**
  Obtain an out-of-Network claim form.

International Coverage

Medical

- TCP and HDHP Plans
  - Only emergency services are available for international coverage.
  - All services must be verified by a Third Party Administrator.

- NAU Only Blue Cross Blue Shield PPO
  - For assistance with locating a provider and submitting claims call 1-800-810-2583 or 1-804-673-1686.
  - For an international claim form bcbsglobalcore.com

Pharmacy

- MedImpact - Not covered

Dental

- UHC Solstice: Emergency Only
- Delta Dental PPO Plus Premier: Coverage is available under non-participating provider benefits

Vision

- Avesis: Covered as out-of-Network and will be reimbursed based on the Avesis reimbursement schedule.

Flexible Spending Accounts

Flexible Spending Account Administrator - TASC
833-433-4301 | tasconline.com

Overview
Employees have the option to enroll in Health Care and/or Dependent Care (child care) Flexible Spending Accounts (FSAs) administered by TASC. The FSAs allow you to pay eligible out-of-pocket Health Care and dependent care expenses with pre-tax dollars, reducing your taxable wages and, therefore, decreasing your taxes.

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

You specify the annual dollar amount of your earnings to be deposited to each account. This amount is deducted in 26 equal payments, one each pay period. New Hire deductions are spread out over remaining pay periods left in the year.

You will be sent a new debit card automatically upon enrollment and may request additional cards for your dependents. The card is valid until the expiration on the front. The card will arrive in a plain white envelope for security reasons, so be sure to watch your mailbox.

TASC FSA MasterCard Debit Card
- Your debit card will be pre-loaded with the entire amount of the deductions you selected for the plan year - the same card works for Healthcare and Dependent Care FSAs.
- This makes it much more convenient to use your FSA contributions.
- The TASC FSA MasterCard Debit Card is a limited-use benefit card that will allow you to pay the merchant or healthcare provider directly from your health FSA account.
- The card is accepted at healthcare and retail providers that accept MasterCard. At the point-of-sale, simply present your card for payment.
- The advantage of the card is that you do not have to pay with cash or personal credit card.
- The merchant will process the transaction; then the card company will then report the transaction to TASC.

Health Care FSA
This account allows you to set aside pre-tax dollars to pay for copays, coinsurance, deductibles, prescriptions, over-the-counter health care products, dental and vision care services. Over-the-counter medications are eligible with a prescription from your physician.

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

Limited Purpose Flexible Spending Account
The limited purpose health FSA is a money-saving option available only to members who are enrolled in a High Deductible Health Plan with Health Savings Account. It works the same way as our traditional FSA with the difference that it limits what expenses are eligible for reimbursement. Dental and Vision care costs are the only reimbursable expenses covered under the limited purpose health FSA.

Before you incur an expense under your limited purpose health FSA, determine if it is eligible for reimbursement on the TASC website, tasconline.com.

Members including dependents enrolled in the HDHP with HSA are not allowed to enroll in a traditional Health Care Flexible Spending Account.

- **Limited FSA Highlights**
  - Allows you to set aside pre-tax dollars, reducing your taxable wages and, therefore, decreasing your taxes.
  - You can specify the annual dollar amount to be deposited. This amount is deducted in 26 equal payments, one each pay period.
  - At your request, your FSA reimbursement may be deposited into your checking or savings account by enrolling in Direct Deposit. To obtain an application, visit the TASC website at tasconline.com or sign into your online account and update your personal settings.
  - Unclaimed funds are forfeited in accordance with the IRS regulations.

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

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

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

Before you incur an expense, determine if it is eligible for reimbursement on the TASC website, tasconline.com.

Deciding How Much to Deposit
Estimate the amount you expect to pay during the plan year for eligible, uninsured out-of-pocket health and/or dependent expenses. This estimated amount cannot exceed the established limits (Health Care limit = $2,700; Dependent Care limit = $10,500). Be conservative in your estimates, since any money remaining in your accounts will be forfeited. You can avoid forfeitures by planning carefully and contributing only the amount to cover routine, predictable expenses.

1. **Healthcare FSA - Minimum: $130 / Maximum: $2,850 (2023)**
   Pays for qualified medical, dental, and vision expenses, including insurance copays and deductibles. (TCP participants only.)

2. **Limited Purpose FSA - Minimum: $130 / Maximum: $2,850 (2023)**
   Pairs with a health savings account to help you pay for dental and vision expenses. (HSA participants only.)

3. **Dependent Care FSA - Minimum: $260 / Maximum: $5,000 ($2,500 if married & filing separately)**
   Pays for the care of a dependent child or adult so that you can work. (IRS regulations may require ADOA to reduce your contribution due to IRS non-discrimination test requirements. The Dependent Care FSA for Highly Compensated Employee contribution is limited to $1,600 in 2023. A Highly Compensated Employee is defined by the IRS as having earned $135,000 or more in 2022.)

Estimate your eligible, uninsured out-of-pocket health care expenses for the plan year, which is January 1, 2023 through December 31, 2023.

End of Employment - Your coverage ends at the end of the pay period of your last deduction when you leave employment. If your employment ends prior to the end of the plan year, any expenses must be incurred prior to your termination date for you to receive reimbursement.

FSA Vendor - TASC

Our Flexible Spending Account vendor, Total Administrative Services Corporation (TASC) offers 24/7 account access with many enhanced features.

- Website – Visit tasconline.com to manage your accounts, set email alerts and pay providers.
- App – See account balances, upload receipts, check on expense eligibility, set alerts and more. Search for TASC in your app store and look for the green icon.
- Debit Card – Access healthcare and dependent care FSA accounts with the same MasterCard debit card.

You have from January 1, 2023 through December 31, 2023 to use account funds. All the claims for health care and dependent care expenditures must be filed with TASC prior to March 31, 2023 for reimbursement.

TASC Enrollment

- After you enroll in TASC Flexible Spending Account, you will receive an email directly from TASC to create your personal account. You will receive a MasterCard in a plain white envelope in the mail within 10-14 business days after your benefits become available. Your debit card will be pre-loaded with the entire amount of the deductions you selected for the plan year. This makes it much more convenient to use your health care FSA contributions.
- The TASC Debit Card is a limited-use benefit card that will allow you to pay the merchant or health care provider directly from your health care FSA account. The card is accepted at health care and retail providers that accept MasterCard.
- At the point-of-sale, simply present your card for payment. The advantage of the card is that you do not have to pay with cash or personal credit card. The provider, pharmacy, or merchant will process the transaction; then the card company will report the transaction to TASC.
- Use of the debit card is not paperless, and documentation is required in many cases. TASC will notify you if documentation is required. Only provide documentation to TASC upon request.

