Arizona Department of Administration

ADOA Benefit Options
2019 Benefit Guide
COBRA Enrollees

ARIZONA
DEPARTMENT OF ADMINISTRATION
BENEFITS

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Introduction

This guide describes the comprehensive benefits package “Benefit Options” offered to COBRA enrollees by the State of Arizona, Department of Administration Benefit Services Division effective January 1, 2019. 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.

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 Changes for Plan Year 2019

The 2019 Benefits Plan Year is January 1 - December 31, 2019. Important changes are being made effective January 1, 2019, which will impact all employees who elect State benefits. See below for a quick overview of what is changing for 2019. For a full explanation, please see the pages noted.

- **Contribution Rate, pg. 8**
  - For the Exclusive Provider Organization (EPO) and Preferred Provider Organization (PPO) plans, your portion of the medical premium will rise by 3%.
  - The High Deductible Health Plan (HDHP) and Health Savings Account (HSA) contribution will remain the same.

- **New EPO Deductible, pg. 17**
  - The EPO medical plan will have a deductible of $100 for individuals and $200 for families. This means you will have to pay $100 or $200 in qualified out-of-pocket expenses before the plan begins to pay.

- **Staying the Same**
  - All other health plan coverage and carriers will remain the same for 2019.

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.

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.

COBRA Eligibility

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:
    - Death of the employee;
    - Termination of the employee's employment for a reason other than gross misconduct;
    - Reduction in the employee's hours of employment resulting in a loss of eligibility for coverage;
    - Divorce or legal separation from the employee;
    - The employee becomes eligible for Medicare.
3. An employee's dependent child who had coverage through Benefit Options and lost the coverage for any of the following reasons:
    - Death of the employee (parent);
    - Termination of the parent's employment for a reason other than gross misconduct;
    - A reduction in the parent's hours of employment resulting in a loss of eligibility for coverage;
    - The parents' divorce or legal separation;
    - The parent becomes eligible for Medicare or,
    - The dependent ceases to be a dependent child as defined by the Benefit Options program.

The ADOA Benefit Services Division will determine final eligibility for COBRA coverage. The ADOA Benefit Services Division will determine whether the life event you are experiencing qualifies under the Section 125 regulations.

COBRA Coverage

Electing Your COBRA Benefits

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

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

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

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

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

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

Changing Your COBRA Benefits

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

Second Qualified Life Event

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

The extension applies only to qualified beneficiaries, including children of the employee who were born or adopted while the employee was on COBRA coverage. (Qualified beneficiaries include an employee's spouse who was covered by the Plan and an employee's dependent children who were covered by the Plan). Qualified beneficiaries must inform the ADOA Benefit Services Division no later than 31 days from the QLE.

COBRA for Dependent Children over 26

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

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

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

Your Contributions

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

When to Pay

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

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

Maximum Period of Continuation of Coverage

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

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

If a second qualified life event occurs while under COBRA coverage, qualified beneficiaries may be granted an extension of coverage for up to 36 months. Qualified beneficiaries must inform the ADOA Benefit Services Division no later than 31 days from the QLE.

COBRA Participant Monthly Insurance Premiums Summary

MEDICAL PREMIUM			
	EPO PLAN	**PPO PLAN**	**HDHP with HSA PLAN**
Participant Only	$637.54	$718.86	$422.38
Participant + Adult	$1,352.40	$1,519.25	$896.23
Participant + Child	$905.85	$1,016.83	$599.08
Participant + Family	$1,586.39	$1,772.65	$1,048.06

DENTAL PREMIUMS		
	CIGNA DHMO	**DELTA DENTAL PPO Plus Premier**
Participant Only	$8.69	$36.66
Participant + Adult	$17.38	$77.14
Participant + Child	$16.92	$61.69
Participant + Family	$26.05	$120.63

VISION PREMIUMS	
	Avesis Advantage Program
Participant Only	$4.07
Participant + Adult	$13.20
Participant + Child	$13.02
Participant + Family	$16.42

Continuation Coverage Explained

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

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

Continuation Coverage Duration

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

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

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

Extending COBRA Continuation Coverage Period

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

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

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent's child ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage. Qualified beneficiaries must inform the ADOA Benefit Services Division no later than 60 days from the QLE.

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

COBRA Continuation Coverage Election

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

to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all the qualified beneficiaries.

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

COBRA Continuation Coverage Cost

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

COBRA Continuation Coverage Payments

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage no later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) COBRA begins the day after your active coverage ends and is not effective until payment is made. If you do not make your first payment for continuation coverage in full no later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact Member Services at 602.542.5008 or 800.304.3687 to confirm the correct amount of your first payment.

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in this notice. The periodic payments can be made monthly. Under the Plan, each of these periodic payments for continuation coverage is due on the 1st day for that coverage period. You may instead make payments for continuation coverage for the following coverage periods, due on the following dates: If you make a periodic payment on or before the first day of the coverage period to which it applies your coverage under the Plan will continue for that coverage period without any break. Billing statements are mailed as a courtesy. If you do not receive a bill, you may call Member Services at 602.542.5008 or 800.304.3687 for assistance.

Grace periods for periodic payments

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

Submitting Payments

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

Payment address:
Arizona Department of Administration - Health Insurance Trust Fund (HITF)
100 N. 15th Ave., Suite 302
Phoenix, AZ 85007

Declining COBRA Coverage

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

Enrolling in Another Group Health Plan

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

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

What factors should I consider when choosing coverage options?

