

Arizona Department of Administration
Benefit Services Division

State of Arizona Employees
Open Enrollment 2009-2010

2009-2010 Benefit Guide active state employees

IN THIS GUIDE

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- BENEFIT CHANGES
- BENEFIT ELIGIBILITY
- MEDICAL & PRESCRIPTION BENEFITS
- DENTAL & VISION BENEFITS
- WELLNESS PROGRAM
- QUESTIONS & ANSWERS
- AND MORE!



Benefit Options

Choice. Value. Health.

CONTACT INFORMATION

ADOA Contacts

Benefit Services Division
100 N. 15th Ave #103
Phoenix, AZ 85007
602.542.5008 or 1.800.304.3687
www.benefitoptions.az.gov
bencissucs@azdoa.gov

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

Employee Assistance Program
602.771.9355
www.benefitoptions.az.gov/wellness/eap.asp

Medical Plans

Aetna
1.866.217.1953
www.aetna.com
Policy Number 476687

Blue Cross Blue Shield
of Arizona administered by
AmeriBen
1.866.955.1551
<https://services.ameriben.com>
Policy Number 1009013

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

UnitedHealthcare
1.800.896.1067
www.myuhc.com
Policy Number 705963

Pharmacy Plan

MedImpact
1.888.648.6769
www.benefitoptions.az.gov
ADOAcustomerservice@medimpact.com

Vision Plan

Avesis, Inc.
1.888.759.9772
www.avesis.com
Policy Number 10790-1040
Discount Policy # 9000

Dental Plans

Delta Dental
602.588.3620
1.866.9STATE9
www.deltadentalaz.com
Policy Number 7777-0000

Total Dental Administrators
Health Plans, Inc. (TDAHP)
602.381.4280
1.866.921.7687
www.totaldentaladmin.com
Policy Number 680100

Flexible Spending Accounts

ASI Member Services
1.800.659.3035
www.asiflex.com
asi@asiflex.com

Life & Short-Term Disability Plans

The Hartford
1.866.712.3443
<http://groupbenefits.thehartford.com/arizona/>
Policy Number 395211

Long-Term Disability Plans

Sedgwick CMS
(ASRS participants)
1.800.495.9301
www.sedgwickcms.com/calabasas

(continued on next column)

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

Travel Assistance

Europ Assistance Services USA
1.800.243.6108
<http://groupbenefits.thehartford.com/arizona/>
Policy Number 395211

For University Employees

UNUM - Short-Term Disability
1.800.799.4455
www.unum.com

Aetna Life Insurance
1.800.523.5065
www.aetna.com

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

Arizona State University
Tempe and Polytechnic
campus employees
480.965.2701
www.asu.edu/hr/benefits/
OpenEnrollment@asu.edu

West and Downtown campus
employees
602.543.8400
www.asu.edu/hr/benefits/
OpenEnrollment@asu.edu

Northern Arizona University
Human Resources
928.523.2223
www.hr.nau.edu/
hr.contact@nau.edu

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Introduction

Welcome to the 2009-2010 Benefit Guide. This guide has been designed with you, the employee, in mind. It has been reformatted and enhanced to make it more user-friendly. As you review this year's guide, you may notice some of the enhancements: the left margin notes with helpful tips and quick page references, more educational content, and an easy-to-read layout. A lot has changed this year for both the guide and for benefits, so we encourage you to review each section before making your benefit elections. Within the guide pages you will find an overview of the State of Arizona's comprehensive employee benefits package and the information necessary to make the best benefit elections for you. To maximize your benefits, it is important to review and understand the coverage and plan options available. Use the comparison charts to help make an informed decision.

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

Dates & Events

Learn More.
Ask Questions.

Attend a Benefit Expo

Would you like to know more about your 2009-2010 benefits? The Benefit Services Division will be on location to answer your questions. Speak with the benefit plan vendors face-to-face at a Benefit Expo near you. The calendar below shows the dates and times for the Benefit Expos and health screenings. The screenings will include a full lipid panel, blood glucose and more.

August-September 2009				
Monday	Tuesday	Wednesday	Thursday	Friday
17	18	19	20	21
			Open Enrollment Begins	
24	25	26	27	28
Flagstaff Benefit Expo 10am-2pm Screening 10am-12pm	Phoenix Benefit Expo 10am-2pm Screening 10am-2pm	Phoenix Benefit Expo 10am-2pm Screening 10am-12pm	Tucson Benefit Expo 11am-2pm Screening 11am-2pm	Tempe Benefit Expo 10am-2pm
31	01	02	03	04
Phoenix Benefit Expo 10am-2pm				Open Enrollment Ends

Benefit Expo Locations

- Phoenix: ADOA Lobby, 100 N. 15th Ave., Phoenix, AZ 85007
- Flagstaff: Radisson Woodlands Hotel, 1175 W. Route 66, Flagstaff, AZ 86001
- Tempe: Four Points Sheraton, 1333 S. Rural Rd., Tempe, AZ 85281
- Tucson: Marriott University Park Hotel, 880 E. 2nd St., Tucson, AZ 85719

OPEN ENROLLMENT



IMPORTANT

The 2009-2010 mandatory Open Enrollment will begin Thursday August 20th and close Friday September 4th

REMEMBER

All Benefit Expos are open to employees & their families. Select the most convenient location and stop by. Booths will be set up in a meet and greet format, so you may come and go as you please

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Open Enrollment will begin Thursday, August 20th at 8 a.m. and end Friday, September 4th at 5 p.m. (Arizona time). **The 2009-2010 Open Enrollment will be mandatory, meaning employees must take action.** Changes made during Open Enrollment will be effective for the plan year running October 1, 2009 through September 30, 2010.

Benefit Expos

Open Enrollment Benefit Expos will be held to allow employees an opportunity to meet with the medical, pharmacy, dental, vision, STD, LTD, life, and flexible spending account vendors and representatives from ADOA. Booths will be set up to allow you to learn about your benefit options, ask questions, and choose the best plan for you.

Information for Open Enrollment

Your 2009-2010 Open Enrollment benefit elections will be made online using the YES website. Instructions are on pages 9 - 10 of this guide entitled "Where to Enroll."

You will need the following information:

- Your State or University issued Employee Identification Number (EIN). You can contact your agency human resource office to obtain your EIN.
- Dependents' names, dates of birth and Social Security Numbers. You will need this information to add eligible dependents to your benefits coverage. Other documentation may also be necessary in certain circumstances. Please refer to the Eligibility section of this guide on pages 7 - 8 for more information.
- Beneficiary information. The name, address, and phone number of your desired beneficiary are helpful, if you wish to make changes.

Once you have submitted your benefit elections and the Open Enrollment period ends, you will not be able to change your benefits. Changes are only permitted with a Qualified Life Event (QLE) such as a marriage, divorce, birth, death, or change in employment status for you or your spouse. QLEs are outlined in more detail at benefitoptions.az.gov.

Special Notice

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



Questions

For answers to your Open Enrollment questions, you may contact the ADOA Benefit Services Division by calling 602.542.5008 or toll-free 1.800.304.3687 between 8 a.m. and 5 p.m. Monday through Friday (Arizona time). You can also email your questions to beneissues@azdoa.gov.

BENEFIT CHANGES FOR PLAN YEAR 2009-2010



IMPORTANT
State employees and their dependents are not eligible to participate in the Children's Health Insurance Program. Based on your family income, you may be eligible for other Medicaid programs. For more information, please visit the Arizona Health Care Cost Containment System website azahcccs.gov

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Vendors

New Pharmacy Benefit Vendor

The State of Arizona has contracted with a new pharmacy benefit management vendor called MedImpact. Some notable differences include: a modified formulary, new requirements for prior authorization and limited coverage of specific medications. MedImpact uses the Walgreens Health Initiative (WHI) system for both mail-order and specialty drug purchases. Therefore, those members who use these services will experience no disruption.

Medical Networks

The State has selected three new health plans to offer services for the Plan Year 2009-2010. We will now offer four networks: Aetna, Blue Cross Blue Shield of Arizona administered by AmeriBen, CIGNA, and UnitedHealthcare. In addition, the State will offer a new type of plan this year. The new Health Savings Account (HSA) Option will be offered alongside the familiar EPO and PPO plans.

New STD, LTD, and Life Insurance Vendor

The Hartford has been selected as the new contractor to provide Short-Term Disability, Long-Term Disability, and Life insurance to eligible State of Arizona employees. The Hartford contract will be replacing the services previously provided by The Standard. More information about this change can be found on pages 43 through 46 of this guide.

Statewide & National Coverage

With the new health plan networks, statewide & national coverage is available. No longer are some plans 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 contracting with one of the new networks.

Tier Structure

Four Tiers

A fourth premium tier option has been added to the previous three. The "Employee +1" tier will now be divided into "Employee +adult" and "Employee +child" tiers. This change will more accurately reflect the cost of dependents.

Legislation

Autism Coverage

A new state law prohibits some group health plans from denying coverage, imposing dollar limits, or charging higher deductibles/copays based solely on the diagnosis of autism spectrum disorder. It also requires plans to cover the cost of behavior therapy up to \$50,000 per year for a child up to age 9 and \$25,000 per year for a child age 9-16. The ADOA plan will be adjusted to comply with the state regulation.

HEART Act

In accordance with the Heroes Earnings Assistance and Relief Tax Act of 2008 (the "HEART Act"), qualified military reservists who participate in a flexible spending account (FSA) program may withdraw FSA funds (and avoid the use-it-or-lose-it rules) when they are called to active duty for 180 days or more or for an indefinite period. The withdrawal must be made during a period beginning on the day the reservist is called to active duty and ending on the last day of the coverage period of the FSA plan that occurs during the period of active duty. If you have an FSA and are called to active duty during plan year 2009-2010, please contact the ADOA Benefits Services Division to learn about your FSA withdrawal options.

BENEFIT CHANGES

Continued



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For a complete
version of the
COBRA notice

TURN to...
page 23 &
24

For the
Medical Plan
Comparison
Chart with
more copay
information

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Legislation - Continued

Michelle's Law

A new federal law allows continued coverage for seriously ill college students. A college student will be able to maintain health plan eligibility for up to one year after full-time student status is lost due to a medically necessary leave of absence from school. "Michelle's Law" was named after New Hampshire college student Michelle Morse, who, despite being diagnosed with cancer, attended school full-time to stay enrolled in her parents' health insurance.

COBRA Premium Assistance

Under a new federal law, a person involuntarily terminated between September 1, 2008 and December 31, 2009 may be eligible for COBRA premium assistance. Under this program, the individual pays 35% of the COBRA premium and the federal government subsidizes the remaining 65%. Please see the Benefit Options website:

benefitoptions.az.gov/cobra.asp if you are involuntarily terminated before December 31, 2009.

Genetic Information Nondiscrimination Act (GINA)

Under a new federal law, group health plans are prohibited from adjusting premiums or contribution amounts for a group on the basis of genetic information. A health plan is also prohibited from requiring an individual or his/her family member to undergo a genetic test, although the plan may request that a voluntary test be taken for research purposes.

Cost Sharing Changes

Rate Increase

Each year ADOA projects receipts and expenses for the next plan year. When the projected expenses are greater than the projected receipts, a rate increase is often necessary. Due to the State's ongoing budget challenges, employees will assume a significant percentage of that increase in the coming plan year. Employees enrolling in the PPO "Employee only" tier will be impacted the least (6% increase) while employees enrolling in the EPO "Employee+adult" tier will be impacted the most (62% increase).

PPO Changes

PPO members will experience higher costs in plan year 2009-2010 for in-network and out-of-network services. The deductible and out-of-pocket maximums have increased. There is now an in-network deductible. PPO members will also be required to pay 50% coinsurance after the deductible for out-of-network services.

Primary Care and Specialist Copay

The copays for Primary Care Physicians and Specialists will be increasing this plan year from \$10/\$20 to \$15/\$30. OB/GYN copays will remain at \$10.

Urgent Care Copay

The copay for urgent care visits will increase this plan year from \$20 to \$40.

Hospital Admission Copay

A \$150 copay for hospital admission will be implemented this plan year.

Dental State Contribution

The employer contribution is now the same for the prepaid/DHMO and the indemnity/PPO plan. The indemnity/PPO employee contribution has increased as a result.

BENEFIT CHANGES

Continued



IMPORTANT

Bariatric Surgery: Full criteria will be available in our plan description located on the website benefitoptions.az.gov

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Cost Sharing Changes - Continued

Outpatient Surgical Center Copay

A \$50 copay for non-diagnostic, outpatient surgery services will be implemented this year. The copay will be applicable to both EPO and in-network PPO plans.

Bariatric Surgery Coinsurance

Bariatric surgeries will be covered under the Health Plan in accordance with the Centers for Medicare and Medicaid Services (CMS) eligibility guidelines. Members will pay a 20% coinsurance on the surgery, but the hospital admission copay will be waived. The coinsurance will not apply toward the member's deductible or out-of-pocket maximum.

Maternity Copay

Members who are or become pregnant will have a \$250 per baby copay at the time of delivery. The copay will be reimbursed for members who enroll in and complete the "Healthy Pregnancy" program offered through the disease and case management vendors. Members must be enrolled by the 12th week of pregnancy to qualify for the reimbursement of copay. For members beyond the 12th week at the time the new plan year begins, please contact the Benefit Services Division by October 31, 2009.

Coverage Changes

Home Health Services

In-home services such as cardiac care, pain management, therapy, infusion, and wound care will be limited to 168 hours per plan year. These services were not previously limited.

Erectile Implants

The coverage for implants will be eliminated this plan year.

Cosmetic Surgery Complications

Medical costs associated with complications from an elective cosmetic surgery will no longer be covered under the Health Plan.

TMJ Surgery

The surgery to repair or correct TMJ will no longer be covered under the Health Plan. Members in need of the surgery will have to pay out-of-pocket to cover the cost.

Infertility Services

Infertility counseling, diagnosis, and treatment previously covered at 50% up to \$1,000 per member or \$2,000 per family will no longer be covered. Medical services for infertility will be the responsibility of the member.

Surrogacy

Maternity benefits for surrogates will no longer be covered under the Health Plan.

Bariatric Surgery Criteria

The Health Plan criteria for bariatric surgery will be changed to meet CMS guidelines. Procedures will be covered only when a member is diagnosed with obesity (BMI 35+) and/or two or more of the following: hypertension, type 2 diabetes, coronary heart disease, stroke, gallbladder disease, osteoarthritis, sleep apnea, respiratory problems, and certain types of cancers. Additionally, procedures must only be performed at facilities certified as "Centers of Excellence" by the American College of Surgeons and the American Society for Bariatric Surgery.

BENEFIT CHANGES

Continued

Pharmacy Changes

Limited Prescription Drug Coverage

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

Name Brand Drug Coverage

Coverage of name brand drugs will be restricted this plan year. If a member requests the name brand drug instead of the generic alternative, regardless of whether the physician indicated “dispense as written” or “substitution permissible,” the member will be required to pay the copay plus the difference in cost between the name brand drug and the generic equivalent (if available). Brand name drugs for which there are no generic alternatives will be covered under the applicable copay tier.

