

Arizona Department of Administration
Benefit Services Division

State of Arizona Retirees
Open Enrollment 2009-2010

2009-2010 Benefit Guide retired state employees

IN THIS GUIDE

- BENEFIT EXPO DATES
- BENEFIT CHANGES
- BENEFITS ELIGIBILITY
- MEDICARE
- MEDICAL & PRESCRIPTION BENEFITS
- DENTAL & VISION BENEFITS
- 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
beneissues@azdoa.gov

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

Medical Plans

Aetna
1.866.217.1953
www.aetna.com
Policy Number 476687

Blue Cross Blue Shield
of Arizona 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

SecureHorizons
1.866.622.8055
www.securehorizons.com

Pharmacy Plan

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

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

Vision Plan

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

Long-Term Disability Plans

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

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

Retirement Systems

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

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

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TABLE OF CONTENTS

Introduction

Welcome to the 2009-2010 Benefit Guide. This guide has been designed with you, the retiree, 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 retiree 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.

| | | | |
|---|-------|---|-------|
| Dates and Events | 1 | Medical Management | 39-40 |
| Open Enrollment | 2-4 | Pharmacy Plan Information | 41-44 |
| Benefit Changes | 5-8 | Pharmacy Online Features | 45 |
| Eligibility | 9-11 | Pharmacy Benefits Summary | 46 |
| Where to Enroll | 12-15 | Dental Plan Information | 47 |
| Changing Your Benefits | 16-17 | Dental Online Features | 48 |
| Summary of Insurance Premiums | 18-19 | Dental Plans Comparison Chart | 49 |
| Understanding Your | | Vision Plan Information | 50 |
| Insurance Cost | 20-23 | Vision Online Features | 51 |
| Medicare Advantage Plan | 24 | Vision Plans Comparison Chart | 52-53 |
| Medicare Part A & B | 25-27 | International Coverage | 54 |
| Medicare Part D | 28 | Long-Term Disability Members | 55 |
| Medical Plan Information | 29-30 | Question & Answers | 56-57 |
| Medical Online Features | 31-34 | COBRA Coverage Notice | 58-64 |
| Network Options Outside Arizona | 35 | HIPAA Notice | 65-69 |
| Medical Plans Comparison Charts | 36-37 | Glossary | 70-72 |
| Integrated and Non-Integrated Chart | 38 | | |

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 retirees and 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 will end Friday, September 4th at 5 p.m. (Arizona time).

The 2009-2010 Open Enrollment will be mandatory, meaning retirees 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 retirees an opportunity to meet with the medical, pharmacy, dental, vision, LTD 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. The Benefit Expo dates, times, and locations can be found on the "Dates and Events" page of this guide (pg. 1).

Information for Open Enrollment

Your 2009-2010 Open Enrollment benefit elections can be made online using the YES website. Instructions are on pages 12-15 of this guide entitled "Where to Enroll."

You will need the following information:

- Your State or issued Employee Identification Number (EIN). You can contact the ADOA Benefit Services Division at 602-542-5008 to inquire about your EIN.
- Dependents' names, dates of birth and Social Security Numbers. You will need this information to add eligible dependents

to your benefits coverage. Other documentation may also be necessary in certain circumstances. Please refer to the Eligibility section of this guide on pages 9 - 11 for more information.

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

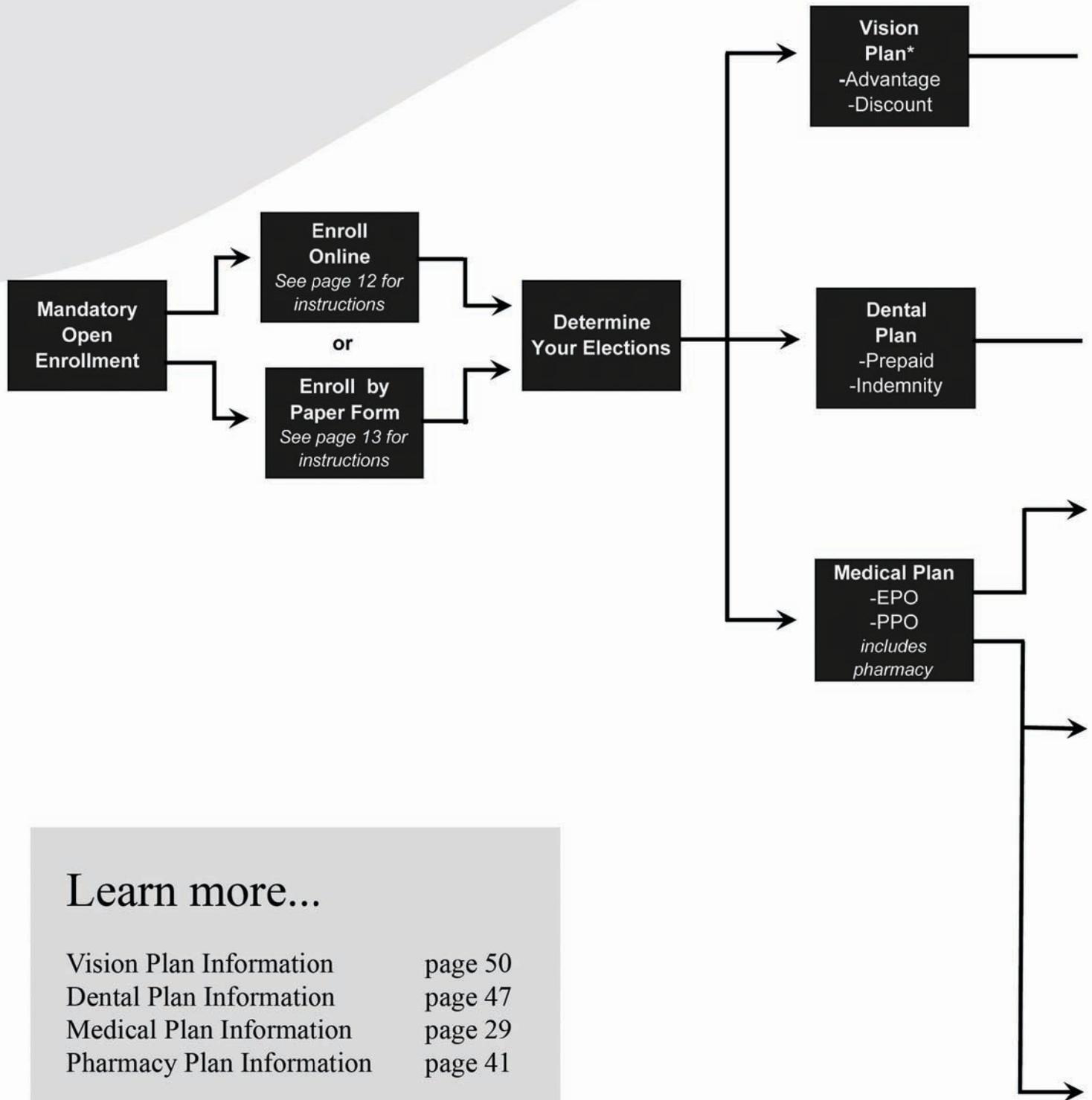
Special Notice

Retirees will be required to provide Social Security Numbers (SSN) for all dependents enrolled in 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.

2009 - 2010 RETIREE OPEN



Learn more...

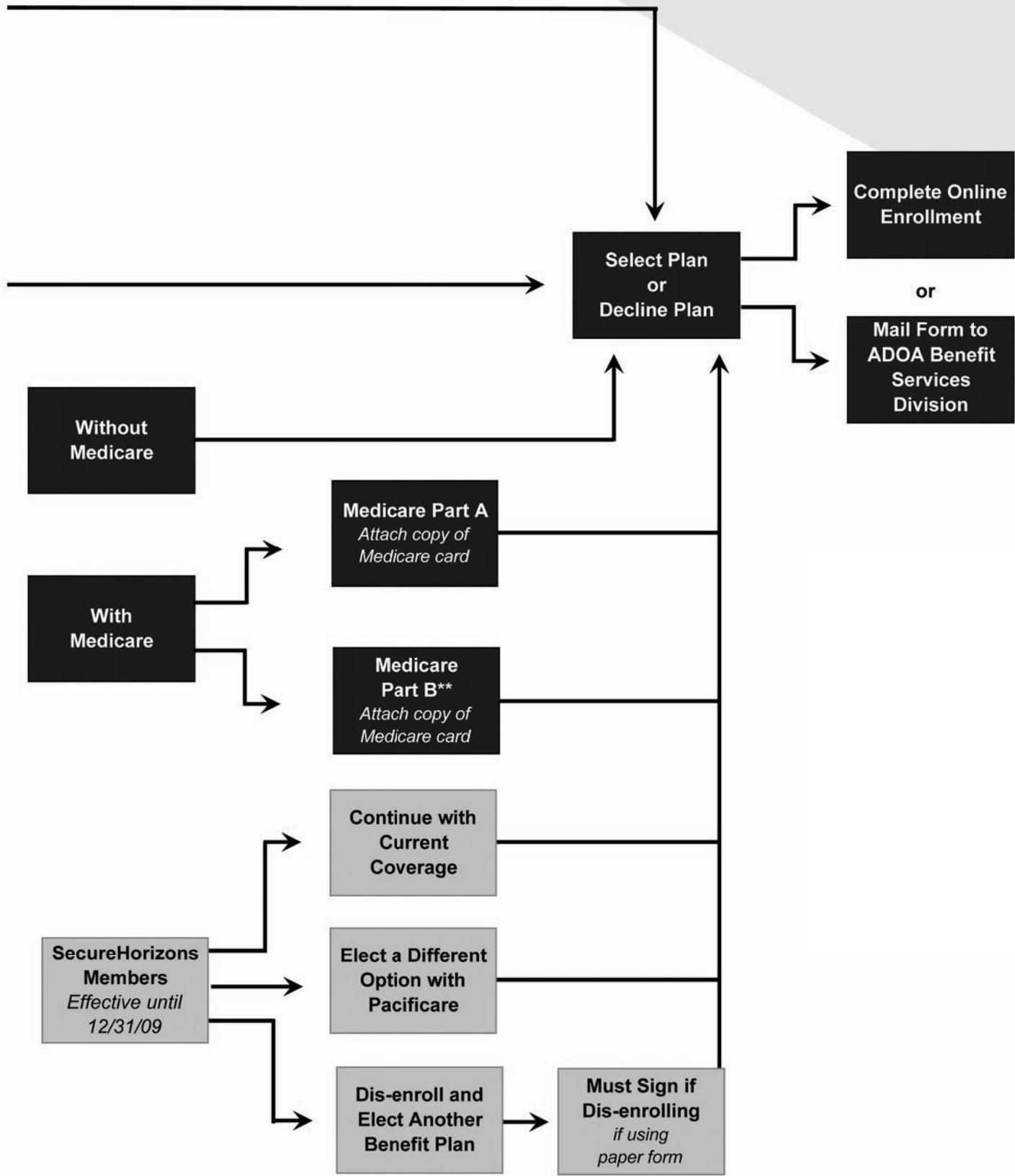
| | |
|---------------------------|---------|
| Vision Plan Information | page 50 |
| Dental Plan Information | page 47 |
| Medical Plan Information | page 29 |
| Pharmacy Plan Information | page 41 |

*Only available if medical and/or dental coverage is selected

**If you are eligible for Medicare Part B and choose not to elect it, you will be responsible for the cost of services covered by Medicare Part B

ENROLLMENT

AT-A-GLANCE



BENEFIT CHANGES FOR PLAN YEAR 2009-2010

New Pharmacy Benefit Vendor

The State of Arizona has contracted with a new pharmacy benefit management vendor called MedImpact. Some notable differences include: a new 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.