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

- ***Premiums:*** Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.
- ***Provider Networks:*** If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
- ***Drug Formularies:*** If you're currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
- ***Severance Payments:*** If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all your COBRA payments for a period. In this scenario, you may want to contact the Department of Labor at 866.444.3272 to discuss your options.
- ***Service Areas:*** Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.
- ***Other Cost-Sharing:*** In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

If you fail to return an enrollment form, your right to COBRA coverage will expire after 60 days from the date on of the notice. If you have any questions or need additional information, please visit: benefitoptions.az.gov/cobra or cms.hhs.gov/COBRAContinuationofCOV.

This does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available on page 66 or in your summary plan description.

For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at dol.gov/ebsa or call their toll-free number at 866.444.3272.

Keep Your Plan Informed of Address Changes

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

Health Insurance Marketplace

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage.

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

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

If I sign up for COBRA continuation coverage, can I switch to coverage in the Marketplace? What about if I choose Marketplace coverage and want to switch back to COBRA continuation coverage?
If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period.

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

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

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

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit HealthCare.gov or call 800.318.2596.

Medical Plan Information

Definitions of Terms

For the plan year beginning January 1, 2019, employees have the option of choosing from three plans, four Networks with nationwide coverage, and four coverage tiers.

- "Network" describes the company contracted with the State to provide access to a group of providers (doctors, hospitals, etc.) Certain providers may belong to one Network but not another.
- "Plans" are loosely defined as the structure of your insurance policy: the premium, deductibles, copays, and out-of-Network coverage.
- "Tier" describes the number of persons covered by the medical plan.

Choosing the Right Plan

1. Assess the costs you expect in the coming year including: employee premiums, copays, and coinsurance. Refer to pg. 19 for plan comparisons to help determine costs.
2. Determine if your doctors are contracted with the Network you are considering. Each medical Network has a website or phone number to help you determine if your doctor is contracted with the Network.
3. Once you have selected which plan best suits your needs and your budget, make your benefit elections online in yes.az.gov.

Transition of Care (TOC)

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

If you are approved, you will receive in-Network benefits for your current doctor during a transitional period after January 1, 2019. Transition of care is typically approved if one of the following applies:

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

ID Cards

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

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

Three Medical Plans

There are three medical plans offered by Benefit Options:

- Exclusive Provider Organization (EPO)
- Preferred Provider Organization (PPO)
- High Deductible Health Plan with Health Savings Account (HDHP with HSA)

The EPO Plan

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

The PPO Plan

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

*HDHP with HSA**

This option is a High Deductible Health Plan for active employees. The Plan allows you to open a Health Savings Account to use for qualified medical expenses with investment options available. Services can be obtained in-Network or out-of-Network, but will have higher costs for out-of-Network services. Additionally, there are in-Network and out-of-Network deductibles that must be met. In-Network preventive services are covered at 100%. More detailed information on the HSA is available on page 18.

*Available to Active Employees and COBRA participants who are not eligible for Medicare.

Understanding the HSA Plan

1. The HSA Plan is a High Deductible Health Plan that works in conjunction with a Health Savings Account:
   - You have the option of establishing a Health Savings Account. To establish this account, members must complete the Customer Identification Process (see page 19).
   - HSA is a special type of savings account that allows tax-free contributions, earnings and healthcare related withdrawals.
2. The HSA offers financial advantages in that, an HSA member:
   - Pays lower employee premiums (paycheck deductions).
   - Receives qualified preventive services at no cost.
   - May have lower out-of-pocket costs.
   - Is eligible to open and contribute to a Health Savings Account.
3. The HSA presents financial considerations in that:
   - HSA members pay copays and/or coinsurance after the deductible is met (qualified preventive services are covered at 100%).
4. The HSA might be right for you if:
   - You want to open a tax-advantaged HSA and save for future healthcare costs.
   - You are willing to accept some degree of financial risk.
   - You can afford to pay a high deductible if necessary.
5. The HSA may be wrong for you if:
   - You prefer copays because they are simple and predictable.
   - You are not willing to accept some degree of financial risk.
   - You cannot afford to pay a high deductible.
   - You are entitled to benefits under Medicare.

Non-Permitted Coverage

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

Cost for Services/Prescriptions

The cost for services/prescriptions depends on three things (please see table on next page):

1. Whether the service/prescription is:
   - Qualified Preventive
   - Non-Preventive
   - Emergency
2. Whether the provider is:
   - In-Network
   - Out-of-Network
3. How much you have paid so far during the plan year:
   - Less than the deductible
   - More than the deductible, but less than the out-of-pocket maximum

At the top of the table you can see that:

- In-Network qualified preventive services are covered at no additional cost, even before the deductible is satisfied.
- In-Network qualified preventive prescriptions will cost the regular copay amounts up to the out-of-pocket maximum.
- Once the out-of-pocket maximum is satisfied, in-Network qualified preventive prescriptions are covered at 100% for the remainder of the Plan Year.

In the middle of the table you can see that:

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

Individual/Employee+Adult/ Employee+Child/Family total out-of-pocket cost at time of expense			Less than deductible	More than deductible, less than out-of-pocket maximum	Out-of-pocket maximum
IN-NETWORK	**Qualified Preventive**	Services	$0	$0	$0
		Prescriptions	$15/$40/$60 copays	$15/$40/$60 copays	
	Non-Preventive	Services	100% of contracted rate	10% of contracted rate	
		Prescriptions	100% of contracted rate	$15/$40/$60 copays	
	Emergency	Services	100% of contracted rate	10% of contracted rate	
OUT-OF-NETWORK	Qualified Preventive	Services	50% of total cost	50% of total cost	$0
	Non-Preventive	Services	100% of total cost	50% of total cost	
	Emergency	Services	100% of total cost	10% of total cost	

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 in nature

HSA Overview

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

1. You open your Health Savings Account.
   - You maintain ownership even after ending State employment.
   - You can invest the money like you would invest money in an IRA, once funds reach $1,000.
   - Your funds will earn interest.
2. When your HSA is opened, the State will make pay period contributions to your HSA.
   - For Employee only coverage, the State will contribute $27.69 per pay period.
   - For Employee+adult, Employee+child, and Family coverage, the State will contribute $55.38 per pay period.
3. You can make additional contributions to your HSA through:
   - Payroll deductions (pre-tax).
   - Lump-sum deposits (tax deductible).
4. The IRS has released new 2019 Health Savings Account (HSA) Limits. Contribution limits are $3,500 for individuals and $7,000 for family coverage.
5. You can spend HSA funds on a tax-free basis for qualified healthcare-related expenditures (defined by the Internal Revenue Service).