Flexible Spending Comparison Chart

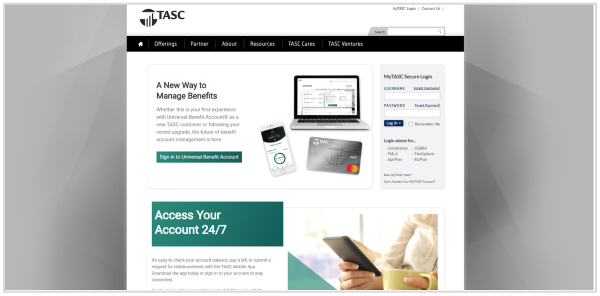
	Health Care	Limited Purpose Health Care	Dependent Care
Maximum Contributions	$2,850/year	$2,850/year	$5,000year $2,500/year-*married filing separately*
Minimum Contributions	$130/year	$130/year	$260/year
Use of the Account	• To pay (with pre-tax money) for health- related expenses that are not covered or only partially covered, including expenses for your spouse or children not enrolled in your medical, dental, or vision plans	• Eligible only to members enrolled in the HSA plan; To pay (with pre-tax money) for dental and/or vision related expenses that are not covered or only partially covered, including expenses for your spouse or children not enrolled in our dental or vision plans • Only for use for dental and/or vision expenses	• To pay expenses for care of dependent provided by a non-dependent • To pay care provided for your children under the age of 13 for whom you have custody, for a spouse who is disabled or other dependents who spend at least eight hours a day in your home • To pay dependent care so that you can work
Sample of Eligible Expenses	• Copays • Deductibles • Coinsurance • Dental fees • Eyeglasses, exam fees, contact lenses, LASIK surgery • Orthodontia	• Dental deductibles • Dental coinsurance • Dental fees • Eyeglasses, exam fees, contact lenses and solution, LASIK surgery • Orthodontia	• Services provided by a day care facility. Must be licensed if the facility cares for six or more children • Babysitting services while you work • Day Camp
What's Not Covered	• Premiums for medical or dental plans • Items not eligible for the health care tax exemptions by IRS • Long-term care expenses • Expenses for cosmetic treatments or general good health	• Premiums for dental or vision plans • Items not eligible for the health care tax exemptions by IRS • Medical expenses that are not dental or vision expenses	• Private school tuition including kindergarten • Overnight camp expenses • Babysitting when you are not working • Transportation and other separately billed charges • Residential nursing home care
Restrictions/Other Information	• For allowed expenses, see IRS Publication 502 or visit tasconline.com. Expenses in this plan qualify based on when services are provided regardless of when you pay for the expense. • You cannot transfer money from one account to the other • Your election amount may be increased (but not decreased) if you have a qualified life event • Your election may be changed by ADOA because of non-discrimination testing requirements	• For allowed expenses, see IRS Publication 969 or visit tasconline.com. Expenses in this plan qualify based on when services are provided regardless of when you pay for the expense. • You cannot transfer money from one account to the other • Your election amount may be increased (but not decreased) if you have a qualifying life event	• For allowed expenses, see IRS Publication 503 or visit tasconline.com. Expenses in this plan qualify based on when services are provided regardless of when you pay for the expense. • You may not use the account to pay your spouse, your child under 19 or a person whom you could claim as a dependent for tax purposes • You cannot change your election unless you have a qualified life event • Your election may be changed by ADOA because of non-discrimination testing requirements

FSA Worksheets

Tax-Free Health Expense Worksheet for Healthcare Flexible Spending Account and Limited Purpose Flexible Spending Account	
Out-of-pocket Expenses	
Medical	$
Dental	$
Vision	$
Prescriptions	$
Over the Counter Healthcare	$
Total for the Year	$
Divide ÷ By paychecks (26, or less if new hire) you will receive during the plan year.	
Per Pay Period Contribution for	$

Tax-Free Dependent Care Worksheet for Dependent Care Flexible Spending Account	
Number of Weeks *You will have dependent (child, adult or elder) care expenses for the plan year. Remember to subtract holidays, vacations, and other times you may not be paying for eligible dependent care.*	
Multiply The amount of money you expect to spend each week	$
Total Dependent Care Expenses for the Year Total contribution cannot exceed IRS limits of $10,500. ($5,250 if married and filing separately)	$
Divide ÷ By paychecks (26, or less if new hire) you will receive during the plan year.	
Per Pay Period Contribution	$

Flexible Spending Vendor Website | TASC



Members: tasconline.com
Click: “Sign into Universal Benefit Account” in the middle of the screen. Then login.

App: Available from your app store

TASC's website is designed to be a valuable resource for plan participants. You have access to a number of user-friendly and educational features as follows:

Universal Benefit Account
- To login: Click: “Sign into Universal Benefit Account” in the middle of the screen.
- Create an account.
- View your account statement
- Submit claims online
- Read and respond to secure messages sent to you
- Update or manage your personal settings for direct deposit, electronic communications, login credentials, etc.

TASC Mobile App
- Download the app from your app store
- Check your account balance from your smartphone or tablet
- Submit claims on-the-go
- Snap a picture of your documentation and submit

Education
- FlexSystem (FSA)
- Educational videos
    - How to Enroll in FlexSystem
    - All FSA Types
    - Healthcare and Dependent Care FSAs
    - Healthcare FSA Only
    - How to Manage your FlexSystem Plan

Resources
- Benefits plans information
- Calculators to figure potential tax savings
- Extensive listing of eligible/ineligible expenses
- MyTasc help
    - Browser Help
    - Login Instructions
    - MyTASC FAQs
- Benefits limits information
- Helpful webinar videos

Short-Term Disability Insurance

Short-Term Disability Administrator - MetLife

- Info: metlife.com/StateofArizona | 866-232-0596
- Claims: mybenefits.metlife.com/stateofarizona | 866-264-5144

Overview
STD Insurance is voluntary insurance where you pay the entire premium.