New Medical Networks

The State has selected new health plans to offer services for the Plan Year 2009-2010. We have chosen four new contractors: Aetna, Blue Cross Blue Shield of Arizona administered by AmeriBen, CIGNA, and UnitedHealthcare.

New LTD

The Hartford has been selected as the new contractor to provide Long-Term Disability eligible State of Arizona employees. The Hartford contract will be replacing the services previously provided by The Standard.

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.

SecureHorizons Medicare Advantage Plan

SecureHorizons will remain effective until December 31, 2009. During the 2009-2010 Open Enrollment retirees enrolled in the plan can elect to keep their current benefits or dis-enroll from SecureHorizons and elect one of the other plan options now being offered. If you choose to keep SecureHorizons until December 31, 2009, you will receive a communication in November 2009 with your options for continuing your benefits.

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.



BENEFIT CHANGES

Continued

Legislation - Continued

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.

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%.

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

State law requires ADOA to offer the same coverage to retirees as active employees receive. Due to the State's ongoing budget challenges, members will assume a percentage of that increase in the coming plan year.

PPO Changes

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



TURN to...
page 58

For a complete
version of the
COBRA notice

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BENEFIT CHANGES

Continued

Cost Sharing Changes Continued

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.

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 be applied towards 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. However, 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.



BENEFIT CHANGES

Continued



TURN to...
page 41

For more
information on
the new
pharmacy plan
with
MedImpact

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Coverage Changes - Continued

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 to become eligible 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.

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 and 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.

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.

ELIGIBILITY

Eligible Retirees

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

- A. Retirees receiving a pension under a state-sponsored retirement plan and continuing enrollment in the Retiree health and/or dental plan.
- B. Long-Term Disability (LTD) participants collecting benefits under a state-sponsored plan.
- C. Eligible former elected officials and their qualified dependents if the elected official has at least 5 years of credited service in the Elected Officials Retirement Plan; was covered under a group health or accident plan at the time of leaving office; served as an elected official on or after January 1, 1983; and applies for enrollment within 31 days of leaving office or retiring.
- D. Surviving spouses and qualified dependents provided they were covered at the time of the Retiree's death.
- E. Surviving spouses of former elected officials provided they were covered at the time of the official's death.

Eligibility Rules

- A. As an eligible Retiree, if you elected ADOA's medical or dental insurance, you may make changes to your plan(s) during Open Enrollment or changes consistent with a Qualified Life Event (QLE).

- B. If you have declined or cancelled ADOA's medical and/or dental coverages in the past, but have maintained either coverage through ADOA, you may re-elect medical and/or dental coverages during the Open Enrollment period.
- C. If you have a qualified dependent that is not currently enrolled in Arizona Benefit Options, he or she may be added during the Open Enrollment period. Dependents not enrolled during Open Enrollment cannot be added until the next Open Enrollment, unless there is a Qualified Life Event (QLE). You have 31 days from the QLE to change your enrollment through the ADOA Benefit Services Division. The change must be consistent with the event. Please refer to the Benefit Services Division website for more information about QLEs.

Eligible Dependents

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

- A Your legal spouse
- B Your domestic partner subject to the following qualifications:
 - a. Shares the retiree's permanent residence;
 - b. Has resided with the retiree continuously for at least 12 consecutive months before filing an application for benefits and is expected to continue to reside with the retiree indefinitely as evidenced by an



CONTACT

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

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ELIGIBILITY

Continued

Eligible Dependents - Continued

- affidavit filed at 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 applications 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 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. Each agreeing in writing to assume financial responsibility for the welfare of the other, such as durable power of attorney; or

- vi. Naming the partner as beneficiary on the retiree's life insurance, under the retiree's will, or retiree'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
- vii. Other proof of financial interdependence as approved by the Director.

C. Your child defined as:

- a. You 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. You 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. You 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



CONTACT

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

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ELIGIBILITY

Continued

- 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 court-ordered guardianship when the child was 18 years old or younger.

Dependent Documentation Requirements

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 Benefit Services Division. 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 Retirees

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

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).

Return to Work Retirees

Former retired State employees returning to Active State Employment can receive health benefits through the Benefit Options Health Plan. If a retiree returns to work and meets the eligibility guidelines, they can elect to enroll in Active benefits and decline retiree benefits. Leaving state service is considered a Qualified Life Event (QLE). The QLE then allows them to enroll in retiree benefits again.



CONTACT

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

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WHERE TO ENROLL ONLINE

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

System will be available on August 20th, 2009

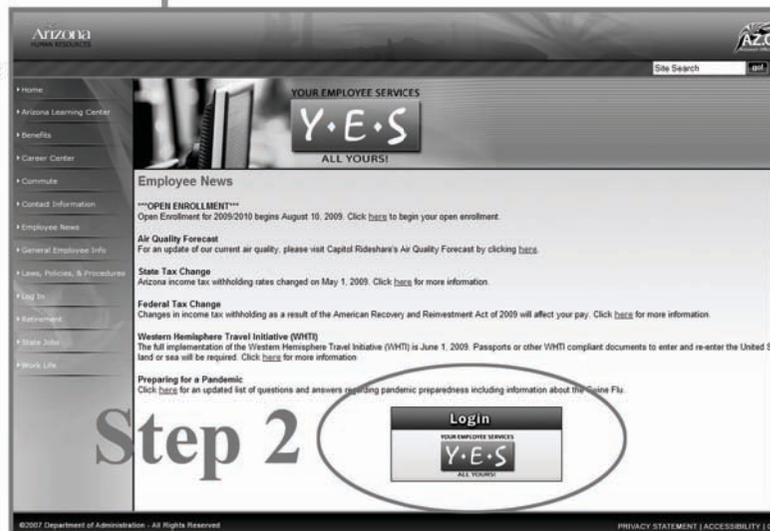
YES Login

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 from the Benefit Services Division at 602.542.5008
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.



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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WHERE TO ENROLL - ONLINE

WHERE TO ENROLL ENROLLMENT FORM

FOR INSTRUCTIONAL PURPOSES ONLY
PLEASE DO NOT COMPLETE THE FORM BELOW

1. Indicate your reason for completing the form.

- If you are retired or receiving LTD benefits and you are re-enrolling in retiree/LTD coverage because it is mandatory during this year's open enrollment, please mark OPEN ENROLLMENT.
- If you just retired and this is your first time enrolling in retiree/LTD coverage, please mark NEW RETIREE.
- If you recently started receiving LTD benefits and this is your first time enrolling in retiree/LTD coverage, please mark NEW LTD PARTICIPANT.
- If you are notifying ADOA of an address change, please mark ADDRESS CHANGE.
- If you are changing your enrollment options due to a qualified life event, please mark QUALIFIED LIFE EVENT.
- If you are terminating coverage, please mark TERMINATE INSURANCE.

1.
2.
3.
4.
5.

| Benefit Options <small>Choice. Value. Health.</small> | | STATE OF ARIZONA BENEFIT OPTIONS RETIREE/LTD ENROLLMENT FORM 2009-2010 | | | | | | |
|---|--------------------------|--|---|---|------------------------------|---------------------------------|------------------------|-----------------------------|
| <input type="checkbox"/> NEW RETIREE <input type="checkbox"/> QUALIFIED LIFE EVENT | | <input type="checkbox"/> NEW LTD PARTICIPANT <input type="checkbox"/> TERMINATE INSURANCE | | <input type="checkbox"/> ADDRESS CHANGE <input type="checkbox"/> OPEN ENROLLMENT | | | | |
| <input type="checkbox"/> RETIRED <input type="checkbox"/> DISABLED <input type="checkbox"/> SURVIVING SPOUSE | | Retirement System <input type="checkbox"/> ASRS (ZA) <input type="checkbox"/> PSPRS, CORP, EORP (ZP) <input type="checkbox"/> OPTIONAL (ZT) | | | | | | |
| EFFECTIVE DATE: | DECEASED MEMBER'S NAME: | DECEASED DATE: | | | | | | |
| MEMBER IDENTIFICATION | | | | | | | | |
| LAST NAME, FIRST NAME, M.I. | EMPLOYEE EIN or SSN | <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE | <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE | DATE OF BIRTH | | | | |
| STREET ADDRESS | COUNTY OF RESIDENCE | CITY, STATE, ZIP CODE | | | | | | |
| LAST DAY WORKED | DATE RETIRED | MEDICARE <input type="checkbox"/> YES <input type="checkbox"/> NO | HOME PHONE NUMBER () -) | | | | | |
| Are you enrolling a Domestic Partner? (circle one) | | Yes or No | | | | | | |
| Are you enrolling an Older Child(ren) that is neither a full-time student nor a disabled dependent? (circle one) | | Yes or No | | | | | | |
| To qualify a Domestic Partner for the first time, you will need to complete and submit the DOMESTIC PARTNER AFFIDAVIT FORM (this form must be notarized). This form can be found on the Benefit Options website at www.benefitoptions.az.gov . To qualify as an Older Child (ages 19 to 25 and neither a full-time student nor a disabled dependent), the Older Child must have been covered on an ADOA plan at the age of 18 years old (see the website www.benefitoptions.az.gov). | | | | | | | | |
| DEPENDENTS MUST BE LISTED FOR FAMILY COVERAGE | | | | | | | | |
| LAST NAME, FIRST NAME, MIDDLE INITIAL | DATE OF BIRTH (Required) | RELATIONSHIP CODE S=Spouse D=Domestic Partner C=Child G=Guardian P=Placed for adoption T=Stepchild | MEDICARE A=Medicare A B=Medicare B C=Medicare A & B D=Medicare Unknown E=No Medicare | SOCIAL SECURITY NUMBER (Required) | MALE OR FEMALE M OR F | FULL-TIME STUDENT Y OR N | DISABLED Y OR N | ADD OR DELETE A OR D |
| MEMBER: | | | | | | | | |
| SPOUSE OR DOMESTIC PARTNER: | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

2. Indicate your current status (RETIRED, DISABLED, or SURVIVING SPOUSE), the effective date and the retirement system with which you are affiliated. If you are a surviving spouse, indicate the deceased member's retirement system, name, and date of death.