Other Changes

Annual Health Assessment

The newest addition to Wellness is the Mayo Clinic Health Assessment, a professionally-developed questionnaire designed to help members (including spouses) become knowledgeable about their health. This year’s Annual Health Assessment will be available online August 20, 2009 through January 29, 2010. Members will have access to the Health Assessment through the Mayo Clinic EmbodyHealth Web Portal at bewellstaywell.az.gov. Upon completion of the Health Assessment, members may also be eligible for FREE one-on-one telephonic EmbodyHealth Coaching with a Mayo Clinic professional. Participants can choose from five EmbodyHealth modules: Healthy Weight, Exercise, Stress, Tobacco Cessation, and Nutrition.

Eligibility Audit

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

Subrogation

Subrogation is the right of an insurer to recover from a third party all amounts paid out on behalf of its insured.

In the event you, as a Benefit Options member, suffer an injury or illness for which another party may be responsible, such as someone injuring you in an accident, and Benefit Options pays benefits as a result of that injury or illness, Benefit Options will be subrogated and succeed to the right of recovery against the party responsible for your illness or injury to the extent of benefits we have paid.

As a Benefit Options member you are required to cooperate with ADOA in its subrogation process. Failure to do so may result in legal action by the State to recover funds awarded you in related settlement(s).



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For more
information on
the new
pharmacy plan
with MedImpact

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ELIGIBILITY



Eligible Employees

Active employees regularly scheduled to work 20 hours or more per week for six months or longer (except those listed below as ineligible) and their qualified dependents may participate in the Benefit Options Programs, provided they comply with the requirements of their selected plans.

Ineligible Employees

- A. Employees who work fewer than 20 hours per week
- B. Employees in seasonal, temporary or emergency positions
- C. Patients or inmates employed in State institutions
- D. Non-State employee officers and enlisted personnel of the National Guard of Arizona
- E. Employees in positions established for rehabilitation purposes
- F. Student and work study employees

Eligible Dependents

At Open Enrollment you may add the following dependents to your plans. Proper documentation may be required (see right).

- A. Your legal spouse
- B. Your domestic partner subject to the following qualifications:
 - a. Shares the employee's or retiree's permanent residence;
 - b. Has resided with the employee or retiree continuously for at least 12 consecutive months before filing an application for benefits and is expected to continue to reside with the employee or retiree indefinitely as evidenced by an affidavit filed at the time of enrollment;
 - c. Has not signed a declaration or affidavit of domestic partnership with any other person

- and has not had another domestic partner within the 12 months before filing an application for benefits;
- d. Does not have any other domestic partner or spouse of the same or opposite sex;
- e. Is not legally married to anyone or legally separated from anyone else;
- f. Is not a blood relative any closer than would prohibit marriage in Arizona;
- g. Was mentally competent to consent to the contract when the domestic partnership began;
- h. Is not acting under fraud or duress in accepting benefits;
- i. Is at least 18 years of age; and
- j. Is financially interdependent with the employee or retiree in at least three of the following ways:
 - i. Having joint mortgage; joint property tax identification, or joint tenancy on a residential lease;
 - ii. Holding one or more credit or bank accounts jointly, such as a checking account, in both names;
 - iii. Assuming joint liabilities;
 - iv. Having joint ownership of significant property, such as real estate, a vehicle, or a boat;
 - v. Naming the partner as beneficiary on the employee's life insurance, under the employee's will, or employee's retirement annuities and being named by the partner as beneficiary of the partner's life insurance, under the partner's will, or the partner's retirement annuities; and
 - vi. Each agreeing in writing to assume financial responsibility for the welfare of the other, such as durable power of attorney; or
 - vii. Other proof of financial interdependence as approved by the Director

CONTACT

For answers to eligibility questions call the ADOA Benefit Services Division at 602.542.5008 M-F 8:00am-5:00pm

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ELIGIBILITY

Continued



C. Your child defined as:

- a. Your or your domestic partner's natural, adopted and/or stepchild who is unmarried and under age 19, or under 25 if a full-time student at an accredited educational institution
- b. A person under the age of 19 for whom you or your domestic partner have court-ordered guardianship
- c. Your or your domestic partner's foster children under the age of 19
- d. A child placed in your home by court order pending adoption
- e. Your or your domestic partner's natural, adopted and/or stepchild who was disabled prior to age 19

D Older Child as qualified by:

- a. A dependent younger than 25, and
- b. A dependent who is unmarried and
- c. A dependent who was covered by a health insurance plan made available by the state during the year that the individual was 18, and
- d. A dependent that resides in Arizona, if the individual is:
 - i. A natural child, adopted child, or step child of an employee, officer, retiree, or former elected official; or
 - ii. A natural child, adopted child, or step child of a domestic partner; or
 - iii. A child for whom an employee, officer, retiree, or former elected official received a courtordered guardianship when the child was 18 years old or younger.

Dependent Documentation Requirements

- A. If your dependent child is approaching age 19 and is disabled, application for continuation of dependent status must be made within 31 days of the child's 19th birthday.

You will need to provide verification that your dependent child has a qualifying permanent disability, that occurred prior to his or her 19th birthday, in accordance with Social Security Administration guide lines.

- B. If you are enrolling a dependent whose last name is different from your own, the dependent's coverage will not be processed until supporting documentation such as a marriage license for a spouse or a birth certificate or court order for a dependent, is provided to the ADOA Benefits Office. If your dependent is a full-time student over the age of 18, ADOA and/or your insurance carrier will request a copy of the dependent's class schedule.

Qualified Medical Child Support Order (QMCSO)

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

If You and Your Spouse are Both State Employees

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

WHERE TO ENROLL - STATE



PASSWORD

If you have forgotten your password, you may reset it through the YES homepage at: yes.az.gov

CONTACT

For issues or questions with the YES system contact the HRIS Help Desk at 602.542.4700 or email hrishelpdesk@azdoa.gov

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During the 2009-2010 Open Enrollment, August 20th through September 4th, benefit elections are mandatory and must be made using the YES system online at yes.az.gov. For employees unfamiliar with the YES website function, some basic instructions are listed below.

YES Login

1. Open the YES website at yes.az.gov
2. Click **Login** located at the bottom of the YES homepage
3. In the new Login window, enter your **Username** and **Password** and then click the Login tab
4. Once you are logged into YES, click the **Open Enrollment** link on the left navigational bar
5. Follow the instructions to begin your benefit elections

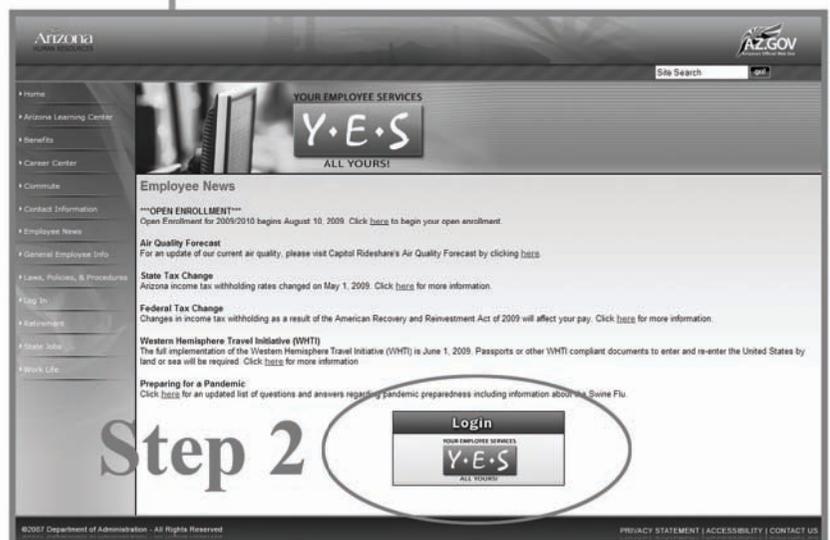
First Time YES Users

1. Open the YES website at yes.az.gov
2. Click **Login** located at the bottom of the YES homepage
3. a. In the new Login window, Enter your Employee Identification Number (EIN) as your **Username** which is the 5 or 6 digit number given to you by your Human Resource Office

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

4. Once you are logged into YES, click the **Open Enrollment** link on the left navigational bar

5. Follow the instructions to begin your benefit elections



WHERE TO ENROLL - UNIVERSITIES



ASU Employees - Check the Human Resources Benefits website at: www.asu.edu/hr/benefits for a direct link to the Open Enrollment site.

Step 1: Review benefit options, rates, and required information for enrollment found on the Human Resources Benefits website: <http://www.asu.edu/hr/benefits/openenrollment.html>.

Step 2: Go to <http://my.asu.edu/> and log into MyASU using your asurite and password.

Step 3: Click on the Benefits tab under My Compensation.

Step 4: Click on the Benefit Enrollment link.

Step 5: Under the Benefit Enrollment page, click the Select button for your Open Enrollment benefit event. **IMPORTANT:** If you do not see an open event, please contact the HR Employee Service Center at 480.965.2701.

Step 6: Follow the instructions provided as you progress through the online open enrollment pages.



NAU Employees - Go to www.peoplesoft.nau.edu and log into LOUIE. Under “Benefits Info,” click on View your Benefits Summary.

Step 1. Go to <https://peoplesoft.nau.edu>

Step 2. Log into the LOUIE using your ID and password.

Step 3. Under the “Benefits Info” heading, click on the Enroll in Benefit Plans link.

Step 4. On the Benefits Enrollment page there will be an Open Enrollment event listed. The event status **MUST** be “open” to make elections. If the event is not listed or the event listed is not “open” please contact the Human Resources Department at 928.523.2223 or send an email to Hr.Contact@nau.edu. The Human Resources website can be found at www.hr.nau.edu/m/.



UA Employees - University of Arizona employees will login to Employee Link which is accessible from the HR website at: www.hr.arizona.edu

Step 1. Log in to Employee Link with your UA NetID and password

Step 2. Select “Open Enrollment” from the menu on the left

Step 3. Enter, confirm and save your elections

If you do not know your UA NetID, please see your payroll representative for assistance.

SUMMARY OF MONTHLY INSURANCE PREMIUMS 2009-2010

Monthly Medical Premium

Plan	Tier	Employee Premium	State Premium	Total Premium	Agency HSA Contribution
EPO (Aetna, BCBS of AZ*, CIGNA, UnitedHealthcare)	Emp only	\$39	\$484	\$523	-
	Emp+adult	\$97	\$1,013	\$1,110	-
	Emp+child	\$79	\$967	\$1,046	-
	Family	\$178	\$1,264	\$1,442	-
PPO (Aetna, BCBS of AZ*, UnitedHealthcare)	Emp only	\$154	\$641	\$795	-
	Emp+adult	\$328	\$1,318	\$1,646	-
	Emp+child	\$309	\$1,268	\$1,577	-
	Family	\$443	\$1,699	\$2,142	-
HSA (Aetna)	Emp only	\$25	\$444	\$469	\$42
	Emp+adult	\$80	\$906	\$986	\$83
	Emp+child	\$59	\$879	\$938	\$83
	Family	\$150	\$1,143	\$1,293	\$83

Monthly Dental Premium

Plan	Tier	Employee Premium	State Premium	Total Premium
DHMO (Total Dental Administrators)	Emp only	\$5.00	\$4.96	\$9.96
	Emp+1	\$9.00	\$9.92	\$18.92
	Family	\$14.00	\$13.70	\$27.70
PPO (Delta Dental)	Emp only	\$29.86	\$4.96	\$34.82
	Emp+1	\$67.93	\$9.92	\$77.85
	Family	\$118.12	\$13.70	\$131.82

Monthly Vision Premium

Plan	Tier	Employee Premium
Insured plan (Avesis)	Emp only	\$4.83
	Emp+1	\$13.52
	Family	\$16.86
Discount card (Avesis)	Emp	\$0.00

Medical plan coverage is nationwide

*Blue Cross Blue Shield of Arizona administered by AmeriBen.

SUMMARY OF MONTHLY INSURANCE PREMIUMS

2009-2010 Continued

Supplemental Life and AD&D Plan

Your Age	Cost per \$5,000/mo.
29 AND UNDER	\$0.50
30-34	\$0.60
35-39	\$0.70
40-44	\$1.20
45-49	\$1.60
50-54	\$2.60
55-59	\$3.70
60-64	\$6.70
65-69	\$6.70
70+	\$10.60

Dependent Life and AD&D Plan

Coverage Amount	Cost/mo.
\$2,000	\$0.94
\$4,000	\$1.88
\$6,000	\$2.82
\$12,000	\$5.64
\$15,000	\$7.05
\$50,000*	\$24.25

Short-Term Disability Plan

Employee Cost
\$0.70 per \$100 of your earned monthly wages
Monthly premium = (Earned monthly wages/100) x \$0.70
Example: Earned monthly wages = \$1,000;
Monthly premium = (\$1,000/100) x \$0.70 = \$7

*Only available if employee also carries \$35,000 in additional supplemental life.

MEDICAL PLAN INFORMATION



TURN to...
page 14

For information
on Transition of
Care

TURN to...
pages 9

For the YES
instruction page
when you are
ready to enroll
for your benefits.

Benefit Options
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In order to have medical coverage effective October 1, 2009, you must choose one of the new medical networks: Aetna, CIGNA, Blue Cross Blue Shield of Arizona administered by AmeriBen or UnitedHealthcare. Each of these new networks provides nationwide access to providers.

Understanding Your Options

For the plan year beginning October 1, 2009 employees will choose from three plans, four networks, and four coverage tiers. The word network describes the company contracted with the State to provide access to a group of physicians, hospitals, etc. Certain physicians 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.

	Aetna	BCBS of AZ*	CIGNA	UnitedHealthcare
EPO	X	X	X	X
PPO	X	X		X
HSA Option	X			

*Blue Cross Blue Shield of Arizona administered by AmeriBen.

Finally, you must choose the tier that meets your needs. A tier describes the number of persons covered by the medical plan. The State has expanded the number of tiers available and now offers four levels: Employee, Employee +Adult, Employee +Child, and Family.

How the Plans Work

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

The EPO

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 administered by AmeriBen, CIGNA, and UnitedHealthcare.

The PPO

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 in-network and out-of-network services. Additionally, there is a in-network and out-of-network deductible that must be met. Under the PPO plan, you will pay the monthly premium and any required copay or coinsurance (percent of the cost) at the time of

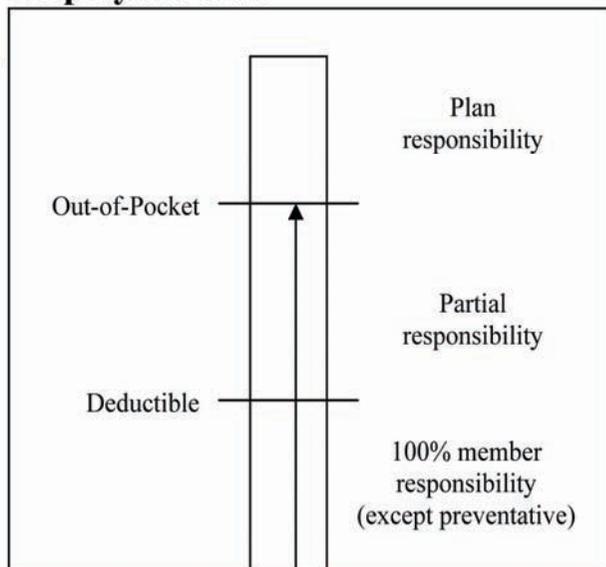
service. The PPO plan is available with Aetna, Blue Cross Blue Shield of Arizona administered by AmeriBen, and UnitedHealthcare.