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

How STD Works
If you elect Short-Term Disability (STD) insurance and MetLife determines you are unable to work due to illness, pregnancy, or a non-work-related injury, you may receive a weekly benefit for up to 26 weeks for an injury, 22 or 18 weeks for illness. The STD benefits will pay up to 66-2/3% of your pre-disability earnings during your disability. The weekly minimum benefit is $67.31; the weekly maximum benefit is $897.43. There are no pre-existing conditions or limitations. You must meet the actively-at-work provision.

Paid Benefits

- Weekly Minimum: $67.31 or 10% of the Weekly Benefit before reductions for Other income Benefits, which is greater
- Weekly Maximum: $897.43
- Offsets to Paid Benefits
    - Benefits are reduced by 100% of any sick or annual leave paid to you after the benefit waiting period.
    - Paid benefits will be offset after the benefit elimination period is exhausted by any sick or annual leave paid to you.

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

Coverage Effective Dates
If you previously waived STD coverage and enroll during Open Enrollment, your insurance becomes effective on January 1, 2023.

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

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

Claims

Reporting Your Absence

If you are absent or expect to be absent from work due to sickness, pregnancy, or for an accidental injury, there are two steps that you must take to report your absence. First, you must notify your supervisor of the reason for absence and expected length of absence. Second, you must contact MetLife to report the absence by calling 866-264-5144 or through the MyBenefits website at mybenefits.metlife.com/stateofarizona. The Claims Center is available Monday through Friday, 8:00am to 11:00pm Eastern Time.

Information MetLife May Need from You

- Personal & Job Information
- Sickness/Injury Information & Treatment
- Authorization to Release Your Medical Information

After you submit a claim, MetLife will send you a written acknowledgement of your request. You may be contacted by a MetLife Case Manager within a few business days to clarify any of your information or if any information is missing. MetLife may also contact your healthcare provider(s) and/or your employer.

You can edit or update your claim by visiting mybenefits.metlife.com/stateofarizona.

You are encouraged to call your Case Manager at any time should you have questions or concerns about your case. A Customer Service Unit is also available from 8:00am to 11:00pm ET to answer your questions. You can reach them by calling 866-264-5144.

University Faculty And Staff: To assist you in making an informed decision, please refer to your Human Resources website to compare both the state-sponsored and university-sponsored plans.

Additional Disability Plan Benefits

Services to help you get back to work:

- **Nurse Consultant or Case Manager Services**
  Specialists who personally contact you, your physician and your employer to coordinate an early return-to-work plan when appropriate.
- **Vocational Analysis**
  Help with identifying job requirements and determining how your skills can be applied to a new or modified job with your employer.
- **Job Modifications/Accommodations**
  Adjustments (e.g., redesign of work station tools) that enable you to return to work.
- **Retraining**
  Development programs to help you return to your previous job or educate you for a new one.
- **Financial Incentives**
  Allow you to receive Disability benefits or partial benefits while attempting to return to work.

Long-Term Disability

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

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

Medical documentation of your disability is required to continue your payment of benefits. You may learn more about the LTD plan offered by ASRS by visiting: azasrs.gov or calling 602-240-2000 or 1-800-621-3778 if outside of Phoenix. For the hearing impaired, please call TTY 602-240-5333.

LTD Claims through Broadspire
You should file a claim as soon as it appears that you will have a period of disability for six consecutive months. If you are not certain how long your disability will last, you should file your claim when you have been off of work or have been working limited duty for two months. Contact your Human Resources, Benefits, or Payroll Department to obtain the employee claim packet.

You may return the employee claim packet to your Human Resources, Benefits or Payroll Department to submit the claim to Broadspire along with the employer claim packet, or you may submit the employee claim packet directly to Broadspire. Once Broadspire has received the claim, it will be processed and you will be sent a written notice of the status of your claim.

The earlier you file your claim, the more likely it is that Broadspire can complete all of the processing necessary, including gathering additional information, to provide you with a decision regarding your claim on or before the date that benefits would be payable.

Notification of Decision
A decision regarding your claim will be made promptly after Broadspire receives all completed required forms, requests and receives any additional documentation, and reviews the information. Broadspire may request that you be examined by an independent physician of its choice at no cost to you and may also make any other investigation deemed necessary to determine benefits that may be payable under the program.

Once you have been approved for LTD benefits, you are required by Arizona law to be under the direct care of a licensed physician in order for monthly benefits to continue. In order to verify that you continue to have a disability and continue to be under the care of a physician, a supplemental statement form completed by your attending physician will be required as deemed necessary by Broadspire. This form will be provided to you at no cost; however, the cost of having this form completed will be your responsibility. Broadspire will advise you when additional medical or other evidence is necessary to determine if benefit payments can continue.

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

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

Your benefits may be subject to an offset based on Social Security payments, retirement benefits and other income benefits. LTD benefits can be paid until age 65 or until you are able to return to work after your disability as determined by MetLife. Medical documentation of your disability is required to continue your payment of benefits.

If you are facing a possible long-term disability, you should contact MetLife within 90 days from the date of your illness or injury. You will be provided the information you need to apply for LTD benefits. This could include a waiver of insurance premiums or you may be eligible for life insurance conversion (converting your supplemental policy from a group policy to an individual one). You must initiate a Life Insurance Waiver of Premium claim by contacting Securian online at lifebenefits.com/plandesign/Arizona or call 833-745-5517. Although your life and/or disability insurance premiums may be waived, your medical, dental and vision insurance premiums are not waived. You are still responsible for payment of these premiums. Failure to remit timely premium payments will result in the termination of your benefits.

LTD Claims through MetLife
If you are absent or expect to be absent from work due to sickness, pregnancy, or for an accidental injury, there are two steps that you must take to report your absence.

- First, you must notify your supervisor of the reason for absence and expected length of absence.
- Second, you must contact MetLife to report the absence by calling 866-264-5144 or through the MyBenefits website at mybenefits.metlife.com/stateofarizona. The Claims Center is available Monday through Friday, 8:00am to 11:00pm Eastern Time.

Information MetLife May Need from You to File a Claim

- Personal & Job Information
- Sickness/Injury Information & Treatment
- Authorization to Release Your Medical Information

After you submit a claim, MetLife will send you a written acknowledgement of your request. You may be contacted by a MetLife Case Manager within a few business days to clarify any of your information or if any information is missing. MetLife may also contact your healthcare provider(s) and/or your employer.