3. Complete the MEMBER IDENTIFICATION section.

4. Answer the questions regarding enrollment of a domestic partner and older child(ren). If you are enrolling either type of dependent, read the instructions printed on the enrollment form.

5. Complete the last section on page 1 if you are enrolling dependents.

WHERE TO ENROLL ENROLLMENT FORM

Continued

FOR INSTRUCTIONAL PURPOSES ONLY
PLEASE DO NOT COMPLETE THE FORM BELOW

6. Select your vision plan. You may only elect vision coverage if medical and/or dental coverage is also elected. If declining vision coverage, please mark I DECLINE VISION COVERAGE.

7. Select your dental plan. If declining dental coverage, please mark I DECLINE DENTAL COVERAGE.

IF YOU DO NOT HAVE MEDICARE, PROCEED TO STEP 8. IF YOU HAVE MEDICARE,
PROCEED TO STEP 10

8. Select your medical plan. If declining medical coverage, please mark I DECLINE MEDICAL COVERAGE.

9. Skip to step 12 on the next page.

| Benefit Options <small>Choice. Value. Health.</small> | STATE OF ARIZONA BENEFIT OPTIONS RETIREE/LTD ENROLLMENT FORM 2009-2010 | | |
|--|---|------------------------------------|------------------------------------|
| FOR ALL MEMBERS | | | |
| <i>VISION PLAN SELECTION - ONLY AVAILABLE IF MEDICAL AND/OR DENTAL COVERAGE IS SELECTED</i> | | | |
| VISION PLAN - MARK APPROPRIATE BOX | | | |
| <input type="checkbox"/> I DECLINE VISION COVERAGE | | | |
| Select A Plan | Retiree Only | Retiree + One | Retiree & Family |
| Avesis | <input type="checkbox"/> \$4.83 | <input type="checkbox"/> \$13.52 | <input type="checkbox"/> \$16.86 |
| DENTAL PLANS - MARK APPROPRIATE BOX | | | |
| <input type="checkbox"/> I DECLINE DENTAL COVERAGE <input type="checkbox"/> I ELECT TO KEEP MY CURRENT DENTAL COVERAGE | | | |
| Select A Plan | Retiree Only | Retiree + One | Retiree & Family |
| Delta Dental | <input type="checkbox"/> \$34.82 | <input type="checkbox"/> \$77.85 | <input type="checkbox"/> \$131.82 |
| Total Dental Administrators | <input type="checkbox"/> \$9.96 | <input type="checkbox"/> \$18.92 | <input type="checkbox"/> \$27.70 |
| MEDICAL PLANS - MARK APPROPRIATE BOX | | | |
| <i>FOR MEMBERS WITHOUT MEDICARE</i> | | | |
| <input type="checkbox"/> I DECLINE MEDICAL COVERAGE | | | |
| STATEWIDE PLANS <small>(MONTHLY PREMIUM AMOUNTS)</small> | Retiree Only | Retiree + One | Retiree & Family |
| EPO PLANS | | | |
| CIGNA EPO | <input type="checkbox"/> \$537.00 | <input type="checkbox"/> \$1255.00 | <input type="checkbox"/> \$1691.00 |
| AETNA EPO | <input type="checkbox"/> \$537.00 | <input type="checkbox"/> \$1255.00 | <input type="checkbox"/> \$1691.00 |
| AMERIBEN EPO | <input type="checkbox"/> \$537.00 | <input type="checkbox"/> \$1255.00 | <input type="checkbox"/> \$1691.00 |
| UNITEDHEALTHCARE EPO | <input type="checkbox"/> \$537.00 | <input type="checkbox"/> \$1255.00 | <input type="checkbox"/> \$1691.00 |
| PPO PLANS | | | |
| AETNA PPO | <input type="checkbox"/> \$853.00 | <input type="checkbox"/> \$2008.00 | <input type="checkbox"/> \$2782.00 |
| AMERIBEN PPO | <input type="checkbox"/> \$853.00 | <input type="checkbox"/> \$2008.00 | <input type="checkbox"/> \$2782.00 |
| UNITEDHEALTHCARE PPO | <input type="checkbox"/> \$853.00 | <input type="checkbox"/> \$2008.00 | <input type="checkbox"/> \$2782.00 |
| <small>NAU Only - Available in ALL regions</small> | | | |
| BCBS of Arizona PPO | <input type="checkbox"/> \$570.12 | <input type="checkbox"/> \$1140.24 | <input type="checkbox"/> \$1596.34 |
| **BENEFIT SERVICES DIVISION USE ONLY** | | | |
| PLAN NAME: _____ | | PLAN OPTION CODE: _____ | |
| **FOR MEMBERS WITH MEDICARE, MAKE ENROLLMENT SELECTIONS ON THE FOLLOWING PAGE** | | | |
| <small>Revised 8/5/2009</small> | | <small>Page 2 of 3</small> | |

WHERE TO ENROLL ENROLLMENT FORM Continued

FOR INSTRUCTIONAL PURPOSES ONLY
PLEASE DO NOT COMPLETE THE FORM BELOW

10. Indicate whether you have Medicare Part A, Medicare Part B, or both. **IMPORTANT: ATTACH A COPY OF YOUR MEDICARE CARD TO YOUR ENROLLMENT FORM**

11. Select your medical plan. Read the note about Pacificare if it impacts you. If declining medical coverage, please mark I DECLINE MEDICAL COVERAGE.

12. Read the statement and sign and date the form. Return form to the address provided.

| Benefit Options <small>Choice. Value. Health.</small> | | STATE OF ARIZONA BENEFIT OPTIONS RETIREE/LTD ENROLLMENT FORM 2009-2010 | | | |
|--|-----------------------------------|---|---|--|--|
| FOR MEMBERS WITH MEDICARE - attach a copy of your Medicare card | | | | | |
| <input type="checkbox"/> I HAVE MEDICARE PART A | | | <input type="checkbox"/> I HAVE MEDICARE PART B | | |
| <input type="checkbox"/> I DECLINE MEDICAL COVERAGE | | | | | |
| STATEWIDE PLANS (MONTHLY PREMIUM AMOUNTS) | Retiree Only with Medicare | Retiree + ONE: Both with Medicare | Retiree + ONE: One with Medicare, the other without | Retiree + ONE: With Medicare; other dependents without | |
| EPO PLANS | | | | | |
| CIGNA EPO | <input type="checkbox"/> \$400.00 | <input type="checkbox"/> \$795.00 | <input type="checkbox"/> \$927.00 | <input type="checkbox"/> \$1055.00 | |
| AETNA EPO | <input type="checkbox"/> \$400.00 | <input type="checkbox"/> \$795.00 | <input type="checkbox"/> \$927.00 | <input type="checkbox"/> \$1055.00 | |
| AMERIBEN EPO | <input type="checkbox"/> \$400.00 | <input type="checkbox"/> \$795.00 | <input type="checkbox"/> \$927.00 | <input type="checkbox"/> \$1055.00 | |
| UNITEDHEALTHCARE EPO | <input type="checkbox"/> \$400.00 | <input type="checkbox"/> \$795.00 | <input type="checkbox"/> \$927.00 | <input type="checkbox"/> \$1055.00 | |
| PPO PLANS | | | | | |
| AETNA PPO | <input type="checkbox"/> \$714.00 | <input type="checkbox"/> \$1426.00 | <input type="checkbox"/> \$1575.00 | <input type="checkbox"/> \$1792.00 | |
| AMERIBEN PPO | <input type="checkbox"/> \$714.00 | <input type="checkbox"/> \$1426.00 | <input type="checkbox"/> \$1575.00 | <input type="checkbox"/> \$1792.00 | |
| UNITEDHEALTHCARE PPO | <input type="checkbox"/> \$714.00 | <input type="checkbox"/> \$1426.00 | <input type="checkbox"/> \$1575.00 | <input type="checkbox"/> \$1792.00 | |
| NAU Only - Available in ALL Regions | | | | | |
| BCBS of Arizona PPO | <input type="checkbox"/> \$510.55 | <input type="checkbox"/> \$1021.36 | <input type="checkbox"/> \$1080.93 | <input type="checkbox"/> \$1379.41 | |
| <p>*FOR SECUREHORIZONS MEMBERS-SECUREHORIZONS WILL REMAIN IN EFFECT UNTIL 12/31/09. YOU CAN ELECT TO KEEP YOUR CURRENT BENEFITS OR DIS-ENROLL FROM SECUREHORIZONS AND ELECT ONE OF THE OTHER BENEFIT PLANS THAT ARE NOW BEING OFFERED. IF YOU CHOOSE TO KEEP SECUREHORIZONS UNTIL 12/31/09, YOU WILL RECEIVE A COMMUNICATION IN DECEMBER 2009 WITH YOUR OPTIONS FOR CONTINUING YOUR BENEFITS.</p> | | | | | |
| <input type="checkbox"/> I currently have SecureHorizons and elect to continue with my current benefit plan with SecureHorizons until 12/31/09. | | | | | |
| <input type="checkbox"/> I currently have SecureHorizons and elect to continue, however, I am electing a different benefit option with SecureHorizons until 12/31/09. | | | | | |
| <input type="checkbox"/> I elect to dis-enroll from SecureHorizons and elect another benefit plan. | | | | | |
| <i>You must sign and date here if you are electing to dis-enroll from SecureHorizons.</i> | | | | | |
| Signature: _____ Date: _____ | | | | | |
| MARICOPA and PINAL COUNTY | | | | | |
| SecureHorizons High | <input type="checkbox"/> \$258.00 | <input type="checkbox"/> \$512.00 | <input type="checkbox"/> \$738.00 | <input type="checkbox"/> \$863.00 | |
| SecureHorizons Low | <input type="checkbox"/> \$150.00 | <input type="checkbox"/> \$296.00 | <input type="checkbox"/> \$573.00 | <input type="checkbox"/> \$605.00 | |
| PINAL COUNTY | | | | | |
| SecureHorizons High | <input type="checkbox"/> \$258.00 | <input type="checkbox"/> \$512.00 | <input type="checkbox"/> \$738.00 | <input type="checkbox"/> \$863.00 | |
| SecureHorizons Low | <input type="checkbox"/> \$150.00 | <input type="checkbox"/> \$296.00 | <input type="checkbox"/> \$573.00 | <input type="checkbox"/> \$605.00 | |
| COCHISE, COCONINO, GRAHAM, GREENLEE, LA PAZ, YAVAPAI, YUMA COUNTY | | | | | |
| SecureHorizons High | <input type="checkbox"/> \$386.00 | <input type="checkbox"/> \$767.00 | <input type="checkbox"/> \$866.00 | <input type="checkbox"/> \$1033.00 | |
| SecureHorizons Low | <input type="checkbox"/> \$223.00 | <input type="checkbox"/> \$442.00 | <input type="checkbox"/> \$646.00 | <input type="checkbox"/> \$676.00 | |
| PIMA COUNTY | | | | | |
| SecureHorizons High | <input type="checkbox"/> \$258.00 | <input type="checkbox"/> \$512.00 | <input type="checkbox"/> \$738.00 | <input type="checkbox"/> \$863.00 | |
| SecureHorizons Low | <input type="checkbox"/> \$150.00 | <input type="checkbox"/> \$296.00 | <input type="checkbox"/> \$573.00 | <input type="checkbox"/> \$605.00 | |
| SANTA CRUZ COUNTY | | | | | |
| SecureHorizons High | <input type="checkbox"/> \$386.00 | <input type="checkbox"/> \$767.00 | <input type="checkbox"/> \$866.00 | <input type="checkbox"/> \$1033.00 | |
| SecureHorizons Low | <input type="checkbox"/> \$223.00 | <input type="checkbox"/> \$442.00 | <input type="checkbox"/> \$646.00 | <input type="checkbox"/> \$676.00 | |
| <p>I hereby certify, under penalty of perjury, that the information provided in this application for health benefits is correct and true. I am aware that providing false information - including that which is related to my address, spouse, or dependent(s) - may subject me to denial of health benefits, disciplinary action, and prosecution pursuant to ARS 13-2310, 13-2311, 13-2407, 13-2702 and other applicable laws.</p> | | | | | |
| Signature: _____ Date: _____ | | | | | |
| Return form to: ADOA Benefit Services Division, 100 N. 15th Ave., Suite 103 Phoenix, AZ 85007 | | | | | |
| *** BENEFIT SERVICES DIVISION USE ONLY *** | | | | | |
| PLAN NAME: _____ | | | PLAN OPTION CODE: _____ | | |