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

6. There are some fees associated with the HSA, such as:
   - Monthly Account Statements
   - Bill payment via check
   - Stop payment via check
   - Non-sufficient funds

Medical Plan Comparison Charts

MEDICAL PLAN COMPARISON – IN-NETWORK SERVICES				
		EPO PLAN	**PPO PLAN**	**HDHP with HSA[2]**
		IN-NETWORK	**IN-NETWORK**	**IN-NETWORK**
		Aetna BCBSAZ Cigna UnitedHealthcare	**Aetna BCBSAZ[3] UnitedHealthcare**	**Aetna**
Plan Year Deductible[4]	EE Only	**NEW** - $100	$500	$1,350
	EE + Spouse	**NEW** - $200	$1,000	$2,700
	EE + Child	**NEW** - $200	$1,000	$2,700
	Family	**NEW** - $200	$1,000	$2,700
Out-of-Pocket Maximum[4,5]	EE Only	$7,350	$1,000	$2,000
	EE + Spouse	$14,700	$2,000	$4,000
	EE + Child	$14,700	$2,000	$4,000
	Family	$14,700	$2,000	$4,000
Lifetime Maximum		Unlimited	Unlimited	Unlimited
COPAYMENT/CO-INSURANCE[4] AFTER DEDUCTIBLE				
Routine Preventive Services		$0	$0	$0
Office Visits including Mental and Behavioral Health Visits				
Primary Care Physician (PCP)		$20	$20	10%
Specialist[5]		$40	$40	10%
OB/GYN		$20	$20	10%
Telemedicine Services (Doctor on Demand)		$20	$20	10%
Durable Medical Equipment		$0	$0	10%
Emergency Services				10%
Ambulance		$0	$0	10%
Emergency Room		$200[6]	$200	10%
Urgent Care		$75	$75	10%
Inpatient Hospital Admission		$250	$250	10%
Outpatient Facility		$100	$100	10%
Laboratory and X-Ray Services[7]		$0	$0	10%
Major Radiology Services[8]		$100	$100	10%

1 For the NAU only BCBS PPO Plan details, go to nau.edu/human resources/benefits/benefit-plan-document/
2 HDHP with HSA Plan members have access to the Aetna network but can save 15% when using Banner facilities.
3 Copayments apply after the Plan deductible is met. Copayments and Deductible apply to Out-of-Pocket Maximum.
4 The Plan pays 100% after the Out-of-Pocket Maximum is met.
5 Includes Chiropractor and Therapy services. All Mayo Clinic Primary Care Physicians (PCP) contract with Cigna HealthCare as specialists, therefore, all primary care services administered by Mayo PCPs will be subject to the $40 specialist copayment.
6 Emergency room copayment waived if admitted but subject to hospital admission copayment.
7 See summary plan document for more detailed information on covered services.
8 Includes CAT scans, MRI/MRA, PET scans, etc. See summary plan document for more information.

Network Options Outside Arizona

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

	EPO NETWORK	PPO NETWORK	HDHP with HSA NETWORK
Aetna	Aetna Select Open Access	Aetna Choice POS II Open Access	Aetna Choice POS II Open Access
BCBSAZ	BlueCard	BlueCard	Not Available
Cigna	Cigna Open Access Plus	Not Available	Not Available
UHC	UHC Choice	UHC Options PPO	Not Available

Medical Provider Web Resources

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

Aetna
Web Resources
Non-member: aetnastateaz.com
Existing member: aetna.com

Set up your member account to access the following features of the portal:

- ❑ *DocFind*
  Use this online directory to find out if your physician or hospital is contracted with Aetna.

- ❑ *Aetna Navigator—Review Your Plan and Benefits Information*
  You can verify your benefits and eligibility. You will also have access to detailed claims status and claim Explanation of Benefits (EOB) statements.

- ❑ *ID Card*
  Print a temporary or order a replacement ID card.

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

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

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

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

- ❑ *Aetna Mobile*
  Simply type aetna.com in your smart phone to access doctors, Aetna Navigator, and much more. There is an iPhone or Android application available for downloading.

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

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

Blue Cross Blue Shield of Arizona Web Resources

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

Members and Non-members can access:

- ❑ *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.