The HSA Option

The Benefit Options HSA Option is a new offering and unfamiliar to State of Arizona employees. Enrolling in the HSA Option makes you eligible to open a Health Savings Account (HSA) which is a special type of account that allows tax-free contributions, earnings, and healthcare-related withdrawals. If you choose the HSA Option you can use in-network and out-of-network providers. The members must reach a deductible before the insurance “kicks in.” The premiums for the HSA Option are lower, preventative services are free, and members pay coinsurance rather than copays. The chart on the following page may help you understand the costs associated with the HSA Option. More detailed information on the HSA Option is available on pages 15-21.

MEDICAL PLAN Continued

Employee's Cost



Choosing the Best Plan for You and Your Family

To choose the right plan for you:

1. Assess the costs you expect in the coming year including: monthly premiums, copays, and coinsurance. Refer to pages 11 and 12 for monthly premiums and on page 23 and 24 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 (listed to the right) to help you determine if your doctor is contracted.
3. Once you have selected which plan best suits your needs and your budget, you must make your benefit elections online at yes.az.gov.

Transition of Care (TOC)

If you are undergoing an active course of treatment with a provider who is not contracted with one of the new networks, you

can apply for transition of care. If you are approved, you will receive in-network benefits for your current provider during a transitional period after October 1, 2009. Transition of care is typically approved if one of the following applies:

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

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

Effective Dates and ID Cards

Changes made during Open Enrollment 2009-2010 will become effective October 1, 2009. Your personal insurance cards typically arrive 7-14 business days after your benefits become effective.

Contacts

Aetna: 1.866.217.1953, aetna.com

AmeriBen: 1.866.955.1551,
<https://services.ameriben.com>

CIGNA: 1.800.968.7366,
cigna.com/stateofaz

UnitedHealthcare: 1.800.896.1067
myuhc.com



MEDICAL PLAN Continued



TURN to...
page 69

To reference the
definitions for
copay and
coinsurance

Benefit Options
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Understanding the Health Savings Account (HSA) Option

In addition to the familiar EPO and PPO plans, Benefit Options is offering its members a third choice: the Health Savings Account (HSA) Option. Please read this section carefully as it describes the HSA Option and provides information about how the plan could impact you and your family should you choose to enroll.

Things You Should Know About the HSA Option

1. The HSA Option should not be confused with the Health Savings Account:
 - The HSA Option is a health plan. As a Benefit Options member you can choose to enroll in the EPO, the PPO, or the HSA Option.
 - HSA stands for Health Savings Account. It is a special type of savings account that allows tax-free contributions, earnings, and healthcare-related withdrawals.
 - Enrolling in the HSA Option automatically enrolls you in a Health Savings Account. EPO and PPO members are not eligible.
2. The HSA Option is different from the EPO in that:
 - An HSA Option member pays lower monthly premiums (paycheck deductions).
 - An HSA Option member can use out-of-network providers (although it is more expensive than using in-network providers).
 - An HSA Option member's flexible spending account is limited to dental and vision only.
 - In the HSA Option, preventative services are free.

- An HSA Option member must pay a high deductible before the insurance "kicks in" (preventative services are available before satisfying the deductible).
 - An HSA Option member will often pay "coinsurance" instead of "copays"
 - An HSA Option member is eligible to open and contribute to a Health Savings Account (HSA)
3. The HSA Option is similar to the EPO in that:
 - An HSA Option member does not need a referral to see a specialist.
 - An HSA Option member is eligible for disease management if he/she has a chronic condition.
 - An HSA Option member may participate in no- or low-cost wellness events (on-site mammography, mini health screenings, flu shots, classes, etc.).
 4. The HSA Option offers financial advantages in that:
 - An HSA Option member pays lower monthly premiums (paycheck deductions).
 - In the HSA Option, preventative services are free.
 - An HSA Option member may have lower out-of-pocket costs.
 - An HSA Option member is eligible to open and contribute to a Health Savings Account (HSA).

Note: Members enrolled in a Health Savings Account (HSA) do not qualify for the full Medical Flexible Spending Account. Instead they qualify for a Limited Flexible Spending Account. The only expenses qualifying for this Limited Flexible Spending Account are dental and vision care expenses. Please see page 51 for more details.

MEDICAL PLAN Continued

Things You Should Know About the Health Savings Account (HSA) Option - Continued

5. The HSA Option presents financial disadvantages in that:
 - An HSA Option member must pay a high deductible before the insurance “kicks in” (preventative services are available before satisfying the deductible).
 - An HSA Option member may have higher out-of-pocket costs.
 - An HSA Option member’s out-of-pocket healthcare costs are less predictable than an EPO member’s.
6. The HSA Option 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 (and your family members, if applicable) are generally healthy; you believe your healthcare costs between Oct. 1, 2009 and Sep. 30, 2010 will be low.
 - You can afford to pay a high deductible if necessary.
7. The HSA Option may be wrong for you if:
 - You like copays because they are simple and predictable.
 - You don’t like financial risk.
 - You believe your healthcare costs between Oct. 1, 2009 and Sep. 30, 2010 will be high.
 - You cannot afford to pay a high deductible.

Making Sense of HSA Option Benefits

The HSA Option has a different structure than the EPO and PPO plans. This section is included to help you understand how much you will pay for services and prescriptions as an HSA Option member.

Annual Limits

Before discussing specific benefits, however, you’ll need to understand two important terms:

Deductible – fixed dollar amount a member pays before the health plan begins paying for medical covered services. Copayments and/or coinsurance amounts may or may not apply, see comparison charts on pages 23 and 24.

Out-of-pocket maximum – the amount the member will pay annually before the health plan pays 100% of the covered expenses. Out-of-pocket amounts do not carry over year to year, and maximums reset each year.

Only usual and customary charges apply to these limits. If you go to an out-of-network provider who charges more than usual and customary, the excess will not be applied towards your deductible and out-of-pocket maximum. Please refer to page 14 for a graphic that demonstrates the costs associated with the HSA Option.



IMPORTANT

You will not be eligible for the HSA Option if you:

- Are covered by other health insurance
- Can be or are claimed as a dependent by someone else

Benefit Options
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MEDICAL PLAN Continued

Making Sense of HSA Option Benefits - Continued

Cost for Services/Prescriptions

The cost for services/prescriptions depends on three things:

Whether the service/prescription is:

- Preventative
- Non-Preventative
- Emergency

Whether the provider is:

- In-Network
- Out-of-Network

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
- Out-of-pocket maximum

These three areas are shaded below.

At the top of the table you can see that:

- In-network preventative services are free, even before the deductible is satisfied
- In-network preventative prescriptions will cost the regular copay amounts (\$10/\$20/\$40) up to the out-of-pocket maximum.
- Once the out-of-pocket maximum is satisfied, in-network preventative prescriptions are free.

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 Option, make sure you fully understand the table below.

EMPLOYEE COST FOR CARE

		<i>Individual/family total out-of-pocket cost at time of expense →</i>	Less than deductible	More than deductible, less than out-of-pocket maximum	Out-of-pocket maximum
IN-NETWORK	Preventative	Services	\$0	\$0	\$0
		Prescriptions	\$10/\$20/\$40 copays	\$10/\$20/\$40 copays	
	Non-Preventative	Services	100% of contracted rate	10% of contracted rate	
		Prescriptions	100% of contracted rate	\$10/\$20/\$40 copays	
	Emergency	Services	100% of contracted rate	10% of contracted rate	
OUT-OF-NETWORK	Preventative	Services	50% of total cost	50% of total cost	\$0
	Non-Preventative	Services	100% of total cost	50% of total cost	
	Emergency	Services	100% of total cost	10% of total cost	



MEDICAL PLAN Continued

Making Sense of HSA Option Benefits - Continued

Preventative care

Preventative care is defined as:

- Periodic health evaluations, including tests and diagnostic procedures ordered in connection with routine examinations (i.e., annual physicals)
- Routine prenatal and well-child care
- Child and adult immunizations
- Tobacco cessation programs
- Obesity weight-loss programs
- Certain screening services
- Prescriptions that are preventative in nature

Understanding Health Savings Accounts (HSAs)

Benefit Options is now offering its members the opportunity to open a health savings account (HSA). Please read this section carefully as it describes how HSAs work and provides information about how an HSA could impact you and your family.

Things You Should Know About HSAs

1. HSAs should not be confused with the HSA Option:
 - HSA stands for Health Savings Account. It is a special type of savings account that allows tax-free contributions, earnings, and healthcare-related withdrawals.
 - The HSA Option is a health plan. As a Benefit Options member you can choose to enroll in the EPO, the PPO, or the HSA Option.

2. HSAs should not be confused with FSAs:
 - HSA stands for Health Savings Account. It is a special type of savings account that allows tax-free contributions, earnings, and healthcare-related withdrawals.
 - FSA stands for Flexible Spending Account. It is a special type of savings account that allows tax-free contributions and healthcare-related withdrawals.
 - HSAs have no “use-it-or-lose-it” rules. Unused funds will rollover from year to year.
 - FSAs have “use-it-or-lose-it” rules. Unused funds do not rollover from year to year.
3. In order to open or contribute to an HSA through Benefit Options, you must enroll in the HSA Option.
 - The HSA Option is an HSA-qualified plan; the EPO and PPO plans are not HSA-qualified.
 - You do not have to be enrolled in an HSA-qualified plan to spend your HSA funds.
4. If you enroll in the HSA Option and open an HSA, the State will make monthly contributions to your HSA.
 - For Employee HSA Option coverage, the State will contribute \$42 per month (\$504 per year) into your HSA.
 - For Employee+adult, Employee+child, and Family HSA Option coverage, the State will contribute \$83 per month (\$996 per year) into your HSA.
5. You can contribute to your HSA.
 - Payroll deductions (pre-tax).
 - Lump-sum deposits (tax deductible).
 - There are limits to how much you can contribute per year.



TURN to...
page 9

For the YES
instruction page
when you are
ready to enroll
for your benefits

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MEDICAL PLAN INFORMATION

MEDICAL PLAN Continued

Thing You Should Know About HSAs

6. You open your HSA (see right column) and you own the money in your HSA.
 - The State cannot restrict what you spend it on.
 - You maintain ownership even after ending State employment.
 - You can invest the money like you would invest money in an IRA.
 - Your funds will earn interest
7. You can spend HSA funds tax-free on qualified healthcare-related expenditures (defined by the Internal Revenue Service)
 - You can use a debit card or ATM.
 - Non-qualified withdrawals are allowed but are subject to tax and a 10% penalty.
 - Healthcare expenses for a domestic partner or older child are not considered qualified expenditures.
8. HSAs have no “use-it-or-lost-it” rules. Unused funds will rollover from year to year. This allows you to create a healthcare nest egg.
9. The HSA Option is designed to work in conjunction with the HSA.
 - An HSA option member will have to pay a deductible if he/she requires non-preventative services during the plan year.
 - The member can use his/her HSA to save for that deductible tax free.
 - If the member does require non-preventative services, he/she can withdraw HSA funds tax free to pay the deductible.
 - If the member does not require services (other than the free non-preventative services), the money stays in the HSA and grows tax free. It can be used to pay for qualified healthcare costs anytime in the future.

10. HSAs are complex financial instruments. You should fully educate yourself on the subject of HSAs before committing yourself to the HSA Option.

About the Aetna HealthFund HSA

The Aetna HealthFund HSA offers the following features:

- No set-up fees
- No monthly administration fee
- No withdrawal forms
- Debit card and/or checkbook
- HSA tracking through Aetna Navigator

There are some fees associated with the Aetna HealthFund HSA.

Opening Your HSA

A health savings account will automatically be established in your name when you enroll in the HSA Option. You will receive a welcome kit by mail 3-4 weeks after the end of open enrollment. The State will start contributing to your account after October 1, 2009. You should decide what amount, if any, you would like to contribute each pay period. There is no minimum required contribution.

Using Your HSA

- Use the Aetna HSA Visa® debit card to pay for qualified out-of-pocket expenses.
- Invest your HSA funds in a variety of investment options (JPMorgan mutual funds) once the funds reach \$2,000.
- You can contribute to the HSA as long as you are enrolled in a qualified health plan (such as the HSA Option). You may use the HSA funds anytime.



MEDICAL PLAN Continued

COMPARING THE EPO AND HSA OPTION PLANS

The table below shows how a fictional employee's costs would compare under the HSA Option and the EPO plan. While the employee ends up paying the same under both plans, costs for individual services/prescriptions vary widely.

SINGLE COVERAGE			HSA	EPO
	Actual cost	Preventative	Employee cost	Employee cost
Annual check-up	\$350	yes	\$0	\$15
Prescription (generic) (12 months)	\$324	yes	\$120	\$120
PCP visit	\$65	no	\$65	\$15
X-rays	\$75	no	\$75	\$0
Outpatient surgery	\$563	no	\$563	\$50
Prescription (preferred brand)	\$69	no	\$69	\$20
<i>Total cost-share amount</i>			\$892	\$220
State contributions to HSA			\$504	\$0
<i>Total cost-share amount after HSA funds are spent</i>			\$388	\$220
Premiums (paycheck deductions)			\$300	\$468
<i>Total cost to employee for premiums and cost-sharing</i>			\$688	\$688



MEDICAL PLAN Continued

Customer Identification Process

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

Here are some common reasons that may cause a delay:

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

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

HSA OPTION FINANCIAL CONSIDERATIONS

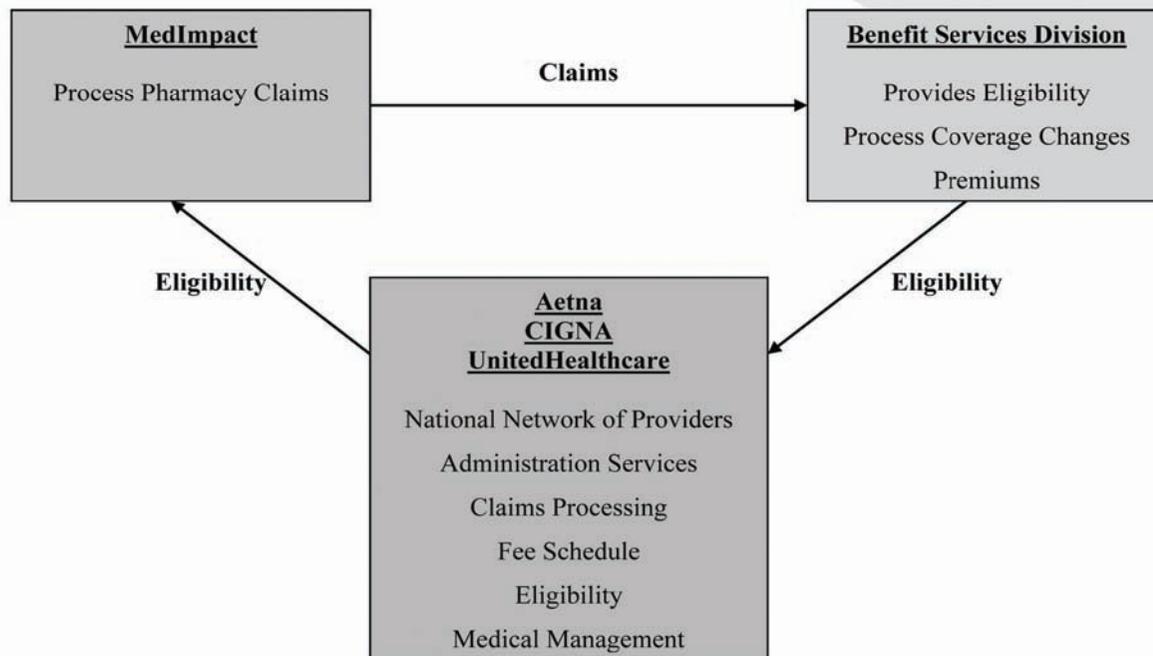
When it comes to finances, the HSA Option presents opportunities and dangers. The table below shows what could be gained and what could be lost by enrolling in the HSA Option.