For questions about open enrollment you may contact the ADOA Benefit Services Division by calling 602.542.5008 or toll-free at 800.304.3687 from 8 a.m. to 5 p.m. Monday through Friday (Arizona Time). You can also email your questions to beneissues@azdoa.gov

CHANGING YOUR BENEFITS

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

Qualifying Life Events

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

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

Submitting a Change Request

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

Effective Date of the Change

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

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

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

Premium Changes Due to QLEs

Any change in premiums due to a QLE will be in effect the 1st of the month following the receipt of all QLE documentation.

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



TURN to...
page 17

For a Flow Chart to help you understand any changes

CONTACT

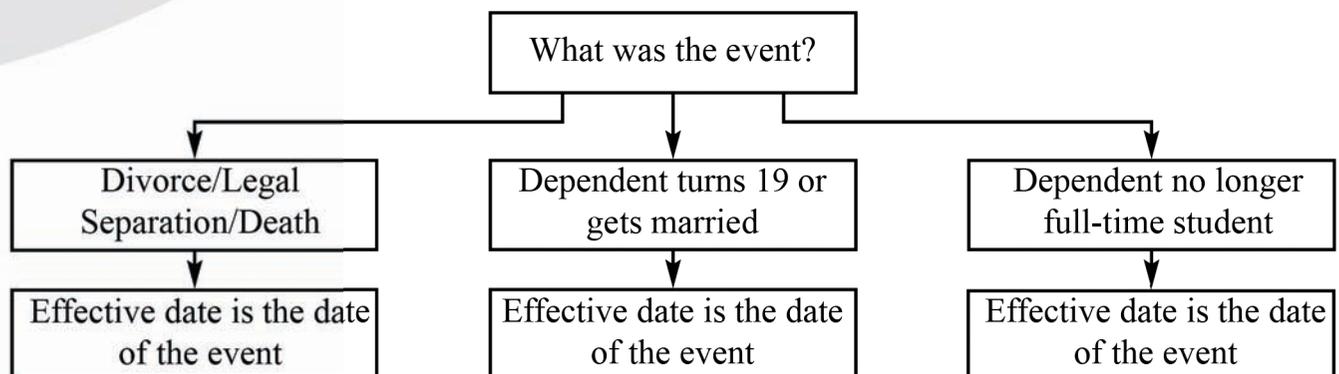
For eligibility questions call the ADOA Benefit Services Division at 602.542.5008 M-F 8:00am-5:00pm

Benefit Options
Choice. Value. Health.

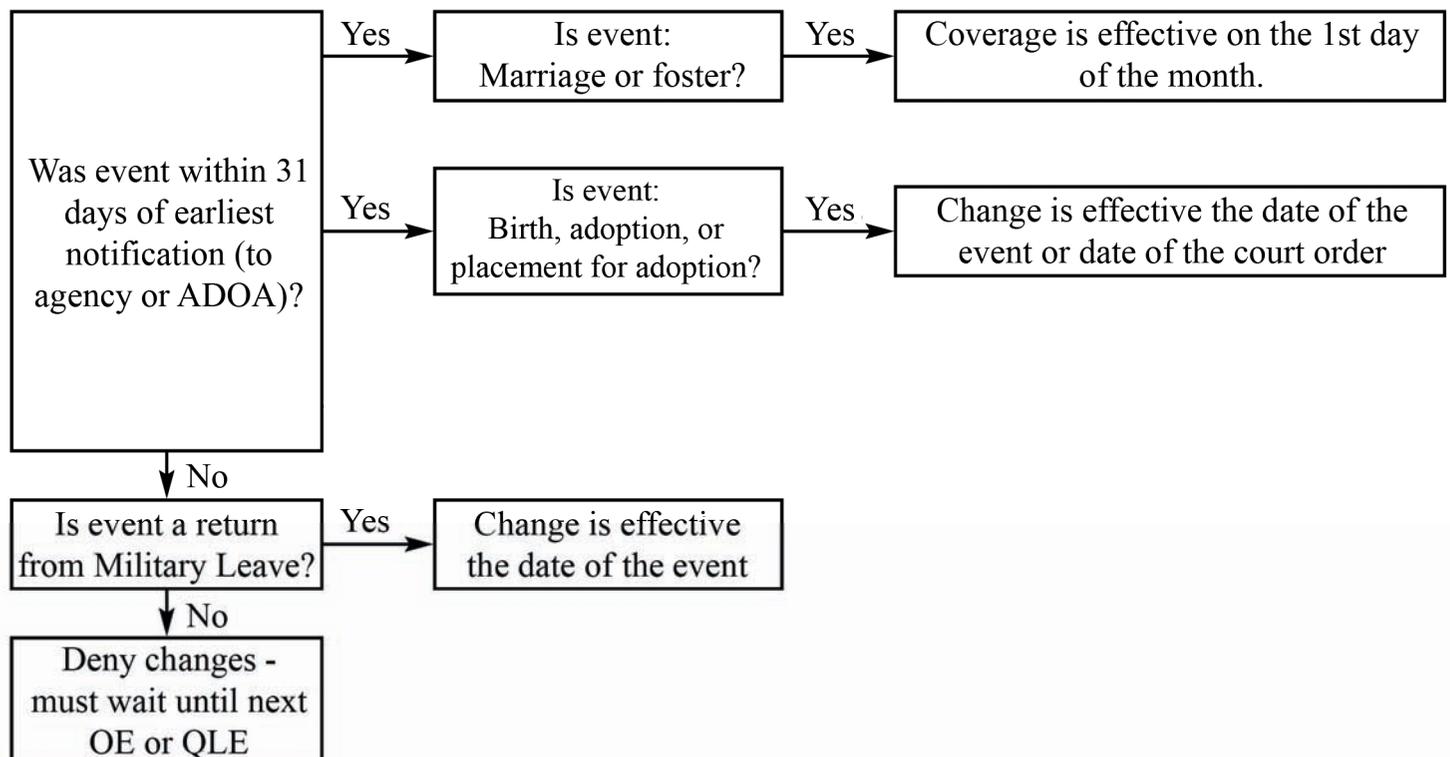
CHANGING YOUR BENEFITS - FLOW CHART

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

LOSING YOUR BENEFITS



ADDING YOUR BENEFITS



SUMMARY OF MONTHLY INSURANCE PREMIUMS

Monthly Medical Premium (Without Medicare)

| | | Premium Payment |
|---|--------------|-----------------|
| EPO (Aetna, BCBS of AZ*, CIGNA & UnitedHealthcare) | Retiree only | \$537 |
| | Retiree +1 | \$1,255 |
| | Family | \$1,691 |
| PPO (Aetna, BCBS of AZ* & UnitedHealthcare) | Retiree only | \$853 |
| | Retiree +1 | \$2,008 |
| | Family | \$2,782 |

Monthly Medical Premium (With Medicare)**

| | | Premium Payment |
|---|----------------------------|-----------------|
| EPO (Aetna, BCBS of AZ*, CIGNA & UnitedHealthcare) | Retiree only | \$400 |
| | Retiree +1 (Both Medicare) | \$795 |
| | Retiree +1 (One Medicare) | \$927 |
| | Family (Two Medicare) | \$1,055 |
| PPO (Aetna, BCBS of AZ* & UnitedHealthcare) | Retiree only | \$714 |
| | Retiree +1 (Both Medicare) | \$1,426 |
| | Retiree +1 (One Medicare) | \$1,575 |
| | Family (Two Medicare) | \$1,792 |

*Blue Cross Blue Shield of Arizona administered by AmeriBen.

**Refer to the Retiree Enrollment form for SecureHorizons Premiums.

ATTENTION: NAU Blue Cross Blue Shield plan rates are not included in this chart, please refer to <http://hr.nau.edu/m/content/view/102/112/> for more information.

SUMMARY OF MONTHLY INSURANCE PREMIUMS

Continued

Monthly Dental Premium

| | | Premium Payment |
|---|--------------|-----------------|
| HMO (Total Dental Administrators) | Retiree only | \$9.96 |
| | Retiree +1 | \$18.92 |
| | Family | \$27.70 |
| PPO (Dental Dental) | Retiree only | \$34.82 |
| | Retiree +1 | \$77.85 |
| | Family | \$131.82 |

Monthly Vision Premium

| | | Premium Payment |
|----------------------------------|--------------|-----------------|
| Insured plan (Avesis) | Retiree only | \$4.83 |
| | Retiree +1 | \$13.52 |
| | Family | \$16.86 |
| Discount card (Avesis) | Retiree | \$0.00 |

UNDERSTANDING YOUR INSURANCE COST



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

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

ESTIMATED MONTHLY PREMIUM WORKSHEET

| | | | |
|--|---|----------------------|----|
| Your monthly medical plan premium | + | <input type="text"/> | A |
| Your monthly dental plan premium | | <input type="text"/> | B |
| TOTAL PREMIUM (A PLUS B) | = | <input type="text"/> | C |
| | | <input type="text"/> | D* |
| Your Total Premium | - | <input type="text"/> | C |
| Your estimated Basic Premium Benefit Subsidy | | <input type="text"/> | D |
| YOUR NET PREMIUM (C MINUS D) | = | <input type="text"/> | E |

**Determine your estimated Premium Benefit Subsidy on page 22 using the chart provided and place it in space D.*

UNDERSTANDING INSURANCE COST Continued

What You Should Know About Premium Payments

You are responsible to pay all premiums; failure to keep your premiums current will result in cancellation of your insurance coverage. If the sum of your premium benefit subsidy and pension is greater than or equal to the total monthly premium, you will be considered a non-direct pay member. Non-direct pay members do not receive a bill.