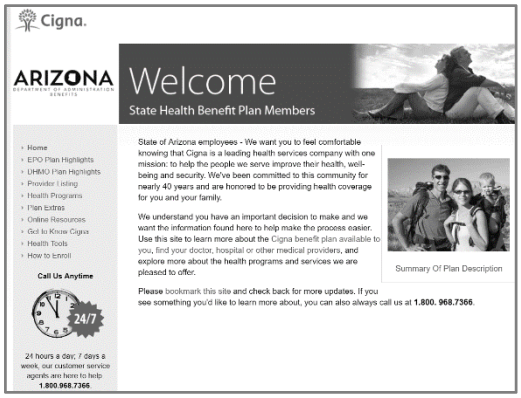
Members can create a user ID and password to have access to:

- ❑ *ID Card*
  Order a new ID card or print a temporary one.
- ❑ *Care Comparison*
  This simple online tool gives you access to price ranges for many common health care services right down to the procedure and the facility in your area. You can also view cost information across many specialties including radiology, orthopedics, obstetrics, and general surgery.
- ❑ *Hospital Compare*
  In this tool, you will find information on how well hospitals care for patients with certain medical conditions or surgical procedures, and results from a survey of patients about the quality of care they received during a recent hospital stay.
- ❑ *Claims Inquiry*
  View and read the detailed status of all medical claims submitted for payment. You can also obtain your Explanation of Benefits (EOB) or Member Health Statement.
- ❑ *Optional Electronic Paperless EOB*
  Reduce mail, eliminate filing and help the planet by going green.
- ❑ *Coverage Inquiry*
  Verify eligibility for you and your dependents.
- ❑ *Wellness Tools*
  You can access wellness information through your personal HealthyBlue homepage.
- ❑ *Online Forms*
  You can find important forms and information online, including a medical claim form and medical coverage guidelines.
- ❑ *Help*
  You can find information on how to contact Blue Cross Blue Shield of Arizona regarding your benefits, claims, or any other questions you may have.

Cigna
Web Resources

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

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



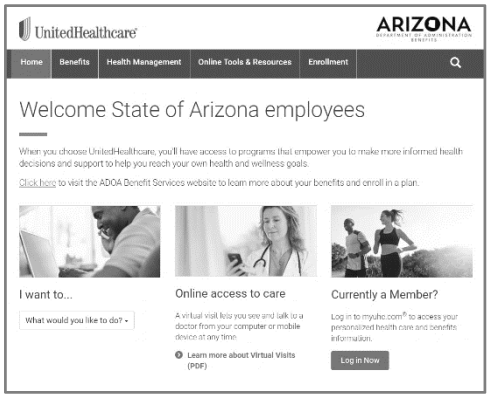
For employees already enrolled in the Cigna plan: visit myCigna.com, for access to:

- ❑ *Personal Profile*
  You can verify your coverage, copays, deductibles, and view the status of claims.
- ❑ *ID Card*
  Order a new ID card or print a temporary one.
- ❑ *Evaluate Costs*
  You can find estimated costs for common medical conditions and services.
- ❑ *Rank Hospitals*
  Learn how hospitals rank by cost, number of procedures performed, average length of stay, and more.
- ❑ *Assess Treatments*
  You can get facts to make informed decisions about condition-specific procedures and treatments.
- ❑ *Conduct Research*
  With an interactive library, you can gather information on health conditions, first aid, medical exams, wellness, and more.
- ❑ *Health Coaching*
  Take a quick health assessment, get personalized recommendations and connect to immediate online coaching resources.
- ❑ *Monitor Health Records*
  Keep track of medical conditions, allergies, surgeries, immunizations, and emergency contacts. You can download a free, personalized smart phone app. From there, you can do almost anything on the go – from getting your ID cards, account balances, locating doctors and hospitals, and so much more. Get the myCigna Mobile app today!

Mayo Clinic Primary Care Physicians (PCP) are contracted with Cigna HealthCare as specialists, therefore all primary care services administered by Mayo PCPs will be subject to the $40 specialist copayment. If you choose a doctor that does not accept assignment from Medicare, your doctor may be allowed to bill you for additional costs up to the Medicare limiting charge.

UnitedHealthcare
Web Resources

Non-member: welcometouhc.com/stateofaz
Existing member: myuhc.com



- ❑ *Visit your support site: welcometouhc.com/stateofaz*
  - From this site, you can access benefit information, learn about available tools, resources and programs, view open enrollment materials and more.
  - View and compare benefit plan options
  - Learn more about wellness programs, specialized benefits and online tools
  - Search for physicians, facilities, and access our site for members, myuhc.com.

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

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

- ❑ *ID Card*
  Order a new ID card or print a temporary one.

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

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

- ❑ *Stay healthy with innovative health and wellness tools.*
  - Wellness tools and health checklists give you tips on living healthy and using health plan benefits to your advantage.
  - 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. Through exciting interactive tools, you can participate in missions and have fun while focusing on wellness.
  - 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.

Medical Management

Services Available

When you choose Benefit Options medical insurance you get more than basic healthcare coverage. You get personalized medical management programs at no additional cost. Under the Benefit Options health plan, the medical Network you select during open enrollment serves their specific members.

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

Utilization Management

Each Medical network provides prior authorization and utilization review for the ADOA Benefit Options plans when members require non-primary care services. Prior to any elective hospitalization and/or certain outpatient procedures, you or your doctor must contact your medical Network for authorization. Please refer to your Plan Document for the specific list of services that require prior authorization. Each Network has a dedicated line to accept calls and inquiries:

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

Case Management

Case management is a collaborative process whereby a case manager from your selected medical Network works with you to assess, plan, implement, coordinate, monitor, and evaluate the services you may need.

Often case management is used with complex treatments for severe health conditions. The case manager uses available resources to achieve cost effective health outcomes for both the member and the State of Arizona.

NurseLine

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

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

Disease Management

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

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

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

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

Your assigned disease manager may also:

- Provide tips on how to keep your diet and exercise program on track
- Help you to maintain your necessary medical tests and annual exams
- Offer tips on how to manage 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. Over the course of the program, participants learn to incorporate healthy habits and improve their overall health.