	Scenario 1: Employee enrolled in single coverage HSA option	Scenario 2: Employee enrolled in family coverage HSA option
Maximum financial gain:	$\$42 \times 12 \text{ months} =$ \$504 in HSA at the end of the plan year This occurs when the individual needs no non-preventative healthcare and no prescriptions during the plan year.	$\$83 \times 12 \text{ months} =$ \$996 in HSA at the end of the plan year This occurs when family members need no non-preventative healthcare and no prescriptions during the plan year.
Maximum financial loss (in-network):	$\$2,000 - (\$42 \times 12 \text{ months}) =$ \$1,496 employee cost during plan year This occurs when the individual has reached the out-of-pocket maximum (total healthcare expenses of \$9,200 or more during the plan year).	$\$4,000 - (\$83 \times 12 \text{ months}) =$ \$3,004 family cost during plan year This occurs when the family has reached the out-of-pocket maximum (total healthcare expenses of \$18,400 or more during the plan year).

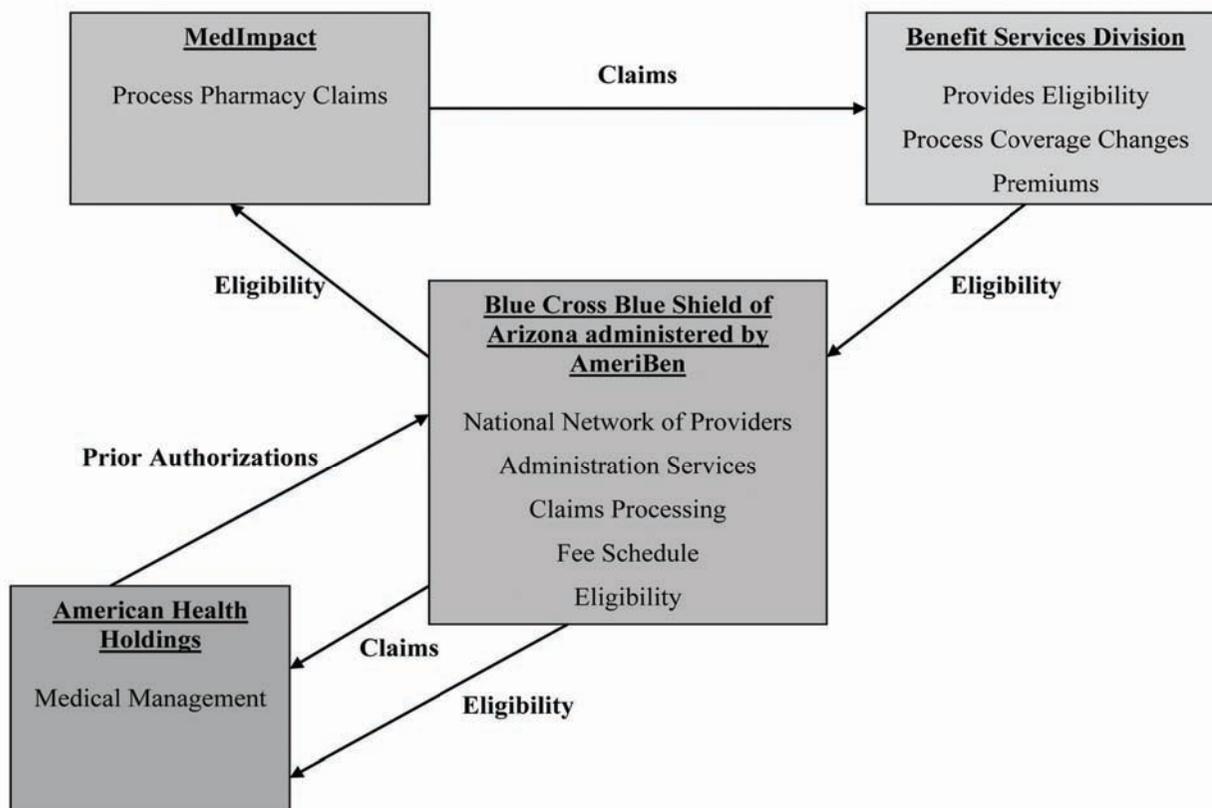


INTEGRATED & NON - INTEGRATED

INTEGRATED



NON-INTEGRATED



MEDICAL PLANS COMPARISON CHART (EPO/PPO)

		EPO	PPO	PPO
Available Plans		<input checked="" type="checkbox"/> Aetna <input checked="" type="checkbox"/> BCBS of AZ* <input checked="" type="checkbox"/> CIGNA <input checked="" type="checkbox"/> UnitedHealthcare	<input checked="" type="checkbox"/> Aetna <input checked="" type="checkbox"/> BCBS of AZ* <input checked="" type="checkbox"/> CIGNA <input checked="" type="checkbox"/> UnitedHealthcare	<input checked="" type="checkbox"/> Aetna <input checked="" type="checkbox"/> BCBS of AZ*
		IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Plan year deductible	Individual	none	\$500***	\$1,000***
	Family	none	\$1,000***	\$2,000***
Out-of-pocket max	Individual	none	\$1,000*** ⁺	\$4,000***
	Family	none	\$2,000*** ⁺	\$8,000***
Lifetime max		none	none	\$2 million
EMPLOYEE COST FOR CARE				
Behavioral health	Inpatient	\$150	\$150	50% after deductible
	Outpatient	\$15	\$15	50% after deductible
Chiropractic		\$15	\$15	50% after deductible
Durable medical equipment		\$0	\$0	50% after deductible
Emergency	Ambulance	\$0	\$0	Amount above in-network rate
	ER copay waived if admitted	ER	\$125	\$125
	Urgent care	\$40	\$40	50% after deductible
Home health services Maximum hours per year		168	168	168
Hospital admission (Room and Board)		\$150	\$150	50% after deductible
Mammography		\$0	\$0	50% after deductible
Maternity admission		\$250**	\$250**	50% after deductible
Office visits	PCP	\$15	\$15	50% after deductible
	Max of 1 copay/day/provider	Specialist	\$30	\$30
		Preventative	\$15	\$15
		OB/GYN	\$10	\$10
Outpatient services				
Freestanding ambulatory facility or hospital outpatient surgical center		\$50	\$50	50% after deductible
Radiology		\$0	\$0	50% after deductible

*Blue Cross Blue Shield of Arizona administered by AmeriBen.

**Reimbursed if patient completes the "Healthy Pregnancy" program (must be enrolled by the 12th week of pregnancy).

***Copayments apply to out-of-pocket maximum after deductible is met for PPO plans. The plan pays 100% after out-of-pocket maximum.

⁺ PPO in-network deductible must be met before co-payment applies.

Changes from last plan year are shown in *italics*

MEDICAL PLANS COMPARISON CHART (HSA)

		IN-NETWORK	OUT-OF-NETWORK
Deductible	Individual	\$1,200*	\$2,400*
	Family	\$2,400*	\$4,800*
Out-of-pocket maximum (including deductible)	Individual	\$2,000*	\$5,000*
	Family	\$4,000*	\$10,000*

Only *usual and customary charges* apply to the annual limits.

*Copayments apply to out-of-pocket maximum after deductible is met.

		EMPLOYEE COST FOR CARE			
Individual/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	Preventative	Services	\$0	\$0	\$0
		Prescriptions	\$10/\$20/\$40 copays	\$10/\$20/\$40 copays	
	Non-Preventative	Services	100% of contracted rate	10% of contracted rate	
		Prescriptions	100% of contracted rate	\$10/\$20/\$40 copays	
	Emergency	Services	100% of contracted rate	10% of contracted rate	
	OUT-OF-NETWORK	Preventative	Services	50% of total cost	
Non-Preventative		Services	100% of total cost	50% of total cost	
Emergency		Services	100% of total cost	10% of total cost	

MEDICAL ONLINE FEATURES



TAKE NOTE

When selecting an Aetna Plan For EPO: Choose "Open Access Aetna Select"
For PPO: Choose "Aetna Choice Pos II"

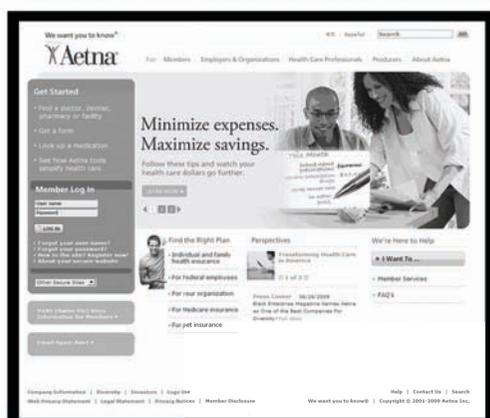
Benefit Options
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You can review your personal profiles, view the status of medical claims, obtain general medical information, and learn how to manage your own healthcare through the available health plan websites.

Aetna (aetna.com)

DocFind

To find out if your physician or hospital is contracted with Aetna use this online directory.



Aetna members can create a user name and password and have access to:

Review Your Plan and Benefits Information

You can verify your benefits and eligibility. You will also have access to a detailed claims status and Claim Explanation of Benefits (EOB) statements.

ID Card

Print a temporary or order a replacement ID card at anytime.

Contact and E-mail

You can also obtain Aetna Member Services contact information and send secure e-mail messages to Aetna Member Services. You can request e-mail alerts when new information is available such as an EOB.

Aetna IntelliHealth

This website will give access to wellness information.

Healthwise Knowledgebase

You can look up a variety of health topics.

SmartSource

A search tool to connect you with useful health information, programs and resources based on your personal profile.

Estimate the Cost of Care

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

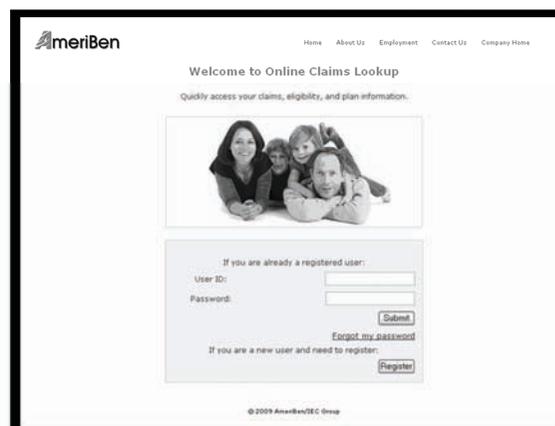
For more features visit aetna.com.

Blue Cross Blue Shield of Arizona Administered by AmeriBen (<https://services.ameriben.com>)

Lookup Provider

To find out if your doctor, hospital, or urgent care provider is contracted with Blue Cross Blue Shield of Arizona administered by AmeriBen use this tool.

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



MEDICAL ONLINE FEATURES

Continued



DID YOU KNOW?

You can view status of medical claims by accessing your health providers website

Claims Inquiry

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

Optional Electronic Paperless EOB

Reduce mail, eliminate filing and help the planet by going green.

Coverage Inquiry

Verify you and your dependents eligibility.

Wellness Tools

You can have access to wellness information.

Online Forms

You can submit and complete important health forms online, including filing an appeal.

Help

You can instant message AmeriBen with questions about your benefits, claims or general information about your health plan.

To learn more about this website visit <https://services.ameriben.com>.

CIGNA (CIGNA.com/stateofaz)

Find Your Doctor

To find out if your doctor, hospital, or other medical provider is contracted with CIGNA you can utilize this online directory.

CIGNA members can create a user ID and Password, and have access to:

Personal Profile

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

ID Card

Order a new ID card or print a temporary one.

Evaluate Costs

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

Rank Hospitals

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

Assess Treatments

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

Conduct Research

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

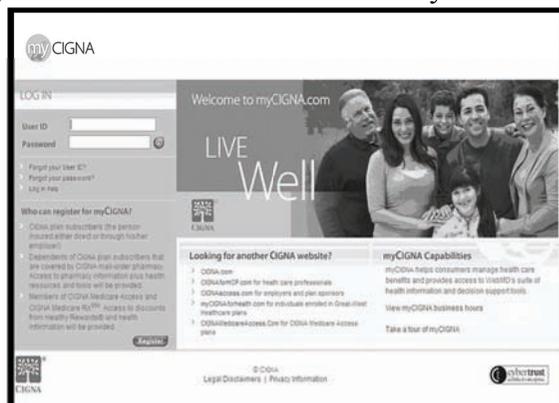
Health Coaching

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

Monitor Health Records

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

For more information visit CIGNA.com/stateofaz



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MEDICAL ONLINE FEATURES

Continued

UnitedHealthcare (myuhc.com)

Provider Search

Find the physicians and hospitals that are convenient and right for you.

UnitedHealthcare members can create a user ID and Password, and have access to:

Personal Profile

Verify benefits and eligibility. Print a temporary or order a replacement ID card anytime.

Provider Information

You may view the status of your member eligibility and all claims submitted. You can also send and receive information through the secure mail feature.

Claims Inquiry

View and read the status of all medical claims submitted for payment, including; billed charges, any deductibles or co-pays made, the amount paid to the provider, and details on provider payments.

Deductible Status

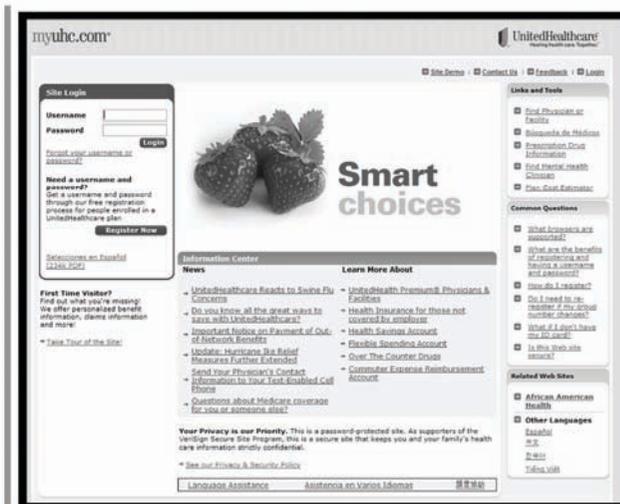
View all of the copays and deductibles paid to date for tax purposes or the amounts accrued towards any plan maximums.