- If you are an LTD member or Surviving Spouse not receiving a pension check from a recognized state retirement plan, you are a Direct Pay Member. You are responsible for the payment of your premium(s) by the first of each month. The monthly premium is stated on your enrollment form.
- If your monthly pension check has insufficient funds to cover your health insurance premiums, then premiums will not be deducted. You will then become a Direct Pay Member. The ADOA Benefit Services Division will notify your current health plan that you did not make a premium payment for that month and will mail a bill to you. It will be your responsibility to pay any outstanding premiums to the ADOA Benefit Services Division. If you do not receive a bill by the first of the month, you must contact the ADOA Benefit Services Division.

- Should the retirement system begin deducting your premium from your pension check and you have also received a bill as a Direct Pay Member, please contact the ADOA Benefit Services Division. Please see the section entitled, "Information for Direct Pay Members."
- Depending on when the Retirement System receives your benefit elections, you may owe one or more months of health and/or dental premiums. After enrolling, check your pension check deductions. If, by your second pension check, the deduction has not occurred or the deduction is incorrect, immediately contact the ADOA Benefit Services Division at 602-542-5008.

Information for Direct Pay Members

If you are or become a Direct Pay Member, you will receive a billing notice regarding future premium payments. If you do not receive a billing notice within 60 days, please call the ADOA Benefit Services Division at 602-542-5008.



UNDERSTANDING INSURANCE COST Continued

Calculating Your Premium Benefit Subsidy

The Arizona State Retirement System (ASRS), the Public Safety Personnel Retirement System (PSPRS), the Elected Officials Retirement Plan (EORP) and the Corrections Officer Retirement Plan (CORP) may provide a payment toward insurance premiums for eligible members and dependents who elect health coverage through the ADOA Benefit Services Division.

The chart below reflects the monthly premium benefit available for eligible members and their qualified dependents.

Basic Premium Benefit Amounts

| Years of Services | Without Medicare | | With Medicare A & B | | Combinations | |
|---|------------------|----------------------------|---------------------|----------------------------|--|--|
| | Retiree Only | Retiree & Dependents (R&D) | Retiree Only | Retiree & Dependents (R&D) | Retiree & Dependents; one with Medicare, other(s) without Medicare | Retiree & Dependent with Medicare, other dependent(s) without Medicare |
| Arizona State Retirement System (ASRS) Members | | | | | | |
| 5.0-5.9 | \$75.00 | \$130.00 | \$50.00 | \$85.00 | \$107.50 | \$107.50 |
| 6.0-6.9 | \$90.00 | \$156.00 | \$60.00 | \$102.00 | \$129.00 | \$129.00 |
| 7.0-7.9 | \$105.00 | \$182.00 | \$70.00 | \$119.00 | \$150.50 | \$150.50 |
| 8.0-8.9 | \$120.00 | \$208.00 | \$80.00 | \$136.00 | \$172.00 | \$172.00 |
| 9.0-9.9 | \$135.00 | \$234.00 | \$90.00 | \$153.00 | \$193.50 | \$193.50 |
| 10.0+ | \$150.00 | \$260.00 | \$100.00 | \$170.00 | \$215.00 | \$215.00 |
| Elected Officials' Retirement Plan (EORP) Members | | | | | | |
| 5.0-5.9 | \$90.00 | \$156.00 | \$60.00 | \$102.00 | \$129.00 | \$129.00 |
| 6.0-6.9 | \$105.00 | \$182.00 | \$70.00 | \$119.00 | \$150.50 | \$150.50 |
| 7.0-7.9 | \$135.00 | \$234.00 | \$90.00 | \$153.00 | \$193.50 | \$193.50 |
| 8.0+ | \$150.00 | \$260.00 | \$100.00 | \$170.00 | \$215.00 | \$215.00 |
| Corrections Officer Retirement Plan (CORP) Members | | | | | | |
| No restrictions on years of service | \$150.00 | \$260.00 | \$100.00 | \$170.00 | \$215.00 | \$215.00 |
| Public Safety Retirement System (PSPRS) Members | | | | | | |
| No restrictions on years of service | \$150.00 | \$260.00 | \$100.00 | \$170.00 | \$215.00 | \$215.00 |

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

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

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



UNDERSTANDING INSURANCE COST Continued

Your Pension Check

Pension checks are issued by ASRS or PSRS. Before either of the retirement systems print and mail your pension check to you, they apply your premium subsidy (refer to the worksheet on page 20). Once the premium subsidy is added into your pension check, the retirement system pays for your dental premium first. With the money left, ASRS or PSRS will pay for your medical premium.

- If your pension is large enough to cover the cost of both your dental and medical premiums, you will be mailed a check for any remaining money.
- If your pension is not enough to pay for the full cost of your dental and medical premiums you will become a Direct Pay Member.

Please refer to the "Payments" column of the pension check Payment Summary.

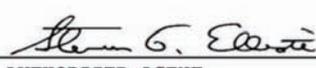
Make note of the inclusion of additional monies reflected in the PREM BEN (basic premium benefit), this amount is the premium benefit to which you may be entitled and it reduces the full monthly medical and/or dental premiums you pay. Also note, under the deductions column, the full health insurance premium for your medical and/or dental coverage (TOT PREM). Though the total premium for health insurance is shown, you are only paying the net premium after the premium benefit is applied.

To help you calculate, use the three step worksheet on page 20. If you feel your pension check is not accurate, you must notify your Retirement System (ASRS or PSRS) as soon as possible. If your enrollment is not processed until after the 5th of the month, it is possible the correct premiums will not be deducted from your pension check until the month following the effective date of your enrollment or change.

(Below is an example of an ASRS pension check for a retiree with ADOA insurance coverage.)

| PAYMENT SUMMARY | | | | | | | |
|-------------------------------|----------|--------------|-------------|--------------------|--------------|----------|--|
| ACCOUNT NUMBER ASRSXXX00XX0XX | | | | DATE OF CHECK | | 01/01/09 | |
| PAYEE NAME JOAN Q PUBLIC | | | | NET PAYMENT AMOUNT | | 2,339.76 | |
| PAYMENTS | CURRENT | YEAR TO DATE | DEDUCTIONS | CURRENT | YEAR TO DATE | | |
| ANNUITY | 2,532.70 | 2,532.70 | FED TAX | 123.00 | 123.00 | | |
| PBI/EPBI | 217.43 | 217.43 | STATE TX AZ | 12.00 | 12.00 | | |
| EXCLUS | 28.63 | 28.63 | TOT PREM | 454.00 | 454.00 | | |
| PREM BEN | 150.00 | 150.00 | TOTAL | 589.00 | 589.00 | | |
| TOTAL | 2,928.76 | 2,928.76 | | | | | |

(Detach Here)

| | |
|---|--|
|  Arizona State Retirement System P.O. Box 33910 Phoenix, AZ 85067-3910 (602) 240-2000 (within metro Phoenix) (520) 239-3100 (within metro Tucson) (800) 621-3778 (toll-free outside metro Phoenix and Tucson) | ASRPMH 60-160/433 |
| | NOT VALID BEFORE OR 180 DAYS AFTER CHECK DATE 01/01/2009 CHECK NUMBER 000012345 |
| PAY...TWO THOUSAND THREE HUNDRED THIRTY NINE DOLLARS 76 CENTS | |
| TO THE ORDER OF: JOAN Q PUBLIC 123 4567-0-0-0XXX 89 W ANY STREET, APT B3 CITY, STATE 01234-5678 | \$*****2,339.76  AUTHORIZED AGENT |
| MELLON BANK N.A. PITTSBURGH, PENNSYLVANIA | |



TURN TO PAGE 21

For more detailed information on Direct Pay members.

DID YOU KNOW

If you are a new Retiree or make changes to your benefit elections during Open Enrollment, do not forget to verify your pension check for the correct premium(s) you pay for the plan(s) you elected.

Benefit Options
Choice. Value. Health.

MEDICARE ADVANTAGE PLAN

SecureHorizons MedicareComplete

SecureHorizons is a MedicareComplete HMO plan for members who are enrolled in Medicare Parts A and B.

SecureHorizons has entered into a contract with the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers Medicare and is regulated by the Arizona Department of Insurance. This contract authorizes SecureHorizons to provide comprehensive health services. By enrolling in

SecureHorizons you make a decision to receive all of your routine health care from SecureHorizons contracted providers. If you receive services from a non-contracted provider without prior authorization, except for emergency services or critical out-of-area services such as renal dialysis, neither SecureHorizons nor Medicare will pay for those services.

If you elect the SecureHorizons plan, you must choose a Primary Care Physician.

SecureHorizons Eligibility

You are eligible for SecureHorizons Plan if:

- At least one member of your household enrolling is Medicare eligible
- You are the primary retiree
- You or your dependent(s) have Medicare Part A and Part B coverage.

SecureHorizons vs. ADOA Benefit Options

The SecureHorizons program is federally approved by Medicare and operates an HMO plan on behalf of Medicare. This is a fully-insured plan designed by SecureHorizons. What the plan covers, copayments, and how the plan operates is contracted and agreed upon between SecureHorizons and Medicare. This is a more managed plan with some restrictions; however, monthly premiums are lower than the other plans offered by Benefit Options.

The other plans offered in the Benefit Options program are self-funded plans and are controlled by ADOA. Although these plans coordinate benefits with Medicare, they are not mandated by Medicare on how the plans operate or what they will cover. These plans offer the same comprehensive benefits as those received by State employees. This is a less managed plan with more flexibility; however, premiums are higher. You do not need to select a Primary Care Physician and may self-refer to see a specialist. All providers must be contracted within the network you select.

Statement of Understanding (SOU)

Any Retirees, LTD members, Surviving Spouses, and/or dependents who have Medicare Parts A and B and who are enrolling in the SecureHorizons Plan must complete the Statement of Understanding. The completed SOU must be submitted to the ADOA Benefit Services Division prior to the first day of the month in which coverage becomes effective.



CONTACT

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

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MEDICARE PART A & B

Eligibility

Medicare is health insurance available to people who are:

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

Medicare eligibility is determined by the Social Security Administration. Many people automatically get Part A and Part B. If you get benefits from Social Security, you will get Part A and Part B starting the first day of the month you turn 65. If you are under the age of 65 and disabled, you automatically get Parts A and B after you get disability benefits from Social Security. You should get your Medicare card in the mail 3 months before your 65th birthday or your 25th month of disability.