Getting Involved

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

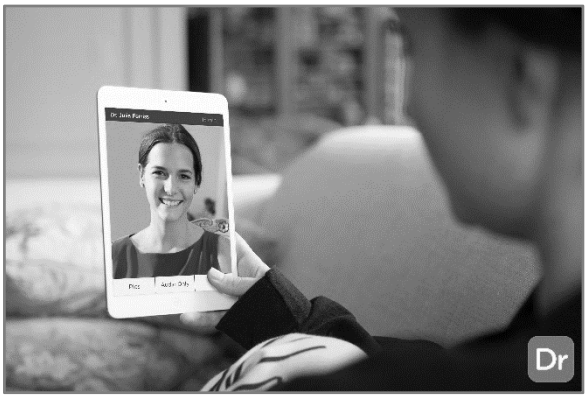
The medical Networks work with the Benefit Options plan to provide this additional service. Participation is optional, private, and tailored to your specific needs. Also, members of the Benefit Options plan who are concerned about a health condition and would like to enroll in one of the covered programs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

Please refer to your medical Network's phone number on page 27 if you or your dependent is interested.

Telemedicine

Doctor on Demand

To register, visit
patient.doctorondemand.com/register/



Connect with doctors right from your phone, tablet, or computer on demand or by appointment – 365 days a year, 24/7. Through live video, our hand-picked doctors review symptoms and medications, perform an exam, and may recommend treatment, including prescriptions and lab work.

Board-certified doctors treat a wide variety of health conditions, including:

- Colds & Flu
- Allergies
- Urinary Tract Infections (UTIs)
- Heartburn & Indigestion
- Migraines
- Prescription Refills
- Pink Eye
- Eczema & Acne

Doctor on Demand video visits cost far less than a trip to the emergency room or urgent care. The cost of your visit is provided up front, so you won't have any surprises after your visit. Here are the costs based on your coverage:

- EPO/PPO: $20 copay. The same as a Primary Care Physician visit.
- HSA: $49. Less than a visit to Urgent Care or the ER.
- No setup or monthly fees.

Download the app through Google Play™ or the Apple Store℠.

Pharmacy Plan Information

MedImpact

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

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

ID Card

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

How it Works

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

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

The MedImpact plan has a three-tier formulary described in the chart on page 29. The copays listed in the chart are for a 31-day supply of medication bought at a retail pharmacy.

Formulary

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

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

Finding a Pharmacy

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

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

Pharmacy Mail Order Service

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

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 e-mail address to receive information on your orders.
- Order refills online at walgreens.com or via phone at 1.866.304.2846. Have your insurance card ready when you call!

Choice90

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

Medication Prior Authorization

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

Step Therapy Program

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

Specialty Pharmacy Program

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

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

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

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

Limited Prescription Drug Coverage

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

Non-Covered Drugs

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

Extended Vacation or Travel Abroad

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

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

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

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

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

MedImpact	
Customer Care Center and Prior Authorization	1.888.648.6769
MedImpact BIN Number	003585
Retail PCN Number	28914

Walgreens	
Mail Order	1.866.304.2846
Specialty Pharmacy	1.888.782.8443

ADOA BENEFIT OPTIONS COPAYS (Aetna, Blue Cross Blue Shield of Arizona, Cigna, UnitedHealthcare)	
Pharmacy Benefits Administered By	MedImpact
Retail Requirements	In-Network pharmacies only, one copay per prescription
Mail Order[1]	Two copays for 90-day supply
Choice90	Two & 1/2 copays for 90-day supply
Generic	$15 copay
Preferred Brand[2]	$40 copay
Non-Preferred Brand[2]	$60 copay
Annual Maximum	See Summary Plan Description

1 Offer available to HSA members only when copays apply.

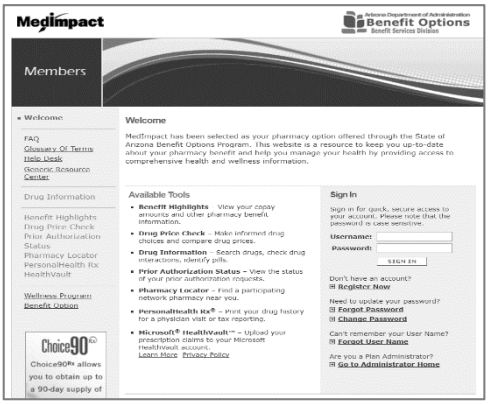
2 Member may have to pay more if a brand is chosen over a generic.

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

Pharmacy Web Resources

Members can view pharmacy information located at benefitoptions.az.gov.
Click the pharmacy link on the home page
Then "MedImpact Pharmacy Website".

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



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

- ❑ *Formulary Lookup*
  Research medications to learn whether they are generic, preferred or nonpreferred drugs. This classification will determine what copay is required. You can search by drug name or general therapeutic category.

- ❑ *Prescription History*
  View your prescription history, including all the medications received by each member, under Personal Health Rx. Your prescription history can be printed for annual tax purposes.

- ❑ *Drug Search*
  Research information on prescribed drugs like how to use the drug, side effects, precautions, drug interactions, and what to do if there is an overdose.

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

- ❑ *Mail Order*
  A link will direct you to the Walgreens website where you may register for mail order service by downloading the registration form and following the step-by-step instructions.

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

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

- ❑ *Choice90*
  Learn more about the Choice90 option. With this program, you can obtain a 90-day supply of medication for a reduced copay.

Dental Plans

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

Prepaid/DHMO Plan – Cigna Dental

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

Each family member may choose a different general dentist from the DHMO provider network. You can select or change your dentist by contacting Cigna by telephone. 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.