Hospital Comparison

Compare hospitals based on quality of care, procedures, and patient safety measures with the "Hospital Comparison" tool.

Treatment Cost

Find out and compare what different treatments will cost using the Treatment Cost Estimator, before you need to make a decision.



Nurseline

Chat online with registered nurses 7 days a week for trusted information and peace of mind when you have a question or during times when you cannot reach your doctor.

Health Information

Look up a variety of health conditions, procedures, and topics. You can research a condition for yourself or on behalf of a loved one with the website's evidence-based medical information from the prestigious Healthwise and Best Treatments organizations.

Expert Information

Participate in monthly online events with leading experts in health care.

For more information visit myuhc.com.



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NETWORK OPTIONS OUTSIDE OF ARIZONA

The charts below indicate the coverage options and networks for members who live out-of-state.

EPO PLAN	LOCATION	NETWORK
Aetna	Nationwide	Aetna Select Open Access
BCBS of AZ* ⁺	BCBS of Arizona network for In-State Services	PHCS / MultiPlan for Nationwide Services
CIGNA	Nationwide	Cigna Open Access
UHC	Nationwide	UHC Choice

PPO PLAN	LOCATION	NETWORK
Aetna	Nationwide	Aetna choice POS II Open Access
BCBS of AZ* ⁺	BCBS of Arizona network for In-State Services	PHCS / MultiPlan for Nationwide Services
UHC	Nationwide	UHC Options PPO

HSA PLAN	LOCATION	NETWORK
Aetna	Nationwide	Aetna choice POS II

**Blue Cross Blue Shield of Arizona administered by AmeriBen.*

⁺The Blue Cross Blue Shield of Arizona network administered by AmeriBen is only available in Arizona. AmeriBen has made the PHCS / MultiPlan network available to those members living out of state.

MEDICAL MANAGEMENT



TAKE NOTE

Strategic Health and American Health Holdings have merged and the names can be used interchangeably

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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 there are four medical management vendors: American Health Holdings (AHH), Aetna, CIGNA, and OptumHealth. Each vendor serves their specific members based on which medical network you select during Open Enrollment.

The three vendors provide medical management services as follows:

- American Health Holdings (AHH) serves Blue Cross Blue Shield of Arizona administered by AmeriBen members only
- Aetna serves only Aetna members
- CIGNA serves members enrolled with the CIGNA network
- OptumHealth serves only UnitedHealthcare members

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

Utilization Management

AHH, Aetna, CIGNA, and OptumHealth provide 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 designated medical management vendor for authorization. Each vendor has a dedicated line to accept calls and inquiries:

American Health Holdings 1.866.244.8977

Aetna 1.888.632.3862

CIGNA 1.800.968.7366

OptumHealth 1.800.896.1067

Case Management

Case management is a collaborative process whereby a case manager from your designated medical management vendor 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 worker uses available resources to achieve cost effective health outcomes for both the member and for Benefit Options.

Disease Management

The purpose of disease management programs are 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
- Healthy Pregnancy
- Coronary Artery Disease

If you are eligible or become eligible for one of the programs above, a disease manager from your designated medical management vendor 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.

MEDICAL MANAGEMENT

Continued



Your assigned disease manager may also:

- Provide tips on how to keep your diet and exercise program on track
- Help you to maintain your necessary medical tests and annual exams
- Offer tips on how to manage stress and help control the symptoms of stress
- Assist with understanding your doctor's treatment plan
- Review and discuss medications, how they work and how to use them.

Generally a disease manager will work with you as quickly or as slowly as you like - allowing you to complete the program at your own pace. Over the course of the program, participants learn to incorporate healthy habits and improve their overall health.

Getting Involved

The Benefit Options disease management programs offered through CIGNA, Aetna, American Health Holdings, and OptumHealth identify and reach out to members who may need help managing their health conditions. The disease management companies work with the State health insurance to provide this additional service. Participation is optional, private, and tailored to your specific needs. Also, members of the Benefit Options health plan who are concerned about a health condition and would like to enroll in one of the covered programs can contact their respective disease management vendors directly to self enroll. Please refer to the your medical management vendor's phone number on the right if you or your dependent are interested.

Nurse Line

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

American Health Holdings 1.866.244.8977

Aetna 1.800.556.1555

CIGNA 1.800.968.7366

OptumHealth 1.800.401.7396

PHARMACY PLAN INFORMATION



DID YOU KNOW?

Walgreens will continue to be the provider for Mail Order and Specialty Pharmacy

YOUR COST

retail pharmacies
30 day supply

Tier	Copay
Generic	\$10
Preferred	\$20
Non-preferred	\$40

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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 32 million members nationwide, providing leading prescription drug clinical services, benefit design, and claims processing since 1989 through a comprehensive network of pharmacies.

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 to the left. The copays listed in the chart are for a 30-day supply of medication bought at a retail pharmacy.

Formulary

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

therapeutic value for the plan are deleted from the formulary. Ask your pharmacist to verify the current copay amount at the time your prescription is filled. To see what medications are on the formulary, go to benefitoptions.az.gov or contact the MedImpact Customer Care Center and ask to have a copy sent to you. Sharing this information with your doctor helps ensure you are getting the best value, which saves money for you and your plan.

Please refer to page 6 for limited prescription and name brand drug coverage changes that may affect you.

Finding a Pharmacy

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

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

Pharmacy Mail Order Service

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

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

- Submit a 90-day written prescription from your physician.
- Request up to a 90-day supply of medication for **two copays** (offer available to HSA Option members only when copays apply).
- Payments can be made by check or credit card: Visa, MasterCard, American Express, or Discover.
- Register your e-mail address to receive

PHARMACY PLAN INFORMATION Continued

information on your orders.

- Order refills online at *WalgreensMail.com/easy* 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 visit *benefitoptions.az.gov* or contact MedImpact Customer Care Center at 1.888.648.6769.

Medication Prior Authorization

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

Step Therapy Program

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

Specialty Pharmacy Program

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

The Walgreens Specialty Pharmacy Program includes monitoring of specific injection drugs and other therapies requiring complex administration methods and special storage, handling, and delivery. Specialty medications are limited to a 30-day supply and may be obtained only at a Walgreens retail pharmacy or by calling 1.888.782.8443.

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

Limited Prescription Drug Coverage

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

Non-Covered Drugs

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

Contacts Chart

Topic	Phone
<i>MedImpact</i> Customer Care Center and Prior Authorization	1.888.648.6769
<i>Walgreens</i> Mail Order Specialty Pharmacy	1.866.304.2846 1.888.782.8443



DID YOU KNOW?

Prescription drugs have two names: The brand and the chemical name

Generic drugs are known by their chemical name rather than a registered brand-name chosen by the manufacturer

CONTACT

MedImpact customer service representatives are available 24 hours a day, 7 days a week at 1.888.648.6769

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PHARMACY PLAN INFORMATION Continued

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

PHARMACY ONLINE FEATURES

Members view pharmacy information by registering at benefitoptions.az.gov. Click pharmacy.

Benefit Highlights

View your current copayment amounts and other pharmacy benefit considerations.

Formulary Lookup

You can research medications to learn whether they are generic, preferred or non-preferred drugs. This classification will determine what copay is required. You can search by drug name or general therapeutic category.

Prescription History

You can view your prescription history, including all of the medications received by each member, under PersonalHealth Rx.

Drug Search

You can 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

You can 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

You can locate a pharmacy near your home address, out-of-town vacation address, or your dependent's address.

The screenshot shows the 'Pharmacy Locator' page on the 'Benefit Options' website. The page has a header with 'MedImpact' and 'Benefit Options' logos. Below the header, there is a navigation bar with 'Members' and 'Pharmacy Locator' links. The main content area is titled 'pharmacy locator | Search' and includes a search form. The form has fields for 'Address', 'City', 'State' (a dropdown menu), and 'Zip'. Below these fields, there is a 'Show Locations Within' dropdown menu set to '5 miles' and a 'Pharmacy Name' field. At the bottom of the form, there are checkboxes for 'Open 24 hours' and 'Choice90', and a 'SEARCH' button. The page is powered by MAPQUEST.

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.



DID YOU KNOW?

Visit benefitoptions.az.gov to have access to your pharmacy online features

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DENTAL PLAN INFORMATION



HOW TO

Before you make an appointment make sure your preferred dentist's services will be covered under your plan

IMPORTANT

Employee-paid portion of premium is now the same for the Prepaid/DHMO and the Indemnity/PPO dental plans

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Dental Plan Options

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

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

- You MUST use a Participating Dental Provider (PDP) to provide and coordinate all of your dental care
- No annual deductible or maximums
- No claim forms
- No waiting periods
- Pre-existing conditions are covered
- Set copayments for services
- Set lab fees for prosthodontic materials

Each family member may choose a different general dentist. You can select or change your dentist by contacting TDAHP by telephone or using the "change my dentist" function on the website totaldentaladmin.com. Members may self-refer to dental specialists within the network. Specialty care copayments are listed in the plan booklet. Specialty services not listed are provided at a discounted rate. This discount also includes pediatric dentistry and TMJ care.

Indemnity/PPO Plan – Delta Dental

- You may see licensed dentist anywhere in the world
- Deductible and/or out-of-pocket payments apply
- You have a maximum benefit of \$2,000 per person per plan year for dental services
- There is a maximum lifetime benefit of \$1,500 per person for orthodontia
- You may need to submit a claim form for eligible expenses to be paid

- Benefits may be based on reasonable and customary charges

Over 80 percent of Arizona's licensed dentists participate in the Delta Dental Plan and agree to accept Delta's allowable fee as payment in full after any deductibles and/or copayments are met. Amounts billed by network providers in excess of the allowable fee will not be billed to the patient. If you choose to see a non-participating dentist, Delta will still provide benefits, although typically at reduced levels. To find participating providers visit deltadentalaz.com.

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 preferred dentist, make sure he/she accepts the plan you are considering.

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

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

Note: The employer contribution is now the same for the prepaid/DHMO and the indemnity/PPO plan. The indemnity/PPO employee contribution has increased as a result.

DENTAL PLANS COMPARISON CHART

PLAN TYPE	TDAHP	
	Total Dental Administrators	Delta Dental
PLAN TYPE	Prepaid/DHMO	Indemnity/PPO
DEDUCTIBLES	None	\$50/\$150
PREVENTATIVE CARE	CoPay	CoInsurance
Office Visit	\$0	\$0 - Deductible Waived*
Oral Exam	\$0	\$0 - Deductible Waived*
Prophylaxis/Cleaning	\$0	\$0 - Deductible Waived*
Fluoride Treatment (to age 19)	\$0	\$0 - Deductible Waived*
X-Rays	\$0	\$0 - Deductible Waived*
BASIC RESTORATIVE		
Office Visit	\$0	\$0
Sealants	\$10 per tooth	20%
Fillings	Amalgam: \$10-\$37 Resin: \$26-\$76	20%
Extractions	Simple: \$30 Surgical \$60	20%
Periodontal Gingivectomy	\$225	20%
Oral Surgery	\$30 - \$145	20%
MAJOR RESTORATIVE		
Office Visit	\$0	\$0
Crowns	\$270 + \$185 Lab Fee (\$455)	50%
Dentures	\$300 + \$275 Lab Fee (\$575)	50%
Fixed Bridgework	\$270 + \$185 Lab Fee (\$455) per unit	50%
Crown/Bridge Repair	\$75	50%
Inlays	\$250 - \$327	50%
ORTHODONTIA		
Child	\$2800 - \$3400	See lifetime
Adult	\$3200 - \$3700	
TMJ SERVICES		
Exam, services, etc.	20% Discount	
MAXIMUM BENEFITS		
Annual Combined Preventive, Basic and Major Services	No Dollar Limit	\$2000 per person
Orthodontia Lifetime	No Dollar Limit	\$1500 per person

*Routine visits and exams are covered only two times per year at 100%.

This is a summary only; please see plan descriptions for detailed provisions.

DENTAL ONLINE FEATURES

Total Dental Administrators Health Plan (TDAHP), Inc

If you are enrolling with TDAHP go to totaldentaladmin.com to access the online features describe below.

Participating Providers

You can search for a specific dentist contracted under this plan.

Select or Change Participating Provider

You can select or change your specific participating provider.

Nominate a Dentist

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

Plan A500S

Learn about the plan by clicking on this option.

Delta Dental

If you choose to enroll in **Delta Dental** visit deltadentalaz.com and set up an ID and password to have access to the Delta online features:

Claims Information

With this secure online system you can check

your claims information by dates for you or your dependents.

Benefits and Eligibility

You can review and print your benefits and eligibility.

Download Claim Forms

Download claim forms by selecting the State of Arizona.

Dentist Search

You can search for a specific provider contracted under the Delta Dental plan or locate a contracted dentist in your area.

Oral Health and Wellness

Information on dental and oral health.

Contact Information

Get the most updated contact information.

CONTACT

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

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VISION PLAN INFORMATION



DID YOU KNOW?

Healthy vision is an important part of your overall wellness!

DID YOU KNOW?

If you choose not to enroll in the fully insured plan, a discount card will be given to you at no cost. No enrollment is necessary

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

Avesis Advantage Program

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

Program Highlights

- Yearly coverage for a vision exam, glasses or contact lenses
- Extensive provider access throughout the state
- \$300 allowance for LASIK surgery
- Unlimited discounts on additional optical purchases
- Increased in-network contact lens allowance.

How to Use the Advantage Program

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

Out-of-Network Benefits

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

reimbursement. The Avesis claim form can be obtained at the website *avesis.com*.

Reimbursement will be made directly to the member.

Avesis Discount Program

If you do not enroll in the fully-insured plan, you will automatically receive an Avesis discount card at no cost. This program will provide each member with substantial discounts on vision exams and corrective materials. **No enrollment is necessary.**

How to Use the Discount Program

1. Find a provider – Go to *avesis.com* or call customer service at 1.888.759.9772.
2. Schedule an appointment – Identify yourself as an Avesis discount card holder employed by the State of Arizona.

In-Network Benefits Only

Avesis providers who participate in the Avesis Discount Vision Care Program have agreed to negotiated fees for products and services. This allows members to receive substantial discounts on the services and materials they need to maintain healthy eyesight.

Providers not participating in the program will not honor any of the discounted fees. The member will be responsible for full retail payment.