You can edit or update your claim by visiting mybenefits.metlife.com/stateofarizona.

You are encouraged to call your Case Manager at any time should you have questions or concerns about your case. A Customer Service Unit is also available from 8:00am to 11:00pm ET to answer your questions. You can reach them by calling 866-264-5144.

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

Additional Disability Plan Benefits
When you are ill or injured for a long time, MetLife believes you need more than a supplement to your income. That's why we offer return-to-work services, financial incentives and assistance in obtaining Social Security Disability Benefits to help you get the maximum benefits from your coverage.

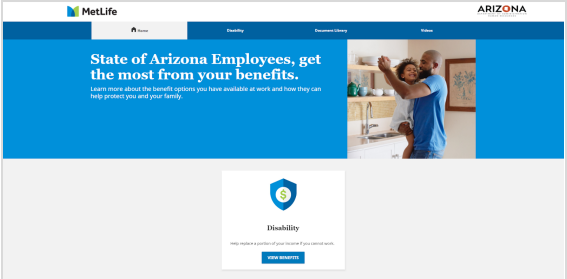
Services to Help You Get Back to Work

- **Nurse Consultant or Case Manager Services**

Specialists who personally contact you, your physician and your employer to coordinate an early return-to-work plan when appropriate.

- **Vocational Analysis**
  Help with identifying job requirements and determining how your skills can be applied to a new or modified job with your employer.
- **Job Modifications/Accommodations**
  Adjustments (e.g., redesign of work station tools) that enable you to return to work.
- **Retraining**
  Development programs to help you return to your previous job or educate you for a new one.
- **Financial Incentives**
  Allow you to receive Disability benefits or partial benefits while attempting to return to work.
- **The Services of Social Security Experts**
  Once you are approved for Disability benefits, MetLife can help you obtain Social Security Disability benefits. Our experts can guide you through the initial application and appeals processes and may also help you access assistance from attorneys or vendors to pursue Social Security benefits.

Short-Term Disability/Long-Term Disability Website | MetLife



Info: metlife.com/StateofArizona/
Claims: mybenefits.metlife.com/stateofarizona

You can access important information about your:

- Short-Term Disability
- Long-Term Disability (Non-ASRS Participants)

Disability

- **MyBenefits Website**
  Here you can file claims, check on your claim status, and update personal information.
- **Product Overview**
  Find information on how MetLife disability insurance benefits you and its importance.
- **LTD Plan Summary**
  Learn more about what the LTD Plan is, its requirements, benefit amounts, and other plan benefits.
- **STD Plan Summary**
  Learn more about what the STD Plan is, its requirements, benefit amounts, and other plan benefits.
- **Frequently Asked Questions**
  Here you can find a link to FAQs on the Disability Page as well as a section dedicated to Short Term/Long Term Disability Insurance FAQs.

Document Library

- **File A Claim**
  Here you can find the steps to filing a claim through MetLife which pertains to STD and LTD.
- **Disability – MyBenefits**
  In this document, you can learn all of the steps to accessing your MetLife claim online.
- **Long Term Certificate**
  This certificate is proof of the benefits that are provided to you through your Group Policy and describes them in entirety.
- **Short Term Certificate**
  This certificate is proof of the benefits that are provided to you through your Group Policy and describes them in entirety.
- **Videos**
  Watch and learn about the benefits that have helped others like you when navigating through challenging situations.

Long-Term Disability Website | Broadspire

Members: azasrs.gov/content/long-term-disability
You can access important information about your:

- Long-Term Disability (ASRS Paricipants)

- **ASRS Member LTD Information**
  Get introduced to Broadspire in relation to the ASRS Long Term Disability Income Program.
  - **Frequently Asked Questions**
    This area is helpful when looking for an answer to a common question. Eligibility, determination, and coverage are a few of the covered topics.
  - **Information and Application**
    - **LTD Employee Guide**
      You can find this guide useful when searching for information on the ASRS Long Term Disability Income Program.
    - **Application Details**
      Discover the steps to obtaining an application packet and the process of applying.
    - **Online Claim Data**
      See for yourself how easy it can be to file a Long-Term Disability claim online, in real time.

- **Broadspire Information**
  - **Contact Information**
    Find all of the ways to contact your LTD vendor, Broadspire. For questions, Broadspire has a 24-hour customer service line that can be reached at 877-232-0596.
  - **Broadspire Member Portal**
    The Broadspire member portal allows members to access status updates of claim or payment information 24 hours a day, 7 days a week.
  - **Links to Forms**
    If you wish to update tax withholdings or direct deposit arrangements, Broadspire provides links to the forms to do this. Also, there is information on how to send in the necessary forms.

Life Insurance

Life Insurance Administrator - Securian

- 833-745-5517 | lifebenefits.com/plandesign/Arizona
- Determine your life insurance needs:
  Benefits Scout - scout.securian.com/?id=012175.0001

Basic Life Insurance and AD&D

- You are automatically covered for $15,000 of basic life insurance provided by the State at no cost to you.
- Non-smokers will receive an additional $1,000; eligibility is determined at the point of claim.
- The State also pays for $15,000 of Accidental Death and Dismemberment (AD&D) insurance coverage.
- A $15,000 Seat Belt Benefit may also be payable if you die in an automobile accident and are wearing a seat belt.
- You are automatically covered in these three programs if you are a benefit-eligible employee.

Supplemental Life Insurance and AD&D

- Supplemental coverage is available in increments of $5,000 if you would like additional insurance beyond the
- $15,000 that the State already provides to you.
- You may elect up to the lesser of 3 times your annual salary up to 500,000.
- Your cost for supplemental life and AD&D insurance is based on your age as of January 1st (the first day of the plan year).
- Premiums for supplemental life coverage above $35,000 are paid on an after-tax basis.

After your initial election period, you may elect to increase or decrease your supplemental life and AD&D coverage only during Open Enrollment or for certain **Qualifying Life Events**.

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

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

Beneficiaries

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

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

Dependent Life Insurance

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

Portability and Conversion
If you leave State employment, you and/or your dependents may have the option to convert your coverage to an individual policy or port it to another group term life policy. Contact Securian at 833-745-5517.

Claims
To file a Life Insurance claim contact Securian at 833-745-5517.