Indemnity/PPO Plan – Delta Dental PPO Plus Premier

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

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

To find a Delta Dental dentist near you, please visit deltadentalaz.com/find.
ID Card - New enrollees should receive a card within 10-14 business days after the benefits become effective

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

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

Dental Plans Comparison Chart

		CIGNA DHMO	DELTA DENTAL PPO Plus Premier
Plan Year Deductibles		None	$50/$150
Annual Combined Basic & Major Svs		No Dollar Limit	$2,000 per person
Orthodontia Lifetime		No Dollar Limit	$1,500 per person
EMPLOYEE COST FOR CARE			
PREVENTIVE CARE CLASS I	Oral Exam	$0	$0 - Deductible Waived[1]
	Emergency Exam	$0 (pain treatment) $55 (after hours office visit)	$0 - Deductible Waived[1]
	Prophylaxis/Cleaning	$0	$0 - Deductible Waived[1]
	Fluoride Treatment	$0	$0 (to age 18) - Deductible Waived[1]
	X-Rays	$0	$0 - Deductible Waived[1]
Sealants		$12 per tooth	20% (to age 19)
Fillings		Amalgam: $0 Resin: $0	20%
Extractions		Simple: $12 Surgical $53	20%
Periodontal Gingivectomy		$91: (1 to 3 teeth) $180: (4 or more teeth)	20%
Oral Surgery		$12 - $850	20%
Crowns		$150 -$500	50%
Dentures		$680 upper & lower	50%
Fixed Bridgework		$135 per unit	50%
Crown/Bridge Repair		$43	50%
Implant Body		$1,025	50%[2]
ORTHODONTIA		Coverage for Adults & Children 24-month treatment fee (see charge schedule)	See lifetime
OTHER SERVICES	TMJ Exam/Services	$330 Occlusal orthotic device	Not covered
	External Bleaching	$165	Not covered

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

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

3 Alaska, Hawaii, Maine, Montana, New Hampshire, New Mexico, North Dakota, Puerto Rico, Rhode Island, South Dakota, Vermont, West Virginia and Wyoming.

Dental Plan Website Resources

Cigna Dental Care (DHMO)
Website Resources
Non-member: Cigna.com/stateofaz
Existing member: myCigna.com

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

For employees already enrolled in the Cigna plan: visit myCigna.com, for access to:

- ❑ *Personal Profile*
  You can verify your coverage, copays, deductibles, and view the status of claims.
- ❑ *ID Card*
  Order a new ID card or print a temporary one.
- ❑ *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.
- ❑ *MyCigna Mobile App*
  You can download a free, personalized smart phone app. From there, you can do almost anything on the go – from getting your ID cards, account balances, locating dental providers, and so much more. Get the myCigna Mobile app today!

Delta Dental PPO plus Premier Website Resources

Non-member: deltadentalaz.com
Existing member: deltadentalaz.com/member

After the benefit year begins on January 1, please visit deltadentalaz.com to create your ID and password in the Member Connection, a secure website that gives you access to the following tools and materials:

- ❑ View and/or print your benefits and eligibility
- ❑ Go paperless and sign up for electronic Explanation of Benefits (EOBs) 24/7 claims information:
  - o Check your claims by dates
  - o Print copies of EOBs for you or your dependents
  - o Download a claim form
- ❑ Use the Find a Dentist tool to search Delta Dental's national dentist directory
- ❑ Download the Delta Dental Mobile App (iOS and Android) to access your ID card, view coverage and claims details, or find a dentist from your phone or tablet
- ❑ Check out the Delta Dental of Arizona Blog at deltadentalazblog.com for oral health articles and tips
- ❑ Assess your risk for dental diseases with the Oral Health Assessment Tool at MyDentalScore.com/DeltaDental

Vision Plan

Coverage for vision is available through Avesis.

Avesis Advantage Program

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

Program Highlights

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

How to Use the Advantage Program

1. Find a provider – You can find a provider using the Avesis website avesis.com or by calling customer service at 1.888.759.9772. Although you can receive out-of-Network care as well, visiting an in-Network provider will allow you to maximize your vision care benefit.
2. Schedule an appointment – Identify yourself as an Avesis member employed by the State of Arizona when scheduling your appointment.

Out-of-Network Benefits

If services are received from a non-participating provider, you will pay the provider in full at the time of service and submit a claim to Avesis for reimbursement. The claim form and itemized receipt should be sent to Avesis within three months of the date of service to be eligible for reimbursement. The Avesis claim form can be obtained at the website avesis.com. Reimbursement will be made directly to the member.

Refractive Surgery Benefit

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

Avesis Discount Hearing Plan

Members have access to a new Hearing Discount Plan. To utilize the Hearing Discount Plan, call 1.866.956.5400 and identify yourself as an Avesis member employed by the State of Arizona to access your benefits.

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

Avesis Comparison Chart

	Advantage Program	
	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
Contact Lenses (in lieu of frame/spectacle lenses)		
Elective	10-20% discount and $150 allowance[2]	Up to $150 reimbursement
Medically Necessary	Covered-in-full	Up to $300 reimbursement
LASIK/PRK		
LASIK/PRK	Up to $600	Up to $600 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 Includes fit, follow-up and materials.
3 No out-of-network benefits for the Discount Vision Care Program.

Vision Plan Web Resources

Avesis
Web Resources

Members: avesis.com/members.html.

If you are already registered, login with your Employee ID Number and password.

Newly enrolled members, simply create a username and password.