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

VISION PLANS COMPARISON CHART

IN-NETWORK BENEFITS		
	Advantage Vision Care Program	Discount Vision Care Program*
Examination Frequency	Once every 12 months	12 months
Lenses Frequency	Once every 12 months	12 months
Frame Frequency	Once every 12 months	12 months
Examination Copay	\$10 copay	No more than \$45
Optical Materials Copay (Lenses & Frame Combined)	\$0 copay	Refer to schedule below
Standard Spectacle Lenses		
Single Vision Lenses	Covered-in-full	No more than \$35
Bifocal Lenses	Covered-in-full	No more than \$50
Trifocal Lenses	Covered-in-full	No more than \$65
Lenticular Lenses	Covered-in-full	No more than \$80
Standard Progressive Lenses	Uniform discounted fee schedule less the allowance for Standard Lenses	No more than the Uniform discounted fee schedule
Selected Lens Tints & Coatings	Uniform discounted fee schedule	No more than the Uniform discounted fee schedule
Frame		
Frame	Covered up to \$100-\$150 retail value (\$50 wholesale cost allowance)	20-50% Discount
Contact Lenses (in lieu of frame/spectacle lenses)		
Elective	10-20% discount & \$150 allowance	10-20% Discount
Medically Necessary	Covered-in-full	20% Discount
LASIK/PRK		
LASIK/PRK	Up to 20% savings & \$300 allowance in lieu of all other services for the plan year	20% Discount

**Members that choose not to enroll in the Advantage Vision Care Program will automatically receive an Avesis discount card at no cost.*

VISION PLANS COMPARISON CHART Continued

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

**Members that choose not to enroll in the Advantage Vision Care Program will automatically receive an Avesis discount card at no cost.*

VISION ONLINE FEATURES

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

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

Search for Providers

Search for contracted network providers near your location.

Benefit Summary

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

Print an ID Card

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

Verifying Eligibility

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

Glossary

You can learn about vision terminology.

Facts on Vision

Learn about different vision facts.

Claim Form

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



CONTACT

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

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INTERNATIONAL COVERAGE

International Coverage	
MEDICAL CARE	
<i>EPO Plans</i>	
Aetna	Emergency & Urgent Only
BCBS of AZ*	Emergency & Urgent Only
CIGNA	Emergency & Urgent Only
UnitedHealthcare	Emergency & Urgent Only
<i>PPO Plans</i>	
Aetna	Emergency & Urgent Only at In-Network Benefit Level**
BCBS of AZ*	Emergency & Urgent Only at In-Network Benefit Level**
UnitedHealthcare	Emergency & Urgent Only at In-Network Benefit Level**
<i>HSA Option</i>	
Aetna	Emergency & Urgent Only
<i>NAU Only</i>	
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, go to www.bcbs.com/bluecardworldwide/index
PHARMACY	
MedImpact	Not covered
DENTAL CARE	
<i>Prepaid/DHMO Plan</i>	
Total Dental Administrators Health Plan, Inc.	Emergency Only
<i>PPO Plan</i>	
Delta Dental	Coverage is available under non-participating provider benefits
VISION CARE	
Avesis	Covered as out-of-network and will be reimbursed based on the Avesis reimbursement schedule

*Blue Cross Blue Shield of Arizona administered by AmeriBen.

**All other services covered at out-of-network benefit level.

LIFE INSURANCE



DID YOU KNOW?

This year you can elect up to 3 times your base annual salary or \$300,000, whichever is less

Benefit Options
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The Hartford

The Hartford is this year's new vendor for Life Insurance. The Hartford is one of the largest insurance companies and serves millions of customers worldwide with nearly 200 years in business.

Basic Life Insurance and AD&D

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

Supplemental Life Insurance and AD&D

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

You may elect to increase or decrease your supplemental life coverage only during Open Enrollment. This year only the maximum coverage you may elect is the lesser of \$300,000 or 3 times your annual salary. You may increase in multiples of \$5,000, up to the limits described above. You can also decrease your coverage in multiples of \$5,000 or cancel coverage.

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

In the event of your death, employee life and AD&D benefits are paid to your designated beneficiary. It is important to keep your beneficiary information current. If you choose more than one beneficiary, you can define the amount paid or a percent paid to each beneficiary. You may change your beneficiary using the YES website during Open Enrollment. ***Remember: adding a beneficiary does not automatically delete a previously-designated beneficiary. If you wish to change a previously designated beneficiary, you must actively do so while enrolling.***

Dependent Life Insurance

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

You can learn more by visiting <http://groupbenefits.thehartford.com/arizona/> or calling 1.866.712.3443.

SHORT-TERM DISABILITY (STD)

The **Hartford** is our new vendor for Short-Term Disability (STD).

How STD Works

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

Effective Dates

Coverage becomes effective on the pay period start date following the agency's receipt of completed forms or successful notifications via the YES website. Your benefits will start on your first day of disability due to accident or the 31st day of disability due to illness or pregnancy, if coverage was elected during your initial new hire/eligibility enrollment period.

If you become disabled during the first 12 months of coverage, your benefits will start on the 61st day of disability due to illness or pregnancy.

If you previously waived STD coverage and enrolled during Open Enrollment or due to a qualified life event, your insurance becomes effective as follows:

- On the following October 1 if you enroll during Open Enrollment.
- On the date of the qualified life event for changes resulting from births, adoptions and placements for adoption; or, on the later of (a) the date of the qualified life event, and (b)

for any other qualified life event, the pay period date following agency receipt of completed forms.

Disabled and Working Benefits

The Hartford STD program allows you to return to work and receive up to 100% of your pre-disability earnings between the STD benefit and your current weekly earnings. To learn how your benefits are calculated for this program see example below:

Weekly benefit calculation under the Disabled and Working Formula = $(A - B) \times C / A$

A = weekly pre-disability earnings (what the STD plan benefit is based on).

B = your current weekly earnings (earnings while disabled).

C = the weekly benefit payable if a claimant were totally disabled.

Assume an employee is covered by the STD plan. The employee's covered earnings (base earnings) are \$1,200 a week. The employee wants to return to work part-time and is able to do so on a reduced schedule.

A = \$1,200; this is what the employee was making weekly prior to being disabled.

Assume B = \$300; this is what the employee is making now on a part-time basis, reduced schedule, while still being considered disabled.

C = \$800; this is the weekly benefit the employee would receive if she was not working at all (1,200 x the weekly benefit percentage of 66 2/3%).

$(1,200 - 300) \times 800 = 720,000 / 1,200 = \mathbf{\$600}$
This is the benefit the employee will receive under the Disabled and Working Formula.

To file a claim visit

<http://groupbenefits.thehartford.com/arizona/>
or call 1.866.712.3443.



DID YOU KNOW?

If it is determined, that you are not able to work due to illness, pregnancy, or non-work related injury, you may receive a weekly benefit for up to 26 weeks if you elect Short-Term Disability

IMPORTANT

If you are already receiving STD benefits from The Standard, your current benefits will not be impacted by this change

Benefit Options
Choice. Value. Health.

LONG-TERM DISABILITY (LTD)

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



IMPORTANT

Medical documentation of your disability is required to continue your payment of benefits

IMPORTANT

If you are already receiving LTD benefits from The Standard, your current benefits will not be impacted by this change

Benefit Options
Choice. Value. Health.

Arizona State Retirement System (ASRS)

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

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

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

The Hartford is the new vendor for Long-Term Disability administered through ADOA.

Your LTD benefit may pay up to 66-2/3% of your monthly pre-disability earnings with a maximum benefit of \$10,000 per month during your disability as determined by The Hartford and based on supporting medical documentation.

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

If you are facing a possible long-term disability, you should contact your agency benefit liaison or human resources office within 90 days from the date of your illness or injury. They can provide the information you need to apply for LTD benefits. This could include a waiver of insurance premiums (while collecting LTD, the LTD carrier may waive your life insurance premiums) or life insurance conversion (converting your supplemental policy from a group policy to an individual one). Although your life and/or disability insurance premiums may be waived, your medical, dental and vision insurance premiums are not waived. You are still responsible for payment of these premiums.

Changing Retirement Systems

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

LIFE, STD, LTD ONLINE FEATURES

You can access important information about your Life and AD&D, Short-Term and Long-Term Disability insurances by visiting <http://groupbenefits.thehartford.com/arizona/>.

It's My Choice Calculator

This calculator will help you estimate your life insurance needs.

Premium Calculator

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

Benefit Highlight Sheets

You can learn important information such eligibility, coverage, effective dates and other information.

File a Claim Online

You can file a short term disability claim by calling The Hartford or online by accessing the link to thehartfordatwork.com.

Your Booklets

Find booklets with your important information about Life, Short Term Disability and Long Term Disability information.

Claims

Learn how to file a claim.

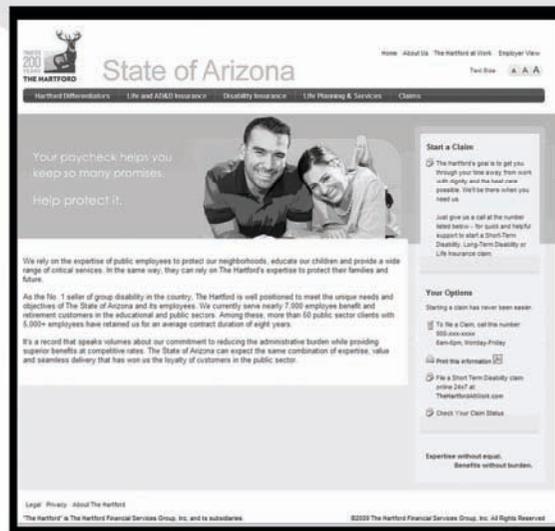
Check Your Claim Status

View the status of all your claims submitted at thehartfordatwork.com.

Life Planning & Services

You can learn about different programs offered by The Hartford, such as Life Conversations, Ability Assist, Beneficiary Assist and others. To learn more about these programs and other features visit

<http://groupbenefits.thehartford.com/arizona/>.



LIFE, STD, LTD ONLINE FEATURES

CONTACT

You can contact
The Hartford at
1.866.712.3443

Benefit Options
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EMPLOYEE WELLNESS



DID YOU KNOW?

Most of the Employee Wellness programs are available for both employees and their dependents enrolled in the health plan

DID YOU KNOW?

An annual flu shot is considered the best way to protect against the flu virus

DID YOU KNOW?

Skin cancers are the most prevalent of all cancers. Arizonans should be aware of the hazards of overexposure to sunlight

Benefit Options
Choice. Value. Health.

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

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

Wellness Programs and Services

Mini-Health Preventative Screening

The work site mini-health screen focuses on prevention and early detection of heart disease and diabetes. Tests included in this screening are the full lipid panel, blood pressure, body composition, and blood glucose. Our vendors also offer optional screens such as osteoporosis or a PSA.

Mobile Onsite Mammography

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

Skin Cancer Screening

This 10-minute screening with a Nurse Practitioner includes a visual assessment for suspicious lesions and education on sun exposure and prevention techniques.

Flu Vaccine Program (October 1, 2009 through December 31, 2009)

Wellness provides free flu shots at many State work sites and public clinic locations for employees. More information can be found on the Wellness website at benefitoptions.az.gov.

Employee Assistance Program (EAP)

EAP is a confidential Wellness benefit that provides short-term counseling to employees, their spouses, and their dependents. Employees can access 6 free counseling sessions to help with personal issues, coping with a loss, stress/anxiety, or financial concerns. ADOA offers an EAP contract which serves most State agencies. The ADOA EAP website and phone number are available 24/7 for local resources, informational articles, and counseling: guidanceresources.com or 1-877-327-2362. The ADOA company code is HN8876C. Other EAP contracts that serve State agencies can be found at benefitoptions.az.gov/wellness/eap.asp

Annual Mayo Clinic Health Assessment (August 20, 2009 through January 29, 2010)

The newest addition to Wellness is the Mayo Clinic Health Assessment, a professionally-developed questionnaire designed to help members (including spouses) become knowledgeable about their health. Members have access to the Health Assessment through the Mayo Clinic EmbodyHealth Web Portal at bewellstaywell.az.gov. The Health Assessment takes 15 minutes to complete and offers members an opportunity to improve their health through lifestyle changes. Upon completion of the Health Assessment, members may also be eligible for FREE one-on-one telephonic EmbodyHealth Coaching. Participants choose from five EmbodyHealth modules: Healthy Weight, Exercise, Stress, Tobacco Cessation, and Nutrition.

EMPLOYEE WELLNESS

Continued

Fees for Wellness Services

Service	Employee Cost
Skin Cancer Screening	\$0
Mini Health	\$0
- Bone Density	\$0 for women 40+
- PSA	\$5 for men 40+
Mammography	\$0
Flu Shot	\$0

Other Wellness Resources Website

The Wellness website provides up-to-date information on Wellness programs, services, and campaigns. An event request form (to host a screening or class) is also available (see right).

Monthly Newsletter (wellNEWS)

This electronic newsletter is sent via email to designated agency contacts and should be distributed to all employees. The newsletter is also posted monthly on the Wellness website homepage benefitoptions.az.gov/wellness



WE HAVE HEARD

About the Mini Health Screening "I was unaware that my cholesterol and blood pressure were high. This screening was a wake up call to see my doctor and start living a healthier lifestyle. Thank you!"

WE HAVE HEARD

About Wellness Services "Thank you so much for your help setting up Wellness events for our agency. The Wellness Program has given us great service..."

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wellNEWS

From the Arizona Department of Administration, Benefit Options Wellness Program

Page 1

www.benefitoptions.az.gov/wellness

Walking for Wellness

Walking is a low-impact exercise with numerous health benefits. Get started today!

Walking is a gentle, low-impact exercise that can ease you into a higher level of fitness and health. Walking is one of your body's most natural forms of exercise. It is safe, simple, does not require practice, and the health benefits are many.

Benefits of walking

Walking, like other exercise, can help you achieve a number of important health benefits. Walking can help:

- Lower low-density cholesterol (LDL)
- Raise high-density lipoprotein (HDL) cholesterol
- Lower your blood pressure
- Reduce your risk or manage type 2 diabetes
- Manage your weight
- Improve your mood
- Stay strong and fit
- Strengthens your heart and lungs
- Promotes better sleep

Preparation helps avoid injury

Before you begin a walking program it is important to prepare. Taking time to prepare yourself may prevent injuries, such as blisters on your feet or excessive muscle pain.

Wear good walking shoes. Before you set out, be sure to select comfortable footwear. A large toe box and heel that rocks forward are two things to look for.

Select comfortable, protective clothing. Dress in loose-fitting, comfortable clothing. If you walk outside, choose clothes appropriate for the weather or layer clothing if you need to adjust to changing temperature. Wear bright colors or reflective tape after dark so that motorists can see you.

Warm up. Spend about five minutes walking slowly to warm up your muscles. You can walk in place if you want. Increase your pace until you feel warm.

Stretch. After warming up, stretch your muscles before walking. Include the calf stretch, quadriceps stretch, and hamstring stretch.



Cool down after each walking session. To reduce stress on your heart and muscles, end each walking session by walking slowly for about five minutes.

Basic of Getting Started:

Start slow and easy. If you have been inactive and tire easily, it is best to start slow and easy. At first, walk only as far or as fast as you find comfortable. If you can walk for only a few minutes, let that be your starting point. You might try short daily sessions of five to 10 minutes and slowly build up to 15 minutes twice a week. Then, over several weeks, you can gradually work your way up to 30 to 60 minutes of walking most days a week.