Eligibility Notification

If you become eligible to receive Medicare due to a disability, receive your Medicare card prior to your 65th birthday, or there is a change in your Medicare status, you must contact the ADOA Benefit Services Division with this information. When you receive your new Medicare card, you must provide a copy of it to the Benefit Services Division. Medicare does not communicate directly with ADOA.

Parts of Medicare

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

Medicare Part A (Hospital Insurance)

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

Medicare Part B (Medical Insurance)

- Helps cover doctors' services and outpatient care
- Helps cover some preventative services to help maintain your health (See Chart on page 27)

*Medicare Part C (Medicare Advantage Plans)***

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

*Medicare Part D (Prescription Drug Coverage)***

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

***If you enroll in either a Medicare Part C or Part D plan you will not be eligible for Benefit Options coverage. (Example: If you enroll in the Humana Part D plan, you are not be eligible to enroll with ADOA Benefit Services Division (CIGNA, Aetna, or Blue Cross Blue Shield of Arizona administered by AmeriBen)*



Important

If you elect Medicare Part D you are not eligible to enroll in the ADOA Medical Plan.

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MEDICARE PART A & B

Continued



Medicare Payments

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

Under the ADOA Benefit Options health plan, you will be financially liable for medical costs incurred if you are eligible for but DO NOT take Part B. These costs will not be paid for by your ADOA Benefit Options health plan.

Medicare and ADOA

If you have Medicare during open enrollment, you may elect either the EPO or PPO plan offered at the “with Medicare” premium.

Medicare Primary

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

- Medicare is primary coverage
- Benefit Options is secondary coverage

How it Works

Medicare A and B will only pay 80% of covered charges once you have met your deductible. Physicians often charge patients the remaining portion of the bill that Medicare has not paid. If you enroll in the Benefit Options plan the remaining portion (20%) will be covered since Benefit Options becomes the secondary payor.

The Benefit Options plan also incorporates MedImpact for pharmacy coverage if you elect medical insurance. Through MedImpact pharmacy coverage there are no annual limits or caps on preferred or non-preferred medications. Copays are \$10, \$20, or \$40. (SecureHorizons is not included)

Copays

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

Medicare Crossover Program

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

CONTACT

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

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MEDICARE PART A & B

Preventative Services Checklist

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

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

MEDICARE PART D



The Medicare Modernization Act (MMA) established on January 1, 2006 a voluntary prescription drug benefit known as Medicare Part D. This benefit is offered to all Medicare-eligible Retirees or LTD members enrolled in Medicare Part A, Medicare Part B, or both Parts A and B.

You are not required to enroll in Medicare Part D. If you choose to enroll in a separate Prescription Drug Plan (PDP), you cannot remain enrolled in the ADOA health plan.

Medicare does not allow a Medicare-eligible person to be enrolled in two approved Medicare PDP's at the same time. Although every Medicare eligible person has the protected right to enroll in a separate PDP if he or she wishes to do so. You will need to decide what is right for you and your family.

Low Income Assistance

If you have limited income and resources, you may qualify for extra assistance through Medicare. Most people who qualify will pay no premiums, no deductibles, and will not pay copays over \$5.00 for each prescription. You may qualify if your income is below 150% of the poverty line applicable to the size of the family involved or your resources are less than \$11,990 if you are single or \$23,970 if you are married and living with your spouse. You automatically qualify if you:

- have Medicare and full coverage from a state Medicaid program that currently pays for your prescriptions.
 - get help from your state Medicaid program paying your Medicare premiums (or belong to a Medicare Savings Program).
 - get Supplemental Security Income.
- If you would like more information or to see if you qualify for assistance, call 1.800.722.1213, log on to socialsecurity.gov, or visit your local Social Security Office.

If you qualify for assistance, you will need to disenroll from the ADOA Benefit Options Program. When you receive your confirmation of acceptance, please contact the ADOA Benefit Services Division for more information.

The ADOA Benefit Options program provides equal to or better coverage than what is offered through Medicare Part D:

- You will not have to pay a separate monthly premium for Medicare Part D;
 - You will not have to pay an annual deductible;
 - You will not need to pay a percentage of your prescription costs; and
 - Your medications will remain at the current \$10, \$20, and \$40 copay levels.
- Learn more about our Pharmacy Plan on page 39.

For more information about Medicare Part D visit medicare.gov or call 1.800.633.4227

CONTACT

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

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MEDICAL PLAN INFORMATION



See...

page 30

For information
on Transition of
Care

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.

If you are currently enrolled in SecureHorizons you can choose to decline coverage during this Open Enrollment period or you can elect to continue coverage with SecureHorizons through December 31, 2009. The option for SecureHorizons will be eliminated effective January 1, 2009 or you may elect a new network option.

Understanding Your Options

For the plan year beginning October 1, 2009 retirees will choose from two plans and three networks. 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 associated with your medical benefit.

How the Plans Work

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

The EPO

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 three networks: Aetna, BlueCross 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 out-of-network services. 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.

| | Aetna | BCBS of AZ* | CIGNA | UnitedHealthcare | SecureHorizons |
|--|-------|-------------|-------|------------------|----------------|
| EPO | X | X | X | X | |
| PPO | X | X | | X | |
| SecureHorizons MedicareComplete HMO | | | | | X |

* Blue Cross Blue Shield (BCBS) of Arizona administered by AmeriBen.

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MEDICAL PLAN Continued

Choosing the Best Plan for You and Your Family

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

1. Assess the costs you expect in the coming year including: monthly premiums, copays, and out-of-pocket. Refer to pages 18-19 for monthly premiums and page 36 for the plan comparisons to help determine costs.
2. Determine if your doctors and specialists are contracted with the network you are considering. Each medical network has a website or phone number (listed to the right) for you to determine if your doctor is contracted.
3. Once you have selected which plan best suits your needs and your budget, you may make your benefit elections online at yes.az.gov or by completing the Open Enrollment Form.

Transition of Care (TOC)

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



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MEDICAL ONLINE FEATURES

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

Aetna (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 detailed claims status and Claim Explanation of Benefits (EOB) statements.

ID Card

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

Aetna IntelliHealth

You will have 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:

Claims Inquiry

View and read the detailed status of all medical claims submitted for payment.



DID YOU KNOW?

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

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MEDICAL ONLINE FEATURES Continued

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

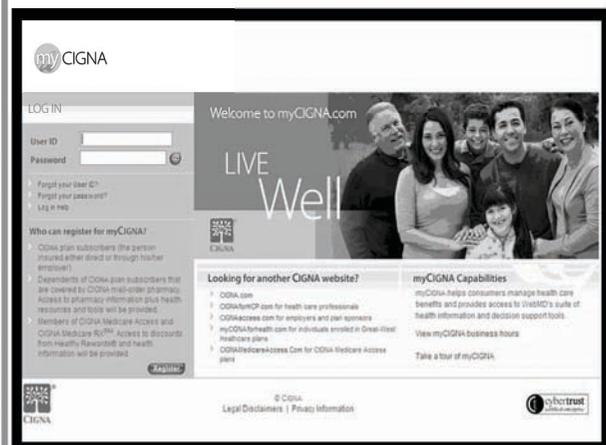
Order a new ID card or print a temporary one.

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.



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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MEDICAL ONLINE FEATURES Continued

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

UnitedHealthcare *(myuhc.com)*

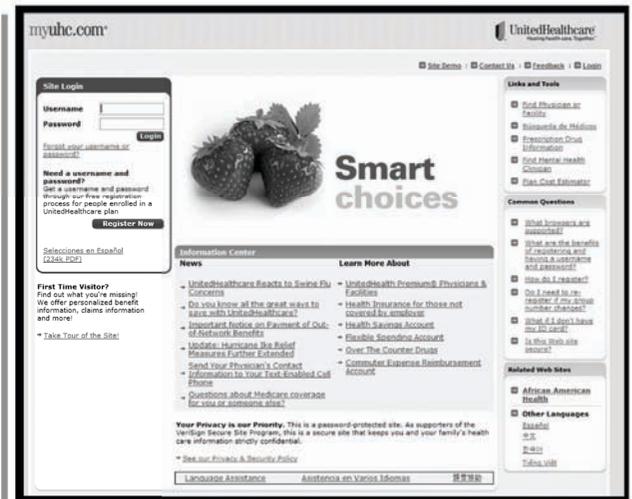
Provider Search

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.



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MEDICAL ONLINE FEATURES Continued

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.

SecureHorizons

SecureHorizons members can view the following information on securehorizons.com:

Provider Search

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

24 Hour Health Information

SecureHorizons' 24-hour Health Information program offers valuable information about medical conditions, health, and lifestyle management. Members can access tools, diaries, and calendars.

Take Charge Programs

Tools and information to help you take charge of diabetes, depression, heart conditions, anti-smoking assistance, and valuable tips to get the most out of your next doctor's visit.

Pharmacy Information

Information about the RX Solutions pharmacy program, mail order service, formulary information and generic drug information.

Resource Center

Valuable information for caregivers; informative articles on health-related topics and how to get the most out of your health care; and internet links to a variety of health-related organizations.



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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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 PLANS COMPARISON CHART

| | | 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*

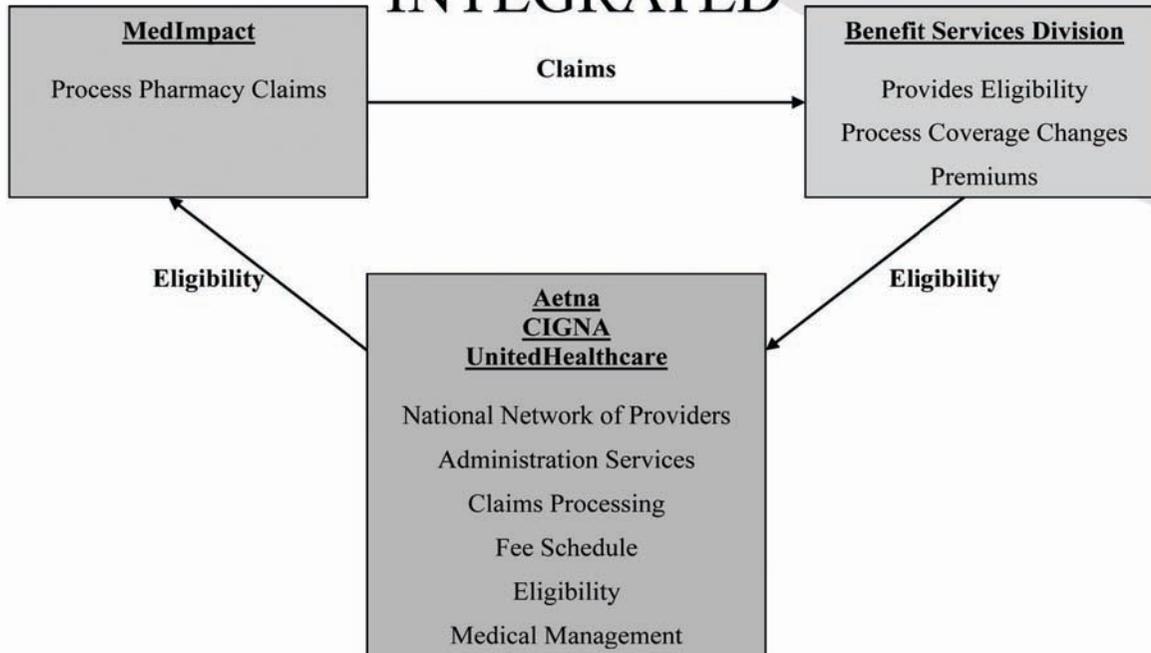
MEDICAL PLANS COMPARISON CHART Continued