- ❑ *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 CARE	
EPO Plans	
Aetna	Emergency Services Only
BCBSAZ	Emergency Services Only
Cigna	Emergency Services Only
UnitedHealthcare	Emergency Services Only
PPO Plans	
Aetna	Emergency Services Only at in-Network Benefit Level[1]
BCBSAZ	Emergency Services Only at in-Network Benefit Level[1]
UnitedHealthcare	Emergency Services Only at in-Network Benefit Level[1]
HSA Plan	
Aetna	Emergency Services Only at in-Network Benefit Level[1]
NAU Only	
Blue Cross Blue Shield PPO	For assistance with locating a provider and submitting claims call 1-800-810-2583 or 1-804-673-1686. For an international claim form *bcbs.com/bluecardworldwide/index*
PHARMACY	
MedImpact	Not covered
DENTAL CARE	
Prepaid/DHMO Plan	
Cigna Dental	Emergency Only
PPO Plan	
Delta Dental PPO plus Premier	Coverage is available under non-participant provider benefits
VISION CARE	
Avesis	Covered as out-of-Network and will be reimbursed based on the Avesis reimbursement schedule

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

Flexible Spending Accounts

COBRA enrollees have the option to continue their enrollment in Health Care and/or Dependent Care (child care) Flexible Spending Accounts (FSAs) administered by ASI. 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.

End of Employment with the State of Arizona

Your State of Arizona 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.

Continuing Your FSA(s) on Your Own

To continue your FSA(s), contact at asiflex.com or 800-659-3035.

Limited Purpose Flexible Spending Account

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

Members including dependents enrolled in an 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 ASI website at asiflex.com or sign into your online account and update your personal settings.
- Unclaimed funds are forfeited in accordance with the IRS regulations.

Purpose

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

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

Submitting Claims

You will need to fill out your claim form and attach copies of itemized invoices or your insurance plan explanation of benefits for services you received. You may file claims as soon as you incur charges and services have been provided. To submit a claim, you can:

- File a claim using the ASIFlex mobile app on your smart phone or tablet. Just snap a picture of your documentation and submit through the app!

- Submit your claims online at asiflex.com. You need your ASI-assigned PIN, along with your State of Arizona employee Identification number (EIN), if you have not previously set up a user name and password. Just san your documentation and submit through your online account.
- Fax your claim and documentation, toll-free to ASI at 1.877.879.9038.
- Mail the claim form and documentation to the location indicated on the claim form.

Reimbursement

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

To sign up for direct deposit, just sign into your account at ASIFlex.com and update your personal settings! We encourage you to also sign up for secure, electronic communication.

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

You have from January 1, 2019 through December 31, 2019 to use account funds. All the claims for health care and dependent care expenditures must be filed with ASI prior to March 31, 2020 for reimbursement.

ASIFlex Card

Health care FSA participants have the option of using an ASIFlex Card debit card. 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 ASIFlex 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 VISA®.

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 report the transaction to ASIFlex.

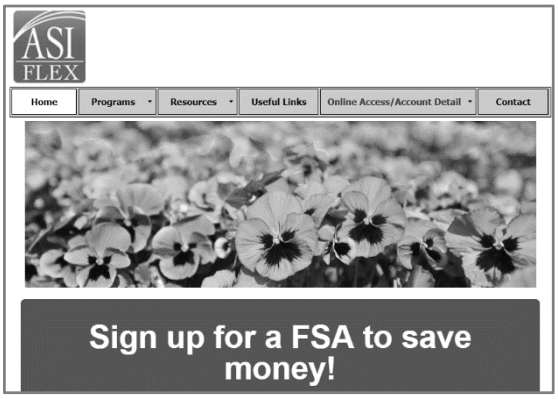
Use of the debit card is not paperless, and documentation is required in many cases. ASIFlex will notify you if documentation is required. Only provide documentation to ASIFlex upon request.

You may apply for an ASIFlex Card with by filling out the application form and submitting it to ASIFlex. Just sign into your account and click on the card image to locate the application.

Flexible Spending Account Web Resources

ASIFlex
Web Resources

Members: asiflex.com



ASIFlex'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:

- ❑ *Online Access/Account Detail*
  - Register to 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.

- ❑ *Program Descriptions*
  - Health Care FSAs
  - Dependent Care FSAs
  - ASFlex Debit Card
    - How to use the card
    - Things to Know when using the card
    - Documentation requirements to substantiate card transactions
    - Quick Guide
    - Wallet Card (print and carry with you)
    - IRS regulations governing use of the card

- ❑ *Link to ASIFlex Mobile App*
  - Download the app
  - Check your account balance from your smart phone or tablet
  - Submit claims on-the-go
  - Snap a picture of your documentation and submit

- ❑ *Resources*
  - Claim and other administrative forms
  - Frequently asked questions
  - Expense estimator and tax-savings calculator
  - Helpful Educational Videos
    - What is an FSA?
    - Filing an FSA Claim
    - Using the ASIFiex Mobile App
  - Extensive listing of eligible/ineligible expenses
  - Link to FSA Store with thousands of eligible over-the-counter health care products

- ❑ *Useful Links*
  - IRS Forms and Publications
  - Over-the-counter drugs & medicines explained
  - ASI Flex Privacy Notice

Flexible Spending Account Comparison Chart

	HEALTH CARE	DEPENDENT CARE	LIMITED HEALTH CARE
Maximum Contributions	$2,650 annually	$5,000 annually ($2,500 if married and filing separate tax returns)	$2,650 annually
Minimum Contributions	$130 annually	$260 annually	$60 annually
Use of the Account	• To pay (with pre-tax money) for health-related expenses that are not covered or only partially covered, including expenses for your spouse or children not enrolled in your medical, dental, or vision plans	• To pay expenses for care of dependent provided by a non-dependent • To pay care provided for your children under the age of 13 for whom you have custody, for a spouse who is disabled or other dependents who spend at least eight hours a day in your home • To pay dependent care provided so that you can work	• 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 to pay for dental and/or vision expenses
Samples of Eligible Expenses	• Copays • Deductibles • Coinsurance • Dental fees • Eyeglasses, exam fees, contact lenses and solution, LASIK surgery • Orthodontia	• Services provided by a day care facility. Must be licensed if the facility cares for six or more children • Babysitting services while you work • Day Camp	• Dental deductibles • Dental coinsurance • Dental fees • Eyeglasses, exam fees, contact lenses and solution, LASIK surgery • Orthodontia
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	• Private school tuition including kindergarten • Overnight camp expense • Babysitting when you are not working • Transportation and other separately billed charges • Residential nursing home care	• 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