Measure the intensity of your workout. Check your heart rate to measure intensity. Knowing your heart rate allows you to increase the intensity to maximize your workout or slow down to avoid overdoing it.

To find out if you are exercising within the range of your target heart rate, check your pulse manually at your wrist or neck or wear an electronic device that displays your heart rate.

Set goals, track progress, stay motivated for success

The good news is that walking — even only a modest amount — provides health benefits. For maximum benefits, work your way up to 30 to 60 minutes a day within your target heart rate zone, most days of the week. To achieve these benefits, it can help to set goals, track your progress and take steps to stay motivated.

Continued on page 2

How to Request a Wellness Event

1. Go to the Wellness Website at benefitoptions.az.gov/wellness and click on the "Request an Event Here" button in the left margin.
2. Click on the online request form and complete all of the required fields: desired event, date, time, location, number of employees, etc.
3. Ensure your agency has a space available to host the requested event on your desired date and time.
4. Click submit button at the bottom of the page.

These steps will send an email request to the Benefit Options Wellness program coordinator and your event will be scheduled. You will receive marketing materials and any registration information to distribute to the employees in your agency. Events should be requested 4-6 weeks in advance to ensure vendor availability. The minimum participation requirements are posted on the Wellness website for reference.

The screenshot shows the Wellness website interface. On the left, there's a sidebar with 'Wellness Programs' including May Clinic Programs, Classes, Employee Assistance, Screenings, Flu Shots, and Tobacco-Free. Below that is an 'EVENT SCHEDULE' for 'Walking for Wellness' with details on dates, times, and locations. A 'REQUEST AN EVENT HERE!' button is visible. On the right, there's a 'Wellness Event Request' form with a 'Submit' button. Below the form, there's a 'Wellness Event Request' section with a 'Submit' button and a 'Interested in submitting a Wellness Event Request? Simply click on the form to the left!' message. The bottom of the page features a 'May Clinic Programs' section and a 'May wellNEWS!' section.

Contact Information

Phone: 602.771.9355

Toll free: 800.304.3687

Email: wellness@azdoa.gov

EMPLOYEE WELLNESS

FLEXIBLE SPENDING ACCOUNTS*

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

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

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

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

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

Medical FSA

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

Dependent Care FSA

A dependent care FSA can be used to pay for out-of-pocket child care expenses for children under the age of 13. If you have an older dependent that lives with you at least 8 hours each day and requires assistance with day living, you can claim these expenses through your dependent care FSA also.

Note: Dependent medical and/or other expenses should be submitted through the medical FSA not the dependent care FSA.

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

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



PLEASE NOTE

University employees are not eligible for this benefit; please contact your human resources office

DID YOU KNOW?

Setting aside pretax money into a FSA allows you to pay for certain health care and dependent care expenses and you can SAVE from 25% to 40% in taxes

Benefit Options
Choice. Value. Health.



***University employees are not eligible for this benefit. Your university might offer a Flexible Spending Account option. Please contact your human resources office for more information.**

FLEXIBLE SPENDING

Continued



IMPORTANT

Enrollment is required if you wish to participate, even if you are currently enrolled

CONTACT

See your agency benefit liaison if you have questions or problems obtaining or submitting a claim

Benefit Options
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File a Claim

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

Submitting a Claim Form

You can:

- Fax your claim and documentation, toll-free to ASI at 1.866.381.9682
- Mail the claim form and documentation to the address shown above
- Submit your claims electronically as an email attachment with the following requirements:

- 1) Attachment must be in pdf or tif format;
 - 2) Only one file attachment (not multiples);
 - 3) Must indicate in the subject line or in the body of the text description of attachment;
- AND
- 4) Must send to claims@asiflex.com

Reimbursement

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

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

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

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

Grace Period for Medical and Dependent Care FSAs

With the medical FSA you have a grace period of 2 months and 15 days following the end of the plan year to incur expenses. This means that you have from October 1, 2009 through December 15, 2010 to use any remaining funds. All the claims for medical expenditures must be filed with ASI prior January 31, 2011 for reimbursement.

Dependent care services **MUST** be utilized in the applicable plan year, October 1, 2009 through September 30, 2010. The claims must be filed with ASI no later than midnight on December 31, 2010.

End of Employment

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

Note: Members enrolled in a Health Savings Account (HSA) do not qualify for this service. Instead they qualify for a Limited Flexible Spending Account. The only expenses qualifying for this Limited Flexible Spending Account are dental and vision care expenses. Please see page 53 for more details.

FLEXIBLE SPENDING COMPARISON CHART

	MEDICAL CARE	DEPENDENT CARE
Maximum Contributions	\$5,000 annually	\$5,000 annually (\$2,500 if married and filing separately)
Minimum Contributions	\$130 annually	\$260 annually
Use of the Account Dental and Vision	<ul style="list-style-type: none"> *To pay (with pretax 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 for over-the-counter medications that will be used to treat an existing or imminent condition 	<ul style="list-style-type: none"> *To pay expenses for care of dependent outside your home *To pay care provided for your children under the age of 13 for whom you have custody, for a physically or mentally handicapped spouse or other dependents who spend at least eight hours a day in your home *To pay dependent care provided so that you can work
Samples of Eligible Expenses	<ul style="list-style-type: none"> *Copayments *Deductibles *Charges above reasonable and customary limits *Dental fees *Eyeglasses, exam fees, contact lenses and solution, LASIK surgery *Orthodontia *Nonprescription medications (e.g., cold medicines, allergy medicines, antacids, pain relievers) 	<ul style="list-style-type: none"> *Services provided by a day care facility. Must be licensed if the facility cares for six or more children *Babysitting services while you work *Practical nursing care *Preschool
What's Not Covered	<ul style="list-style-type: none"> *Premiums for medical or dental plans *Items not eligible for the health care tax exemptions by IRS *Long-term care expenses 	<ul style="list-style-type: none"> *Private school tuition including kindergarten *Overnight camp expense *Babysitting when are not working *Transportation and other separately billed charges *Residential nursing home care
Restrictions/ Other Information	<ul style="list-style-type: none"> *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 <i>asiflex.com</i> 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 	<ul style="list-style-type: none"> *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 <i>asiflex.com</i> 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

FLEXIBLE SPENDING

Continued

Deciding How Much to Deposit Into Your Flexible Spending Accounts

Estimate the amount you expect to pay during the plan year for eligible, uninsured out-of-pocket medical and/or dependent care expenses. This estimated amount cannot exceed the established limits (Medical limit = \$5,000; Dependent Care limit = \$5,000).

Be conservative in your estimates, since any money remaining in your accounts will be forfeited.

TAX-FREE MEDICAL EXPENSE WORKSHEET	TAX-FREE DEPENDENT CARE WORKSHEET
<p>Estimate your eligible, uninsured out-of-pocket medical expenses for the plan year, which is October 1st, 2009 through September 30th 2010.</p>	<p>Estimate your eligible dependent care expenses for the plan year, which is October 1st, 2009 through September 30th, 2010.</p>
<p>YOUR UNINSURED MEDICAL, DENTAL AND VISION EXPENSES</p> <p>\$ _____ \$ _____ \$ _____ \$ _____ \$ _____ \$ _____</p>	<p>NUMBER OF WEEKS You will have dependent (child, adult or elder) care expenses for the plan year. Remember to subtract holidays, vacations, and other times you may not be paying for eligible dependent care.</p> <p>Weeks _____</p>
<p>SUBTOTAL Your total contribution during the year cannot exceed \$5,000.</p> <p>\$ _____</p>	<p>MULTIPLY By the amount of money you expect to spend each week</p> <p>\$ _____</p>
<p>DIVIDE By the number of paychecks (26) you will receive during the plan year.</p> <p>This is your pay period contribution -</p> <p>\$ _____</p>	<p>SUBTOTAL Total contribution cannot exceed IRS limits for the calendar year and your employer's plan year.</p> <p>\$ _____</p>
	<p>DIVIDE By the number of paychecks (26) you will receive during the plan year.</p> <p>This is your pay period contribution -</p> <p>\$ _____</p>

LIMITED FLEXIBLE SPENDING ACCOUNTS*

The Limited Flexible Spending Accounts (FSAs) are a new money saving option available only to members who are enrolled in a Health Savings Account (HSA). You have the option to open a Limited Medical and/or Dependent Care (child care) Flexible Spending Account(s) administered by ASI.

Members enrolled in an HSA are not allowed to enroll in a traditional Medical Flexible Spending Account. See page 47 to learn more.

Limited FSA Highlights

- Allows you to set aside pretax dollars, reducing your taxable wages and, therefore, decreasing your taxes;
- You can specify the annual dollar amount of earnings to be deposited. This amount is deducted in 26 equal payments, one each pay period;
- At your request, your FSA reimbursement may be deposited into your checking or savings account by enrolling in Direct Deposit. To obtain an application, visit the ASI website at asiflex.com.

- Monies not claimed within the plan year will be forfeited in accordance with the Internal Revenue Service regulations.

Limited Medical FSA

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

Dependent Care FSA

A dependent care FSA can be used to pay for out of pocket child care expenses for children under the age of 13. If you have an older dependent that lives with you at least 8 hours each day and requires assistance with day living, you can claim these expenses.

Note: Dependent dental and vision expenses should be submitted through the limited medical FSA, not the dependent care account.

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

Before you incur an expense under your medical and/or dependent care FSAs, determine if it is eligible for reimbursement on the ASI website asiflex.com.

***University employees are not eligible for this benefit. Your university might offer a Flexible Spending Account option. Please contact your human resources office for more information.**



DID YOU KNOW?

With the Limited FSAs you can receive reimbursement for vision and dental expenses and/or dependent care

Benefit Options
Choice. Value. Health.

Welcome to the ASIFlex's Online Customer Service Center

Home | Programs | Forms | FAQ | Useful Links | Account Detail | Contact Us

FSA Quick Links:

- FSA Eligible Expenses
- Claim Forms
- Direct Deposit Sign up form
- Claim Filing Procedures

ASIFlex's website is designed to provide its users with ready access to all necessary information. If you have a particular question, please click on the appropriate link, or feel free to contact our customer service center:

Phone Number: 1-800-659-3035
Hours of Operation: Monday through Friday 7 a.m. to 7 p.m. Central Time, and from 9 a.m. to 1 p.m. Central Time on Saturday.
Contact us via email at any time.

Flexible Spending Accounts allow you to avoid paying taxes on Health Care or Dependent Care expenses you are already incurring. For the Health Care FSA, eligible expenses include co-pays, prescription drugs, many over-the-counter medications, dental work, chiropractic services and massage therapy. Expenses can be for you or any of your tax dependents, even if your dependents aren't on your employer's insurance program. [read more](#)

Each pre-tax program is a little different. If you are thinking about signing up for a program, please follow the link below for more information.

- Health Care FSA
- Dependent Care FSA
- Commuter Benefit Program

LIMITED FLEXIBLE SPENDING

Continued



TAKE NOTE

By using a Limited FSA for dental and vision expenses you can preserve the funds in your HSA

File a Claim

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

Submitting a Claim Form

You can:

- Fax your claim and documentation, toll-free to ASI at 1.866.381.9682
- Mail the claim form and documentation to the address shown above
- Submit your claims electronically as an email attachment with the following requirements:

- 1) Attachment must be in pdf or tif format;
 - 2) Only one file attachment (not multiples);
 - 3) Must indicate in the subject line or in the body of the text description of attachment;
- AND
- 4) Must send to claims@asiflex.com

Reimbursement

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

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

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

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

Grace Period for Medical and Dependent Care FSAs

With the medical FSA you have a grace period of 2 months and 15 days following the end of the plan year to incur expenses. This means that you have from October 1, 2009 through December 15, 2010 to use any remaining funds. All the claims for medical expenditures must be filed with ASI prior January 31, 2011 for reimbursement.

Dependent care services **MUST** be utilized in the applicable plan year, October 1, 2009 through September 30, 2010. The claims must be filed with ASI no later than midnight on December 31, 2010.

End of Employment

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

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LIMITED FLEXIBLE SPENDING COMPARISON CHART

	LIMITED MEDICAL CARE	DEPENDENT CARE
Maximum Contributions	\$5,000 annually	\$5,000 annually (\$2,500 if married and filing separately)
Minimum Contributions	\$130 annually	\$260 annually
Use of the Account Dental and Vision	*To pay (with pretax money) for health-related expenses that are not covered or only partially covered by you, including expenses for your spouse or children not enrolled in your dental and vision plans	*To pay expenses for care of dependent outside your home *To pay care provided for your children under the age of 13 for whom you have custody, for a physically or mentally handicapped spouse or other dependents who spend at least eight hours a day in your home *To pay dependent care provided so that you can work
Samples of Eligible Expenses	*Copayments *Deductibles *Charges above reasonable and customary limits *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 *Practical nursing care *Preschool
What's Not Covered	*Premiums for dental plans *Items not eligible for the health care tax exemptions by IRS *Long-term care expenses	*Private school tuition including kindergarten. *Overnight camp expense *Babysitting when are not working *Transportation and other separately billed charges *Residential nursing home care
Restrictions/ Other Information	*See IRS Publication 502 (expenses in this plan qualify based on when the services are provided regardless of when you pay for the expense) or go to ASI's website at <i>asiflex.com</i> for specific details on what expenses are allowed *You cannot transfer money from one account to the other *Your election amount may be increased (but not decreased) if you have a qualified life event	*See IRS Publication 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 <i>asiflex.com</i> 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

LIMITED FLEXIBLE SPENDING

Continued

Deciding How Much to Deposit Into Your Limited Flexible Spending Accounts

Estimate the amount you expect to pay during the plan year for eligible, uninsured out-of-pocket dental and vision, and/or dependent care expenses. This estimated amount cannot exceed the established limits (Dental and Vision limit = \$5,000; Dependent Care limit = \$5,000).

Be conservative in your estimates, since any money remaining in your accounts will be forfeited.

TAX-FREE MEDICAL EXPENSE WORKSHEET	TAX-FREE DEPENDENT CARE WORKSHEET
<p>Estimate your eligible, uninsured out-of-pocket medical expenses for the plan year, which is October 1st, 2009 through September 30th 2010.</p>	<p>Estimate your eligible dependent care expenses for the plan year, which is October 1st, 2009 through September 30th, 2010.</p>
<p>YOUR UNINSURED MEDICAL, DENTAL AND VISION EXPENSES</p> <p>\$ _____ \$ _____ \$ _____ \$ _____ \$ _____ \$ _____</p>	<p>NUMBER OF WEEKS You will have dependent (child, adult or elder) care expenses for the plan year. Remember <i>to subtract holidays, vacations, and other times you may not be paying for eligible dependent care.</i></p> <p>Weeks _____</p>
<p>SUBTOTAL Your total contribution during the year cannot exceed \$5,000.</p> <p>\$ _____</p>	<p>MULTIPLY By the amount of money you expect to spend each week</p> <p>\$ _____</p>
<p>DIVIDE By the number of paychecks (26) you will receive during the plan year.</p> <p>This is your pay period contribution -</p> <p>\$ _____</p>	<p>SUBTOTAL Total contribution cannot exceed IRS limits for the calendar year and your employer's plan year.</p> <p>\$ _____</p>
	<p>DIVIDE By the number of paychecks (26) you will receive during the plan year.</p> <p>This is your pay period contribution -</p> <p>\$ _____</p>

QUESTIONS & ANSWERS



Older Child (Over 18 and Under 25)

1. If new hires have dependents 19 to 24 years old not attending school, will they be covered?

Answer: No, the rule states that non-fulltime students over 18 and under 25 years of age must have been covered by the ADOA plan when the child was 18 years of age.