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

- Becomes disabled (as defined in the Life Insurance Policy) prior to age 65 and provides proof within one year,
- Remains disabled for at least six consecutive months (elimination period). Premium payment is required during the elimination period.

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

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

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

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

Life Insurance Waiver of Premium Claim Filing
Approval for Long-Term Disability does not automatically approve Waiver of Premium for Life Insurance.

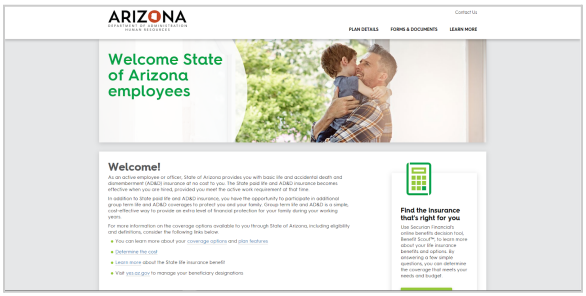
If you are enrolled in The Broadspire Long-Term Disability (LTD) and you expect to be out for longer than 180 days from the date of illness or injury, it is necessary for you to initiate a review for Waiver of Premium. Call Securian at 833-745-5517, 7 am to 6 pm, Monday through Friday.

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

You can learn more by visiting lifebenefits.com/plandesign/Arizona or calling 833-745-5517.

University Faculty and Staff: To assist you in making an informed decision, please refer to your Human Resources website to compare both the state-sponsored and university-sponsored plan.

Life & AD&D Insurance Website | Securian



Members: lifebenefits.com/plandesign/Arizona
You can access important information about your:
Life and AD&D

Plan Features
Learn more about AD&D, the possibility of waiving your premium, and accelerated death benefits. Frequently Asked Questions are located at the bottom of this page for further assistance.

- **Plan at a Glance**
  Detailed basic and supplemental coverages are listed to give members a better sense of what the plan consists of.
- **Certificate of Insurance** - Find out the complete details of your group life insurance plan.
- **Determine the Cost with Benefits Scout**
  - Learn your options - Take the guesswork out of selecting benefits. Learn about your options, what's included and how they can help you.
  - Answer questions - It's quick and easy. Based on your answers, Securian will provide a few recommended packages for amounts of insurance that make sense for you.
  - Get cost estimates - with recommendations designed for you and your family.
  - Visit: scout.securian.com/?id=012175.0001

Lifestyle Benefits
Discover the additional resources that members have automatic access to without any additional fees or enrollments.

- **Beneficiary Financial Counseling**
  Beneficiaries who receive at least $25,000 in policy benefits are eligible for financial counseling. This link will direct you to more information about this additional resource.
- **Grief Counseling**
  Access master's-level consultants by phone for any stage of grief and referrals for loss support.
- **Will Preparation and Legal Services**
  Create a will, get a financial assessment, free consultation with an attorney, and more through services offered by LifeWorks US, Inc.
- **Legacy Planning Resources**
  End-of-life planning, funeral arrangements and more with Securian.
- **Travel Assistance**
  Lost luggage, ID theft support, medical relocation, repatriation of mortal remains, and more are offered through services offered by RedPoint WTP LLC.
- **How to Access Lifestyle Benefits**
  - LifeBenefits.com/Lfg
  - username: lfg
  - password: resources
  - 1-877-849-6034

Wellness

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

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

University Faculty and Staff: Please refer to your Human Resources website for employee assistance and wellness services available to you.

- ASU/ABOR: cfo.asu.edu/employee-assistance-wellness
- NAU: https://in.nau.edu/eaw/hip-wellness-program/
- UA: https://lifework.arizona.edu/

Programs and Services

Health Impact Program (HIP)
The Health Impact Program (HIP) is a Wellness component of the total Benefit Options Plan. HIP is an incentive based employee wellness program for all benefits-eligible State of Arizona employees, their spouses and adult dependents. Through engagement and completion of designated activities, employees will earn points and could receive incentives at various point levels, up to $200 upon reaching the 50,000-point goal by the end of the program.

We partner with Virgin Pulse to offer a state-of-the-art platform for your wellness journey. There are so many ways to take part, including making challenges for yourself and your friends! Plus, you'll be able to sync your wearable fitness device and track your activities effortlessly to earn the $200 annual incentive.

HIP is designed to promote and encourage health and well-being of state employees through sustained engagement in a variety of challenges, preventive health activities and screenings. Program details and guidelines can be found by visiting wellness.az.gov/hip.

Mini-Health Preventive Screenings
The worksite mini-health screening focuses on prevention and early detection of heart disease and diabetes and other conditions. Tests included in this screening are the full lipid panel, blood pressure, body composition, and blood glucose measures. Our vendor also offers optional screens such as Osteoporosis, Hemoglobin A1c, or a Prostate Specific Antigen (PSA) blood test.

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

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

There are no costs to you for the preventive onsite wellness services.

Flu Vaccine Program
From September - December each year, Wellness provides free flu shots at many State worksites and public clinic locations for employees and their dependents. Locations and more information can be found on the Wellness website at wellness.az.gov/flushot.

Weight & Diabetes Management Programs
Get the support and tools necessary for you to improve your health, experience positive outcomes, and achieve your personal health goals.
Our vendors include:

- Real Appeal
- Wondr
- Am I Hungry?
- National Diabetes Prevention Program

These programs are available to Benefits eligible employees, spouses, and dependents age 18 and over. To learn more, visit wellness.az.gov/healthmanagement.

Employee Assistance Program (EAP)

EAP Provider: Guidance Resources - CompPsych

- 877-327-2362 | guidancesresources.com | Web ID: HN8876C
- Other EAP contracts that serve State agencies can be found below

Overview

The EAP is a confidential Wellness benefit that provides short-term counseling to employees, their spouses, and their dependents. Employees can access 12 free counseling sessions to help with personal issues, coping with a loss, stress and anxiety, or financial concerns. ADOA offers an EAP contract which serves most State agencies.

The free counseling can help handle concerns or issues constructively, before they become a major problem. In addition to counseling, EAP offers Critical Incident Stress Management services, work-life benefits and referrals to local affordable resources.