	HEALTH CARE	DEPENDENT CARE	LIMITED HEALTH CARE
Restrictions/Other Information	• See IRS Publication 502 (expenses in this plan qualify based on when the services are provided regardless of when you pay for the expense) or go to ASI's website at asiflex.com for specific details on what expenses are allowed • You cannot transfer money from one account to the other • Your election amount may be increased (but not decreased) if you have a qualified life event • Your election may be changed by ADOA because of non-discrimination testing requirements	• See IRS Publication 503 (expenses in this plan qualify based on when the services are provided regardless of when you pay for the expense) or go to ASI's website at asiflex.com for specific details on what expenses are allowed • You may not use the account to pay your spouse, your child who is under 19 or a person whom you could claim as a dependent for tax purposes • You cannot change your election unless you have a qualified life event • Your election may be changed by ADOA because of non-discrimination testing requirements	• See IRS Publication 969 (expenses in this plan qualify based on when the services are provided regardless of when you pay for the expense) or go to ASI's website at asiflex.com for specific details on what expenses are allowed • You cannot transfer money from one account to the other • Your election amount may be increased (but not decreased) if you have a qualifying life event

Life Insurance

Portability and Conversion

You and/or your dependents may have the option to port or convert your life insurance coverage after you leave the State. For details, contact The Hartford at thehartford.com/arizona or call 1.866.712.3443.

Legal Notices

Health Insurance Marketplace Coverage Options

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 Market place 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 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 employer information chart.

The marketplace can help you evaluate your coverage options, including your eligibility for coverage through the marketplace and its cost. Visit www.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 260
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?	Benefit Services Division
12. E-mail Address	BenefitsIssues@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 EPO, PPO and HSA plan descriptions (Article 3 Eligibility and Participation) posted on the Benefit Options website www.benefitoptions.az.gov
- 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, www.HealthCare.gov will guide you through the process. The employer information you can enter when you visit www.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' and Mothers' Protection Act of 1996 Notice

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 BenefitIssues@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 Benefit Services Division
100 N. 15th Avenue, Suite 260
Phoenix, AZ 85007
602-542-5008 or 1-800-304-3687
BenefitIssues@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 https://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 or 1-800-304-3687.

DÍÍ BAA'ÁKONÍNÍZIN: Diné (Navaj 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.

Patient Protection & Affordable Care Act (PPACA) Notices

Notice of Rescission
Under the PPACA, 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 advanced 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 www.benefitoptions.az.gov. 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 www.benefitoptions.az.gov. Questions can also be sent to ADOA Benefit Services Division via email at BenefitsIssues@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 www.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 www.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.

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.

Glossary

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

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

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

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

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

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

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

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

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

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

Deductible
Fixed dollar amount a member pays before the health plan begins paying for covered medical services. Copays and/or coinsurance amounts may or may not apply (see comparison charts: Medical page 19, Dental page 35, and FSA page 49).

Dependent
An individual other than a health plan subscriber who is eligible to receive healthcare services under the subscriber's contract. Refer to page 6 for eligibility requirements.

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

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

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

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

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

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

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

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

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

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

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

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

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

Member
A person who is enrolled in the health plan.

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

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

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

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

PPO (Preferred Provider Organization)
A type of health plan that allows members to use out-of-Network providers but gives financial incentives if members use in-Network providers.
Pre-Certification/Prior Authorization
The prospective determination performed by the Medical Vendor to determine the medical necessity and appropriateness of a proposed treatment, including level of care and treatment setting.

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

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

Contacts for 2019 Benefits

Plan Type	Vendor Name	Phone	Website | Email | Policy Information
Benefit Options	ADOA Benefit Services Division 100 N. 15th Ave., Ste. 260 Phoenix, AZ 85007	602-542-5008 800-304-3687	benefitoptions.az.gov benefitsissues@azdoa.gov
Dental Plans	Cigna	800-968-7366	cigna.com/stateofaz | Group: 2500541
	Delta Dental of Arizona	602-588-3620 866-978-2839	deltadentalaz.com Group: 77777-0000
Life Insurance Portability and Conversion	Broadspire Services, Inc. *(ASRS participants)*	877-232-0596	azasrs.gov/content/long-term-disability
	The Hartford *(PSPRS, EORP, CORP, & ORP participants)*	866-712-3443	groupbenefits.thehartford.com/Arizona Group: 395211
Medical Plans	Aetna	866-217-1953	aetnastateofaz.com aetna.com | Group: 476687
	Blue Cross Blue Shield of AZ	866-287-1980	azblue.com | Group: 30855
	Cigna	800-968-7366	cigna.com/stateofaz | Group: 3331993
	UnitedHealthcare	800-896-1067	welcometouhc.com/stateofaz Group: 705963
Pharmacy Plan	MedImpact	888-648-6769	benefitoptions.az.gov Rx BIN: 003585 | Rx PCN: 28914
Vision Plan	Avesis, Inc.	888-759-9772	avesis.com | Policy: 11001-2178