2. When does the 25-year-old dependent's coverage end? Birthday? End of birth month?

Answer: Coverage will end at 11:59 p.m. the day before the dependent turns 25 years old.

3. Are non-fulltime students between the ages of 19 to 24 covered if they live out of state?

Answer: No. The rule requires non-fulltime students over 18 and under 25 years of age to reside in the State of Arizona.

4. Some current employees have older dependents that were enrolled in a non-ADOA plan at 19 or older. Can they enroll them on their benefits during Open Enrollment?

Answer: No. The dependent must have been covered by an ADOA health plan during the year he/she was 18 years old.

5. What documentation will be required for dependents that are over 19 and non students?

Answer: Birth certificate or documents proving eligibility as required by ADOA.

6. Do older non-fulltime student dependents (over 18 and under 25 years of age), need to reside in the same household as the employee?

Answer: No, but they do need to reside in the State of Arizona.

7. If an employee gets married, can the employee add an over 18 and under 25 years of age dependent of the new spouse? *Answer: Yes, if the dependent is a fulltime student. No, if the dependent is not a fulltime student and was not covered under an ADOA plan when the child was 18 years of age.*

Domestic Partners

8. If domestic partners are legally married in another state, do they have to complete the same paperwork? *Answer: Yes, and they will need to meet the requirements as outlined in the rules. A.A.C. R2-6-101.*

9. Do dependents of domestic partners have to reside with the member? *Answer: No, but non-fulltime students over age 18 have to reside in the State of Arizona. Fulltime students can reside out of the State of Arizona.*

10. Will we have a specific phone number that employees can call to obtain information on domestic partners and older children? *Answer: Call Benefit Options at (602) 542.5008 and select option "0" for eligibility questions relating to coverage for domestic partners and older children.*

11. If a domestic partner has been living with someone for 9 months on October 1st, can they enroll their domestic partner 3 months after October 1st as a Qualified Life Event? *Answer: Yes.*

12. Are children of a domestic partner covered? *Answer: Yes, if they fall under the definition of a 'child'. A.A.C. R2-6-101.*

13. Will the domestic partner paperwork need to be notarized? *Answer: Yes*

QUESTIONS & ANSWERS

Continued



Wellness

14. Will a Wellness Event Attendance Policy be put in place Statewide?

Answer: It has been proposed but at this time there is no plan to put one in place. Check for your individual agency's policy.

15. Will Wellness programs be available in the rural areas? *Answer: Yes, ADOA is focusing on promoting more Wellness events with increased participation in all rural areas.*

Audit process

16. Will you be auditing the benefit elections for every employee? *Answer: Any employee with dependents may be considered for audit.*

17. During the audit process, will you be auditing student status verification? *Answer: It is possible that it will be a requirement; we are working through that process and may find that the vendor records can be reviewed to verify student status.*

Other

18. What are the dates for the enrollment appeals process? *Answer: September 30th through October 31st (subject to change).*

Transition of Care

19. I am currently undergoing treatment. What happens if my current doctor is not a member of the new network? *Answer: Please refer to page 14 for information about transition of care.*

Health Savings Account Option

20. Are all employees eligible for the HSA option? *Answer: Employees are eligible for the HSA option as long as they are not covered by other health insurance and cannot be claimed as a dependent by someone else.*

21. Do prescription drug copays count toward the deductible and out-of-pocket maximum in the HSA option? *Answer: Prescription drug copays do count toward the out-of-pocket maximum but do not count toward the deductible.*

22. Are domestic partner and older child healthcare expenses eligible for reimbursement under a health savings account? *Answer: Healthcare expenses for a domestic partner or older child are not considered qualified expenditures.*

23. Do HSAs have use-it-or-lose-it rules like FSAs? *Answer: Unused HSA funds will rollover from year to year.*

24. Can I open an HSA if I enroll in the EPO or PPO? *Answer: No, only people enrolling in the HSA option are eligible to open an HSA.*

25. How can I open my HSA? *Answer: See page 19 for information about opening your HSA.*

COBRA COVERAGE NOTICE



DID YOU KNOW?

Under a new federal law, a person involuntarily terminated between September 1, 2008 and December 31, 2009 may be eligible for COBRA premium assistance. Under this program, the individual pays 35% of the COBRA premium and the federal government subsidizes the remaining 65%

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

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

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

Electing COBRA Coverage

To elect COBRA coverage, you must complete the election form according to the directions on the election form and mail or deliver by the date specified on the election form to the

ADOA Benefits Office. Each qualified beneficiary has a separate right to elect COBRA coverage.

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

You may elect COBRA under the group health coverage (medical, dental, vision and health care FSA) in which you were covered under the Plan on the day before the qualifying event. Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected.

However, a qualified beneficiary’s COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under another group health plan (but only after any applicable pre-existing condition exclusions of that other plan have been exhausted or satisfied).

Electing COBRA Under the Healthcare FSA

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

COBRA COVERAGE NOTICE

Continued



TAKE NOTE

COBRA will generally last 18 months for a qualified beneficiary

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COBRA coverage will consist of the health care FSA coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event).

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

Special Considerations in Deciding Whether to Elect COBRA

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

after your group coverage ends because of the qualifying event. You will also have the same special enrollment right at the end of COBRA coverage if you get COBRA coverage for the maximum time available to you.

How Long Will COBRA Coverage Last

COBRA coverage will generally be continued only for up to a total of 18 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage under the Plan as a result of the qualifying event can last up to 36 months from the date of Medicare entitlement. This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months before the termination of employment or reduction of hours: In the case of an loss of coverage due to a employee's death, divorce or legal separation, or a dependent child ceasing to be a dependent under the terms of the Plan, COBRA coverage may be continued for up to a total of 36 months. Regardless of the qualifying event, health care FSA COBRA coverage may only be continued to the end of the plan year in which the qualifying event occurred and cannot be extended for any reason. This notice shows the maximum period of COBRA coverage available to qualified beneficiaries. COBRA coverage will automatically terminate before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing COBRA coverage, under another group health plan (but only after any

COBRA COVERAGE NOTICE

Continued



TURN to...
Page 63

To learn more
about COBRA
coverage cost

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applicable pre-existing condition exclusions of that other plan have been exhausted or satisfied),

- the State ceases to provide any group health plan for its employees; or
- during a disability extension period (the disability extension is explained below), the disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled.

COBRA coverage may also be terminated for any reason that traditional enrollment would be terminated (for example, the Plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage in a case of fraud). You must notify the COBRA administrator(s) in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare (Part A, Part B or both) or becomes covered under another group health plan (but only after any preexisting condition exclusions of that other plan have been exhausted). COBRA coverage will terminate (retroactively if applicable) as of the date of Medicare entitlement or as of the beginning date of the other group health coverage (after satisfaction of any applicable preexisting condition exclusions). The plan will require repayment of all benefits paid after the termination date, regardless of whether or when you provide notice of Medicare entitlement or other group health plan coverage.

Extending the Length of COBRA Coverage

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

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

Disability

If any of the qualified beneficiaries is determined by the Social Security Administration to be disabled, the maximum COBRA coverage period that results from the covered employee's termination of employment or reduction of hours (generally 18 months as described above) may be extended up to a total of 29 months. The disability must have started at some time before the 61st day of COBRA coverage obtained due to the covered employee's termination of employment or reduction of hours with the State and must last until the end of the 18-month period of COBRA coverage. Each qualified beneficiary who has elected COBRA coverage will be entitled to the disability extension if one of them qualifies. The disability extension is available only if you notify the COBRA administrator(s) in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

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

COBRA COVERAGE NOTICE

Continued



DID YOU KNOW?

If a qualified beneficiary becomes disabled, the COBRA period is extended to 29 months

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

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

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

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

Second Qualifying Event

An extension of coverage will be available to spouses and dependent children who are receiving COBRA coverage if a second

qualifying event occurs during the first 18 months (or, in the case of a disability extension, the first 29 months) of COBRA coverage following the covered employee's loss of coverage.

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

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

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

In addition, you must provide documentation supporting the occurrence of the second qualifying event, if the ADOA Benefits Office requests it. Acceptable documentation includes a copy of the divorce decree, death certificate, or dependent child's birth certificate, driver's license, marriage license or letter from a university or institution indicating a change in student status. You must mail this notice within the required time periods to the ADOA Benefits Office. If the

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COBRA COVERAGE NOTICE

Continued

above procedures are not followed or if the notice is not provided within the 60-day notice period, there will be no extension of COBRA coverage due to a second qualifying event.

COBRA Coverage Cost

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

Making Your COBRA Coverage Payment

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

Benefits Office for information about your COBRA payment including how much you owe.

Monthly Payments for COBRA Coverage

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

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

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

Grace Periods for Monthly Payments

Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days after the first day of the month to make each payment for that month. Your COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that your coverage will be suspended.



TAKE NOTE

The first payment for COBRA coverage should be made no later than 45 days after the date of election

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COBRA COVERAGE NOTICE

Continued



If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan. If mailed, your payment is considered to have been made on the date that it is postmarked. If hand delivered, your payment is considered to have been made when it is received. Payments received or postmarked after the due date will not be accepted. You will not be considered to have made any payment if your check is returned due to insufficient funds or otherwise.

More Information About Individuals Who May be Qualified Beneficiaries

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

Alternative Recipients Under QMCSOs

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

This notice does not fully describe COBRA coverage or other rights under the Plan. More information about COBRA coverage and your

rights under the Plan is available from the ADOA Benefits Office.

If you have any questions concerning the information in this notice or your rights, please contact us:

ADOA Benefits Office
100 N. 15th Ave., Suite 103
Phoenix, AZ 85007
602.542.5008 or 800.304.3687
beneissues@azdoa.gov

Information about COBRA provisions for a governmental healthplan is available from the: **Centers for Medicare & Medicaid Services (CMS)**

Private Health Insurance Group
7500 Security Boulevard
Mail Stop S3-16-16
Baltimore, Maryland 21244-1850

Or you may call 1.410.786.1565 for assistance. This is not a toll-free number. The CMS website is cms.hhs.gov.

CONTACT

For more information about COBRA coverage and your rights under the Plan, visit benefitoptions.az.gov

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HIPAA NOTICE



IMPORTANT

This notice tells you about our obligations and how Benefit Options may use and disclose your health information, and your rights

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This notice describes how medical information about you may be used and disclosed, how you may gain access to this information, and the measures taken to safeguard your information. Benefit Options knows that the privacy of your personal information is important to you.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires health plans to notify plan participants and beneficiaries about its policies and practices to protect the confidentiality of their health information. For purposes of this Notice, health information refers to any information that is considered Protected Health Information (PHI) as defined in the Privacy Rule of the Administrative Simplification provision of HIPAA.

Throughout this Notice, all references to Benefit Options refer to the administrators of the Program. Please review it carefully.

Use and Disclosure of Health Information

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

How the Plan May Use and Disclose Health Information

To Make or Obtain Payment

Benefit Options may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive.

For example, Benefit Options may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

To Conduct Health Care Operations

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

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

HIPAA NOTICE

Continued

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

For Treatment Alternatives

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

For Distribution of Health-Related Benefits and Services

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

When Legally Required

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

To Conduct Health Oversight Activities

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

In Connection With Judicial and Administrative Proceedings

As permitted or required by state law, Benefit Options may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or

administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when Benefit Options makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

For Law Enforcement Purposes

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

In the Event of a Serious Threat to Health or Safety

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

For Specified Government Functions

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

For Workers Compensation

Benefit Options may release your health information to the extent necessary to comply with laws related to workers compensation or similar programs.



DID YOU KNOW?

Benefit Options needs to create, receive, and maintain records that contain health information about you to administer the Plan and provide you with health benefits

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HIPAA NOTICE

Continued



PLEASE NOTE

You can request information on disclosures of your health information going back for 6 years from the date of your request, but not earlier than April 14, 2003

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Authorization to Use or Disclose Health Information

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

Your Rights with Respect to Your Health Information

You have the following rights regarding your health information that Benefit Options maintains:

Right to Request Restrictions

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

Right to Receive Confidential Communications

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

Right to Inspect and Copy Your Health Information

You have the right to inspect and copy your health information. If you request a copy of

your health information, Benefit Options may charge a reasonable fee for copying, assembling costs and, if applicable, postage associated with your request.

Right to Amend Your Health Information

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

Right to an Accounting

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

Right to a Paper Copy of This Notice

You have a right to request and receive a paper

HIPAA NOTICE

Continued

copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically.

The ADOA Privacy Officer may be contacted at:

**100 N. 15th Avenue, Suite 401
Phoenix, AZ, 85007
602.542.1500
Fax at 602.542.2199**

Notice Effective Date
April 14, 2003.



DID YOU KNOW?

Benefit Options is required by law to abide by the terms of this Notice.

Benefit Options Duties

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

Changes to This Notice

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

Complaints

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

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

Contact Information

For more information or for further explanation of this notice, you may contact us:

**ADOA Benefits Office
100 N. 15th Ave., Suite 103
Phoenix, AZ 85007
602.542.5008 or 800.304.3687
Email: beneissues@azdoa.gov**

You may also obtain a copy of this Notice at our web site at benefitoptions.az.gov.

Benefit Options
Choice. Value. Health.

GLOSSARY



TAKE NOTE

It is important to understand your options to make an informed decision

Benefit Options
Choice. Value. Health.

Accidental Death and Dismemberment (AD&D)

A type of insurance through which your beneficiary will receive money if you die or if you are accidentally injured in a specific way.

Appeal

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

Balance Billing

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

Beneficiary

The person 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. Copayments and/or coinsurance amounts may or may not apply, see comparison charts on pages 23 and 24.

Dependent

An individual other than a health plan subscriber who is eligible to receive healthcare services under the subscriber's contract. Generally, dependents are limited to the subscriber's spouse and minor children.

Disease Management

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

GLOSSARY

Continued



Domestic Partner

An individual who meets the eligibility requirements established in R2-6-101 of the Arizona Administrative Code.

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.

HSA

(Health Savings Account)

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

ID Card

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

Long-Term Disability

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

Mail-Order Pharmacy

A service through which members may receive prescription drugs by mail.

Member

A person who is enrolled in the health plan.

Medically Necessary

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

CONTACT

Visit
benefitoptions.
az.gov to learn
more about
Open
Enrollment

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GLOSSARY

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-Authorization

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

Preventative Care

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

Short-Term Disability

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

Supplemental Life

Life insurance in an amount above what the state provides.

Usual and Customary (UNC) Charges

The standard fee for a specific procedure in a specific regional area.

Wellness

A Benefit Options program focused on preventing disease, illness, and disability.