| SecureHorizons | | |
|--|--|---|
| High Option Low Option | | |
| SecureHorizons is offered in Cochise, Coconino, Graham, Greenlee, La Paz, Maricopa, Pinal, Pima, Santa Cruz, Yavapai and Yuma counties | | |
| Deductible/Maximums | In-Network (Copayments) | In-Network (Copayments) |
| PCP required for each member? | Yes | Yes |
| PCP referral required to see a specialist? | Yes | Yes |
| Plan year deductibles | None | None |
| Individual | None | None |
| Retiree+one /family | None | None |
| Out-of-pocket maximums | None | \$2,400 |
| Individual | None | per person |
| Retiree+one/family | None | per person |
| Lifetime maximums | None | None |
| Physician services | PCP \$10 copay | PCP \$10 copay |
| Office visits/consultations | PCP \$10 copay | PCP \$10 copay |
| <i>Specialist visits (new copay)</i> | Specialist -\$10 copay | Specialist -\$20 copay |
| Mammography screening (coverage based on patient age or threat) | None | \$10 copay |
| Outpatient services freestanding ambulatory facility or hospital outpatient surgical center | None | \$125 copay |
| Hospitalization services room & board (private room when medically necessary) | None | \$500 copay |
| Intensive care | None | \$500 copay |
| Surgeons and assistants, anesthesiologists, pathologists, radiologist | None | None |
| Emergency care urgent center care | \$20 copay | \$35 copay |
| Emergency room (new copay) | \$50 copay | \$50 copay |
| Ambulance (for medical emergency or required interfacility transport) | None | \$100 |
| Chiropractic | \$10 copay; Medicare covered services | \$20 copay; Medicare covered services |
| Pre-existing conditions | Covered | Covered |
| Durable medical equipment | \$0 | 20% coinsurance |
| Behavioral health | | |
| Outpatient | \$10 copay | \$10 -Group Visit \$20 -Individual Visit |
| Inpatient | \$0; limit of 190 days lifetime | \$500 copay; limit of 190 days lifetime |

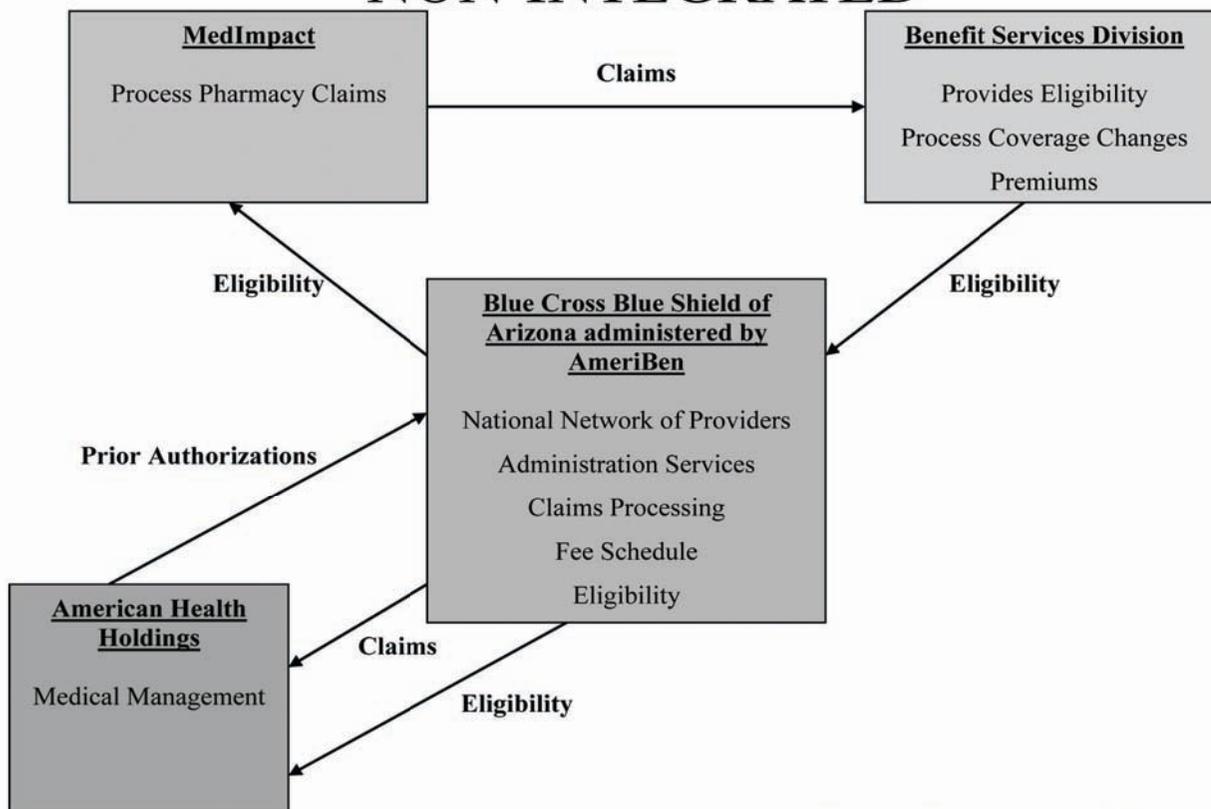
For NAU only BCBS PPO plan details go to <http://hr.nau.edu/m/> and choose benefits, health, BCBS plan book.

INTEGRATED & NON - INTEGRATED*

INTEGRATED



NON-INTEGRATED



*SecureHorizons is a fully insured plan

INTEGRATED/NON-INTEGRATED

MEDICAL MANAGEMENT



TAKE NOTE

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

Benefit Options
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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), CIGNA, Aetna, and OptumHealth. Each vendor serves their specific members based on the medical network you select during Open Enrollment.

The four vendors provide medical management services as follows:

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

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, CIGNA, Aetna, 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

CIGNA 1.800.968.7366

Aetna 1.888.632.3862

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:

MEDICAL MANAGEMENT

Continued



- 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 listed, 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.

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 Benefit Options 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

CIGNA 1.800.968.7366

Aetna 1.800.556.1555

OptumHealth 1.800.401.7396

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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 | Co-pay |
|---------------|--------|
| 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 a medical plan and there is no separate cost.

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 them 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.

Generic and brand name medications

If a name brand medication is prescribed by a physician as "substitution permissible" and a generic version of the medication is

available, members who elect to purchase the brand name medication will pay the copay and the difference between the cost of the brand-name medication and the cost of the generic version.

For example: The cost of a brand name medication is \$100 and the cost of the generic version is \$30 with a \$10 copay. When prescribing the medicine, if the physician indicates that either the brand name or the generic equivalent is acceptable, then the cost for the brand name will be \$80 (\$100 brand name - \$30 generic +\$10 copay) if the member elects the brand name, or \$10 for the generic version. If the physician specifically prescribes the brand name to the member and does not allow for any substitution of a generic version, the member will have to **pay the generic copay and the difference between the cost of the brand name and the generic.**

Generic drugs help you save money without compromising quality. The United States Food and Drug Administration (FDA) require generics to be as safe and effective as their brand name counterparts. Nearly 50% of all prescriptions in the U.S. are now filled with generic medications. Your doctor may choose to prescribe a generic for you, or, if he or she recommends a brand name, you can ask if a generic is available. Pharmacists will usually substitute a generic for a brand name, unless otherwise directed by your doctor or prohibited by law. You will pay the lowest copay for generic drugs. Generic drug prices on average are 20 to 50 percent lower than their brand-name counterparts,

PHARMACY PLAN INFORMATION Continued

so your choice of generics can help keep the Plan's costs down and benefits high.

Formulary

A formulary is a 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 for the medications you need, which saves money for you and your Plan.

Finding a Pharmacy

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

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

Health Management

Programs

Before attempting to have a new prescription filled, it is recommended that

you check MedImpact's online formulary to see if the medication might be categorized under one of the following Health Management Programs:

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.

For a complete list of drugs under this program please refer to the formulary at benefitoptions.az.gov.

Medications for the following conditions through the Specialty Pharmacy Program include, but are not limited to:

- Cystic Fibrosis
- Multiple Sclerosis
- Rheumatoid Arthritis
- Prostate Cancer
- Endometriosis
- Enzyme Replacement
- Precocious Puberty
- Osteoarthritis
- Viral Hepatitis
- Asthma

Step Therapy Program

Step therapy is a program which promotes the use of safe, cost-effective and clinically appropriate medications.



CONTACT

Customer service representatives are available 24 hours a day, 7 days a week at 1.888.648.6769 to help you find a nearby pharmacy

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PHARMACY PLAN INFORMATION Continued

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.

Pharmacy Mail Order Service

A convenient and less expensive mail order service is available for retirees who require medications for on-going health conditions or who will be in an area with

no participating retail pharmacies for an extended period of time.

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

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

Limited Prescription Drug Coverage

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



TAKE NOTE

The list of Medications in the formulary have changed this year. For a complete list visit www.benefitoptions.az.gov

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PHARMACY PLAN INFORMATION Continued



CONTACT

For complete information on your NAU BCBS prescription drug benefit visit <https://hr.nau.edu/m/>
Go to Benefits Health, BCBS Plan Book

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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 |

SecureHorizons Members

If you elect the SecureHorizons plan, Prescription Solutions will provide your pharmacy benefits. Prescription Solutions, a wholly-owned subsidiary of SecureHorizons, offers benefits at a network of local pharmacies.

Prescriptions Solutions Formulary

The SecureHorizons formulary with Prescription Solutions is a list of outpatient prescription drugs that are covered by SecureHorizons when prescribed by a SecureHorizons contracting provider and filled at a SecureHorizons contracting pharmacy. Your physician should have a copy of the formulary and will use it as a reference when prescribing medications. The formulary is available for view at: securehorizons.com when you select the "Standard Retiree Formulary" link.

Prescription Solutions Website

SecureHorizons members can view additional pharmacy information by registering online at rxsolutions.com.