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

AGENCY	CONTRACTED EAP	PHONE	TDD/TTY
ADOA* ADC ADE ADEQ ADOT AHCCCS DCS DES DPS UA	**ComPsych** Visit guidanceresources.com. Register using Web ID HN8876C. ● The Employee Assistance Program (EAP) is administered by ComPsych Guidance Resources. ● The EAP is for all benefits-eligible employees, spouses, and dependents living in their household. ● The program offers someone to talk to and resources to consult whenever you need them for solutions to life's challenges. ● Free and confidential service.	877-327-2362	800-697-0353
ASU	**Employee Assistance Onsite** Visit cfo.asu.edu/eao-wellness ● The ASU Employee Assistance Office provides both personal and work-related counseling and managerial consultation. ● Services include assessment, referral, brief counseling, worksite crisis support and educational workshops to all benefits eligible faculty, staff, their dependents and household members. ● All services are voluntary, confidential and provided at no cost to eligible participants.	480-965-2271	
NAU	**Employee Assistance Program** Visit in.nau.edu/eaw/ ● Assistance with personal and professional issues. All calls and appointments are handled confidentially, promptly, and professionally.	928-523-1552	

**Agencies, Boards, and Commissions are covered under the ADOA ComPsych contract.*

Higher Education Discounts

ADOA has partnered with local and national institutions to offer an exciting opportunity to help you advance your higher education. This benefit provides you with discounts at several accessible, attainable, and affordable degree programs at bachelors, masters and Ph.D. levels. To learn more—visit benefitoptions.az.gov/highered.

- **Discounts**
  Our negotiated discounts range from 5% to 40% and in some instances, your spouse and dependents may also be eligible.

- **Active Employees**
  Available to active employees, their spouses and dependents only.

- **Tuition Reimbursement**
  Policies are set by the agency where you work. Please contact your supervisor for details.

Participating Schools
Schools participating as of the publication of this guide are listed below. More schools may join the program. For the most updated information, please visit benefitoptions.az.gov/highered.

- Arizona Christian University
- Arizona State University
- Benedictine University
- DeVry University
- Grand Canyon University
- North Central University
- Northern Arizona University
- Ottawa University
- University of Arizona
- University of Arizona Global Campus
- University of Phoenix

Shopping Discounts

Local Merchants

- **Arizona Capitol Museum Store**
  - Home and office, kids, books, gifts, ornaments, jewelry
  - 1700 W. Washington, Phoenix (Historic Capitol Copper Dome).
  - 602-926-3666
  - M-F 8:30 am - 4:30 pm
  - In-Person Discount: 10% State Employee Discount with ID
  - Website: azcapitolgifts.ecwid.com | Website Discount - 10% off. Code: AZGOV.
  - You can also use the curbside pickup option.

- **Arizona Highways Store**
  - Calendars, Arizona-related books, unique items
  - 800-543-5432
  - Website: shoparizonahighways.com | Discount - 20% off. Code: P3STA20
  - Arizona Highways magazine
    - One-year subscriptions to the award-winning magazine are $16 each, reduced from the regular $24 rate. (Discount subscription is $36 for addresses outside the U.S.)

- **See's Candies - Camelback**
  - Famous chocolates, candy and gift boxes for all occasions. Kosher, nut-free, dairy-free, egg-free, and soy-free options.
  - 132 E Camelback Rd, Phoenix (NW Corner Central Ave. and Camelback Rd.)
  - 602-266-1727
  - M-S 10 am - 7 pm, Sun 11 am - 6 pm
  - Discount: 10% off with State ID - valid in-store only.

Deferred Compensation Plan | Arizona Smart Save

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

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

- 457(b) Traditional Deferred Compensation Plan – tax-deferred, available to State employees.
- 457(b) Roth Deferred Compensation Plan — after-tax, available to State employees.
- 401(a) Deferred Compensation Plan – tax-deferred, and available to State employees meeting certain age requirements. This plan also has an irrevocable requirement where, once you start making contributions, you cannot stop them or change the amount of the deductions until you sever employment.
- 403(b) Deferred Compensation Plan – tax-deferred, and available to State employees who work at the Arizona Department of Education or the School for the Deaf & Blind. Not available for the University faculty and staff (please refer to your Human Resources website for more information about the University-sponsored voluntary 403(b) retirement savings program.)

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

1. Enroll in your plan – It's easy to participate in deferred compensation. You can enroll on-line or on paper, just visit arizonadc.com for either option. Contributions are automatically deducted from each paycheck and deposited to your account, so you don't have to remember to write a check.
2. Use the Paycheck Impact Calculator, available at arizonadc.com, to see how saving pre-tax will affect your paycheck.
3. Invest your money – Once you are enrolled, you can choose from a wide variety of funds from the list of investment options available within your plan. After enrollment, you can use the Morningstar Retirement ManagerSM to get a personalized retirement strategy, including recommendations for your retirement income goal, savings rate and portfolio asset mix. Keep in mind, any investment involves risk and there's no guarantee that any fund will achieve its investment objectives.
4. Receive income – Many public employees retire earlier than those in the private sector, and if that's the case, you'll want to invest enough to live in retirement on your terms. When investing in a 457(b) plan, distributions are available upon severance from employment, regardless of age! Before you begin taking payments, review our Retirement Checklist (available on arizonadc.com in our Library) to make sure you're ready to transition from saving to spending.

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

- You can start anytime – Your deferred compensation plans will work for you whether you're approaching retirement or just getting started.
- Every little bit helps – Even investing a small amount of money can really add up over time. And if you increase your contributions on a regular basis, the overall impact to your paycheck may not seem too

painful. Consider putting raises or bonuses into deferred compensation – it's an easy way to invest a little more.
- This plan is made for you – Unlike other retirement plans, a 457(b) deferred compensation plan considers that you may retire sooner than workers in the private sector. Generally, you don't have to worry about paying a penalty for retiring early or beginning to take income from the plan before age 59½ (unlike 401(k) plans). Withdrawals are taxable income to you in the year the payments are made.
- You will get On Your Side service – Nationwide is ready and willing to answer your questions. They have been helping public sector employees save for retirement for more than 30 years and their local Retirement Specialists have helped educate thousands of employees about investing through their retirement plans. Feel free to call today — they do not charge a fee to work with a Retirement Specialist.

Contact Us

- Give Nationwide a call at 1-800-796-9753 or in Phoenix at 602-266-2733.
- Go to arizonadc.com to understand more details of the retirement plans and the benefits, use the calculators and tools (including the Interactive Retirement Planner and new Health Care Estimation Tool), view investment options and get started today by enrolling or making account updates.