Login for the following:

- Copay and Drug Information
- Formulary Search
- Download the Formulary
- Locate a Nearby Pharmacy

NAU Retiree BCBS

Member only

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

The BCBSAZ Prescription Medication Guide can be used to determine your copayment and this guide can be found on the BCBS website at <http://www.bcbsaz.com/Medications/Tiered-Copay-Plans.aspx>. Go to 4 level prescription drug benefits.

Up to a 90-day supply of maintenance drugs (the same drug and drug strength) may be obtained through the Prescription Drug Mail-Order Program. Maintenance drugs are drugs you take consistently. The copayment for the 90-day supply is equivalent to two month's copayment.

PHARMACY ONLINE FEATURES

Members can view pharmacy information by visiting benefitoptions.az.gov and clicking the pharmacy link.

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.

Generic Resource Center

Learn more about generic drugs and savings opportunities.

Choice90

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

NAU Retirees only Blue Cross/Blue Shield Members

Refer to more information by accessing Blue Net, BlueCross/ BlueShield of Arizona's online member website at www.bcbsaz.com. Information on the pharmacy plan and copayment levels for prescriptions can be found at <http://www.bcbsaz.com/Medications/Tiered-Copay-Plans.aspx> go to 4-level prescription drug benefit.



**DID YOU
KNOW?**

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

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PHARMACY BENEFITS SUMMARY

| | ADOA Benefit Options (Aetna, Blue Cross Blue Shield of Arizona administered by Ameriben, CIGNA, UnitedHealthcare) | BC/BS NAU Only www.bcbsaz.com |
|-----------------------------------|--|--|
| Pharmacy Benefits Administered By | MedImpact | Blue Cross / Blue Shield |
| Retail Requirements | In-Network pharmacies only: one copay per prescription | In-network only: one copay per prescription |
| Mail Order | Two copays for 90-day supply | One copay for 90-day supply |
| Choice90 | Two & 1/2 copays for 90-day supply | None |
| Generic | \$10 copay | \$7 copay |
| Preferred Brand | \$20 copay | \$20 "brand" |
| Non-Preferred Brand | \$40 copay | \$40 for non-preferred brand "A" \$80 for non-preferred brand "B" |
| Annual Maximum | None | None |

| | SecureHorizons High Option | SecureHorizons Low Option |
|-------------------------------------|---|---|
| Pharmacy Benefits Administered by : | Prescription Solutions | Prescription Solutions |
| Retail Requirements | In-network only: one copay per prescription | In-network only: one copay per prescription |
| Mail Order | Two copays for 90-day supply | Two copays for 90-day supply |
| Generic | \$7 copay | \$20 copay |
| Preferred Brand | \$20 "brand" | \$40 "brand" |
| Non-preferred Brand | Not Covered | Not Covered |
| Annual Maximum | None | None |

DENTAL PLAN INFORMATION

While many of the Benefit Options vendors have changed this year, the dental plans remain the same. A brief description of the dental plans available through Benefit Options is provided below.

Dental Plan Options

Employees may choose between two plan types. They are the Prepaid/DHMO and the Indemnity/Preferred Provider Organization (PPO) plan. 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 a 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 option you are considering.



HOW TO...

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

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DENTAL PLAN Continued & ONLINE FEATURES

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

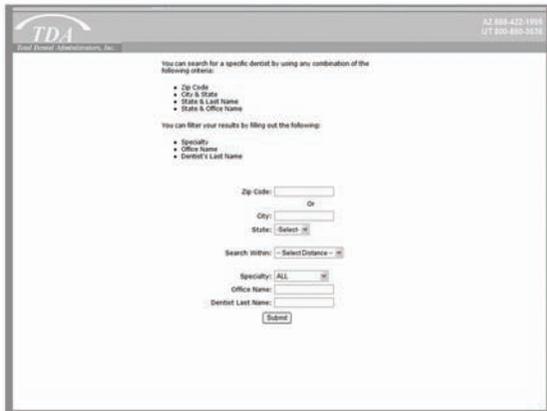
New enrollees should receive a card within 10-14 business days after the benefits become effective.

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 date 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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DENTAL PLANS COMPARISON CHART

| | 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 | |
| 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.

VISION PLAN INFORMATION

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 under 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 under 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.



DID YOU KNOW?

Healthy vision is an important part of your overall wellness!

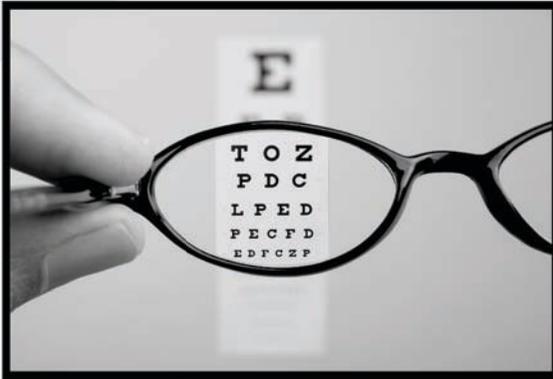
DID YOU KNOW?

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

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VISION PLAN continued & ONLINE FEATURES

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



Online Features

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

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

Search for Providers

Search for contracted network providers near your location.

Benefit Summary

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

Print an ID Card

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

Verifying Eligibility

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

Glossary

You can learn about vision terminology.

Facts on Vision

Learn about different vision facts.

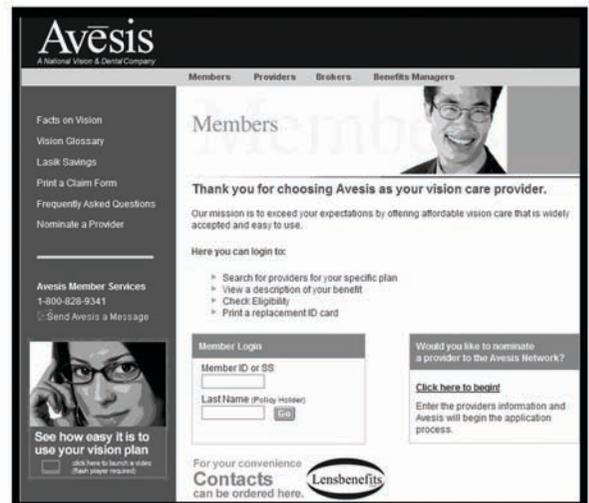
Claim Form

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

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 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.*

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>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.

LONG TERM DISABILITY MEMBERS



DID YOU KNOW?

Members receiving Long Term Disability are considered “Retirees” in our system

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

No Longer Eligible for LTD Benefits and Not Able to Retire

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

Returning to Work

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

Waiver of Premiums

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

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

Disability Benefits from Social Security and Eligibility for Medicare

If you have been receiving disability benefits from Social Security or the Railroad Retirement Board for 24 months, you will be automatically entitled to Medicare Part A and Part B beginning the 25th month of the disability benefit entitlement. You will not need to do anything to enroll in Medicare. Your Medicare card will be mailed to you about 3 months before your Medicare entitlement date. You must mail a copy of your Medicare card to the ADOA Benefit Services Division within 31 days of receiving the card.

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

Receiving Social Security Disability

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

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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 their 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 full-time 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 retirees 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.

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QUESTIONS & ANSWERS

Continued

Domestic Partners - Continued

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*

Audit process

15. Will you be auditing the benefit elections for every employee?

Answer: Any employee with dependents will be considered for audit.

16. 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

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

Transition of Care

18. I am currently undergoing treatment. What happens if my current doctor is not a member of the new network? *Answer: Please refer to page 30 for information about transition of care.*



COBRA COVERAGE NOTICE



DID YOU KNOW?

A Qualified Beneficiary eligible for COBRA is generally a dependent covered under the State of Arizona Benefit Options plan by the time of the qualifying event

COBRA coverage is available when a “qualifying event” occurs that would result in a loss of coverage under the health plan, such as 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 a retiree 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 and vision). 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 retiree’s spouse may elect COBRA coverage even if the retiree 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, and vision) 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).

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COBRA COVERAGE NOTICE

Continued



TAKE NOTE

COBRA will generally last 18 months for a qualified beneficiary

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. If the retiree became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the retiree) 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. In the case of a loss of coverage due to a retiree'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.

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

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing COBRA coverage, under another group health plan (but only after any applicable pre-existing condition exclusions of that other plan have been exhausted or satisfied),
- the State ceases to provide any group health plan for its employees; or
- during a disability extension period (explained on page 61), the disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled.

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COBRA COVERAGE NOTICE Continued



TURN to...
page 62

To learn more
about COBRA
coverage cost

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 the 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 pre-existing 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 pre-existing 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.

Disability

If any of the qualified beneficiaries is determined by the Social Security Administration to be disabled, the maximum COBRA coverage period (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 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.

You must also provide this notice within the original 18 months of COBRA coverage obtained due to the loss of coverage in order to be entitled to a disability extension.

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COBRA COVERAGE NOTICE

Continued



DID YOU KNOW?

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

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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 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.

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 retiree'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 retiree, divorce or legal separation from the covered retiree, 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.

COBRA COVERAGE NOTICE Continued



TAKE NOTE

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

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 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 current month.

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.

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COBRA COVERAGE NOTICE

Continued

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 the month. However, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that your coverage will be suspended.

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

More Information About Individuals Who May Be Qualified Beneficiaries

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



CONTACT

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

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COBRA COVERAGE NOTICE Continued

Alternative Recipients Under QMCSOs

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

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 health plan 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

HIPAA NOTICE

Continued



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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services and compliance programs;

- Business planning and development including cost management and planning analyses and formulary development. In addition, summary health information may be provided to third parties in connection with the solicitation of health plans or the modification or amendment of the existing plan;

- Business management and general administrative activities of Arizona Benefit Options, including customer service and resolution of internal grievances.

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

For Treatment Alternatives

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

For Distribution of Health-Related Benefits and Services

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

When Legally Required

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

To Conduct Health Oversight Activities

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

In Connection With Judicial and Administrative Proceedings

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

For Law Enforcement Purposes

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

In the Event of a Serious Threat to Health or Safety

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

For Specified Government Functions

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

For Workers Compensation

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

Authorization to Use or 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

HIPAA NOTICE

Continued



DID YOU KNOW?

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

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

Right to an Accounting

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

Right to a Paper Copy of this Notice

You have a right to request and receive a paper copy of this Notice at any time, even

if you have received this Notice previously or agreed to receive the Notice electronically.

Benefit Options Duties

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

Changes to this notice

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

Complaints

You have the right to express complaints to Benefit Options and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Benefit Options encourages you to express any concerns you may have regarding the privacy of your information. **Note:** You will not be penalized or retaliated against in any way for filing a complaint.

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HIPAA NOTICE

Continued

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 www.benefitoptions.az.gov.

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.



GLOSSARY



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 36 and 37.

CONTACT

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

Benefit Options
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GLOSSARY

Continued



Dependent

An individual other than a health plan subscriber who is eligible to receive health-care 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.

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.

GLOSSARY

Continued



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.

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.

CONTACT

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

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