Legal Notices

General COBRA Notice
This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. For more information on COBRA, please visit benefitoptions.az.gov/COBRA

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other Members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Benefit Services Division.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a Spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?
COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your Spouse and your Dependent Children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an Employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the Spouse of an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your Spouse dies;
- Your Spouse's hours of employment are reduced;
- Your Spouse's employment ends for any reason other than his or her gross misconduct;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse.

Your Dependent Children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-Employee dies;
- The parent -Employee's hours of employment are reduced;
- The parent-Employee's employment ends for any reason other than his or her gross misconduct;The parent-Employee become entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The Child stops being eligible for coverage under the Plan as a "Dependent Child"

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Benefit Options Plan, and that bankruptcy results in a loss of coverage of any Retired Employee covered under the Plan, the Retired Employee will become a qualified beneficiary. The Retired Employee's Spouse, Surviving Spouse, and Dependent Children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

Health Insurance Marketplace Coverage

General information
When key parts of the health care reform law (the Affordable Care Act or ACA) take effect in 2014, there will be a new way to buy health insurance: through the health insurance marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new marketplaces and employment based health coverage offered by your employer.

What is the health insurance marketplace?
The marketplace is designed to help you find health insurance that meets your needs and fits your budget. The marketplace offers "one-stop shopping" to find and compare private health insurance options. You can enroll for health insurance coverage through the marketplace during an enrollment period that begins in October 2013. Coverage can begin as early as January 1, 2014.

Can I save money on my health insurance premiums in the marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards The savings on your premium that you're eligible for depends on your household income.

Does employer health coverage affect eligibility for premium savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.69% of your household income for that year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the marketplace instead of accepting health coverage offered by your employer, then you will lose any employer contribution to the State of Arizona Benefit Options Plan. Also, this employer contribution – as well as your employee contribution to the State of Arizona Benefit Options Plan – is often excluded from income for Federal and State income tax purposes. Future enrollment in the State of Arizona Benefit Options Plan will be limited to open enrollment (which typically happens in the fall).

How can I get more information?
For more information about your coverage offered by your employer, please check your summary plan description or contact the Arizona Department of Administration Benefit Services Division contact information included in the employer information chart.

The marketplace can help you evaluate your coverage options, including your eligibility for coverage through the marketplace and its cost. Visit HealthCare.gov for more information, including an online application for health insurance coverage and a Health Insurance Marketplace in your area.

Information about health coverage offered by your employer

If you decide to complete an application for coverage in the marketplace, you will be asked to provide the information included in the chart below. This employer information is numbered to correspond to the marketplace application.

Employer Information - Numbers Correspond to the Marketplace Application	
3. Employer Name	State of Arizona
4. Employer Identification Number (EIN)	86-6004791
5. Employer Address	100 N 15th Ave, Suite 301
6. Employer Phone Number	(602) 542-5008
7. City	Phoenix
8. State	AZ
9. Zip Code	85007
10. Who can we contact about employee Health coverage at this job?	Human Resources Division - Benefit Services Division
11. E-mail Address	benefits@azdoa.gov

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to some employees and dependents. Eligible employees and dependents are defined in the Triple Choice Plan, HDHP with HSA plan descriptions (Article 3 Eligibility and Participation) posted on the Benefit Options website benefitoptions.az.gov/resources.
- This coverage provided meets the minimum value standard, and the cost of this coverage is intended to be affordable.

If you decide to shop for coverage in the marketplace, HealthCare.gov will guide you through the process. The employer information you can enter when you visit HealthCare.gov will help you determine if you can get a subsidy (in the form of a tax credit) to lower your monthly premiums for coverage purchased through the marketplace.

Newborns' & Mothers' Health Protection Act (NMHPA)

Under federal law, group health plans and health insurance issuers offering group health insurance generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the plan or issuer may pay for a shorter stay if the attending physician (e.g., your physician, nurse, or a physician assistant), after consultation with the mother, discharges the mother or her newborn earlier. Also, under federal law, plans and insurers may not set the lever of benefits or out-of-pocket costs so that any later portion of the 48-hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. If

you have any questions, contact Benefit Options at 602-542-5008 or 1-800-304-3687 or email Benefit Options at benefits@azdoa.gov.

Notice of Nondiscrimination

Benefit Options complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Benefit Options provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, contact:

ADOA HR - Benefits
100 N. 15th Avenue, Suite 301
Phoenix, AZ 85007
602-542-5008 or 1-800-304-3687
benefits@azdoa.gov

If you believe that we have failed to provide these services or discriminated based on a protected class noted above, you can also file a grievance with ADOA Benefit Services Division.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 602-542- 5008 o 1-800-304-3687.

DÍÍ BAA'ÁKONÍNÍZIN: Diné (Navajo) bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohjį' 602-542-5008 or 1-800-304-3687 hodíilnih.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 602-542-5008 or 1-800-304-3687.

Patient Protection & Affordable Care Act (PPACA) Notices

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

Form W-2 Notice
Pursuant to the PPACA for tax years starting on and after January 1, 2012, in addition to the annual wage and tax statement employers must report the value of each employee's health coverage on form W-2, although the amount of health coverage will remain tax-free.

Summary of Benefits and Coverage (SBC) and Uniform Glossary Notice
On February 9, 2011, as part of the Affordable Care Act (ACA), the federal government announced new rules regarding the disclosure of the Summary of Benefits and Coverage (SBC) and Uniform Glossary. These regulations require group health plans and health insurance issuers that offer coverage for groups and

individuals to provide access to the SBC and Uniform Glossary effective October 22, 2012. The SBC documents along with the uniform glossary will be posted electronically to the Benefit Options Website benefitoptions.az.gov/resources. You may also contact Benefit Services to obtain a copy.

Prescription Drug Coverage and Medicare

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

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage: Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

ADOA has determined that the prescription drug coverage offered by the Benefits Options Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare Drug Plan.

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

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current Benefit Options coverage will be affected. If you enroll in a Medicare Part D Plan, you will not be eligible for Benefit Options medical coverage.

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

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with Benefit Options and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium.

You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage

For further information contact ADOA Benefit Services Division at 1-800-304-3687 or visit our website at benefitoptions.az.gov. Questions can also be sent to ADOA Benefit Services Division via email at benefits@azdoa.gov.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if the coverage through Benefit Options changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit medicare.gov;
- Call your State Health Insurance Assistance Program (see your copy of the *Medicare & You* handbook for their telephone number) for personalized help;
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

HIPAA Privacy Regulation Requirements

This Plan has been modified as required under the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to allow the Disclosure of Protected Health Information (PHI) as defined under HIPAA, to the Plan Sponsor and other parties as necessary to determine appropriate processing of claims.

Special Enrollment Rights for Health Plan Coverage Notice

If you decline enrollment in the State of Arizona's health plan for you or your Dependents (including your Spouse) because of other health insurance or group health plan coverage, you or your Dependents may be able to enroll in the State of Arizona Employee's health plan without waiting for the next Open Enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 31 days after the loss of other coverage.
- Gain a new Dependent as a result of marriage, birth, adoption or placement for adoption. You must request health plan enrollment within 31 days after the marriage birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

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

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

Wellness Program Notice

Health Impact Program (HIP) is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include screening for height, weight, blood pressure and a blood test – lipid profile – including cholesterol, glucose, and an optional Prostate Specific Antigen (PSA) and Hemoglobin A1C screens. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of up to $200 for completing 50,000 activity points. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will be eligible to receive the Health Impact incentive.

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

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as health coaching. You also are encouraged to share your results or concerns with your own doctor.

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

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or

required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) registered nurses and health coaches in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

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

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Wellness at wellness@azdoa.gov.

Women's Health and Cancer Rights Act Notice

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

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

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

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

No Surprises Act

Your Rights and Protections Against Surprise Medical Bills
When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?
When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a healthcare facility that isn't in your health plan's network.

“Out-of-network” describes providers and facilities that haven’t signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “**balance billing**.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can’t control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan’s in-network cost-sharing amount (such as copayments and coinsurance). You **can’t** be balance-billed for these emergency services. This includes services you may get after you’re in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers may be out-of-network. In these cases, the most that providers may bill you is your plan’s in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can’t** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can’t** balance bill you, unless you give written consent and give up your protections.

You’re never required to give up your protections from balance billing. You also aren’t required to get care out-of-network. You can choose a provider or facility in your plan’s network.

When balance billing isn’t allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you’ve been wrongly billed

You may contact Blue Cross Blue Shield of Arizona at 1-866-287-1980 or www.azblue.com; or, UnitedHealthcare at 1-800-896-1067 or www.myuhc.com.

Glossary

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

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

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

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

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

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

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

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

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

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

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

Deductible
Fixed dollar amount a member pays before the health plan begins paying for covered medical services. Copays and/or coinsurance amounts may or may not apply.

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

Disease Management

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

Eligible Employee
Refer to p. 7 for eligibility requirements.

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

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

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

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

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

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

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

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

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

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

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

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

Member

A person who is enrolled in the health plan.

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

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

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

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

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

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

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

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

Supplemental Life
Life insurance is an optional coverage amount above what the state provides.

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.

Contact Information

Plan Type	Vendor Name	Phone	Website | Email | Policy Number
Benefit Options	ADOA Benefit Services Division 1802 W. Jackson St. #94 Phoenix, AZ 85007	602-542-5008 800-304-3687	Info: benefitoptions.az.gov Enroll: hrsystems.azdoa.gov> YES Portal Email: benefits@azdoa.gov
Decision Tool | PicWell	PicWell		adoa.picwell.com
Dental	Delta Dental of Arizona	602-588-3620 866-978-2839	deltadentalaz.com/adoa | Group: 77777
	UHC Solstice S800B	844-208-0223	smilestateofaz.com | Policy: S800B
Discounts	Higher Education Partners		benefitoptions.az.gov/highered
Education Savings	AZ529 Plan - State Treasurer's Office	602-542-7529	az529.gov
Employee Asst Plan-EAP	ComPsych	877-327-2362	guidanceresources.com | Code: HN8876C
Flexible Spending Acct-FSA	TASC	833-433-4301	tasconline.com
Health Savings Acct-HSA	Optum Financial	866-610-4839	optumbank.com/arizona
Life Insurance	Securian	833-745-5517	lifebenefits.com/plandesign/Arizona Group: 34681
Short-Term Disability-STD	MetLife	866-264-5144	Info: metlife.com/stateofarizona/ Claims:mybenefits.metlife.com/stateofarizona
Long-Term Disability-LTD	Broadspire Services, Inc. | ASRS	877-232-0596	azasrs.gov/content/long-term-disability
	MetLife | PSPRS, EORP, CORP & ORP	866-264-5144	Info: metlife.com/stateofarizona/ Claims: mybenefits.metlife.com/stateofarizona
Medical	Blue Cross Blue Shield Arizona	866-287-1980	New members: azblue.com/stateofaz Members: azblue.com | Group: 30855
	UnitedHealthcare	800-896-1067	New members: uhcvirtual.com/stateofaz/ Members: myuhc.com | Group: 705963
Mental Health	Mental Health Resource Page		wellness.az.gov/mentalhealth
	National Suicide & Crisis Lifeline	988	Call or text, 24/7. Services are confidential.
Pharmacy	MedImpact	888-648-6769	Preview for BCBS: bit.ly/MedImpactBCBS Preview for UHC: bit.ly/MedImpactUHC Members: medimpact.com/plan/adoa Rx BIN: 003585 | Rx PCN: 28914
	Birdi Mail Order	855-873-8739	medimpact.com/plan/adoa
	MedImpact Direct Specialty	877-391-1103	medimpact.com/plan/adoa
Retirement-AZ Smart Save (Deferred Compensation)	Nationwide Financial 457(b), 401(k), 403(b), 401(a)	800-796-9753	azsmartsave.com
Retirement Systems	Arizona State Retirement System	602-240-2000 800-621-3778	azasrs.gov
	Public Safety Personnel Retirement System (PSPRS), Elected Officials Retirement Plan (EORP), Corrections Officer Retirement Plan (CORP)	602-255-5575 877-925-5575	psprs.com
Vision Plan	Avesis, Inc.	888-759-9772	avesis.com/arizona | Policy: 11001-2178
Wellness & Flu Shots	ADOA Benefit Services Division	602-771-9355	wellness.az.gov | wellness@azdoa.gov