ARIZONA DEPARMENT OF ADMINISTRATION

BENEFIT SERVICES DIVISION

2013

Retired State Employees **Benefits Guide**

In This Guide:

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

Benefit Options

Choice Value Health

CONTACTS

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

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

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

Blue Cross Blue Shield of Arizona network administered by AmeriBen
1.866.955.1551
www.myameriben.com
Policy Number 1009013

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

UnitedHealthcare
1.800.896.1067
myuhc.com
Policy Number 705963

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

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

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

Vision Plan
Avesis, Inc.
1.888.759.9772
www.avesis.com
Advantage
Policy Number 10790-1040
Plan Number 938AZ
Discount Policy Number 10000-4
Plan Number 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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Welcome to the 2013 Retired Employee Benefit Guide!

This guide describes the benefits offered by the State of Arizona, Department of Administration, Benefit Services Division's comprehensive benefits package "Benefit Options" effective January 1, 2013. Included in this reference guide, are explanations of the benefits programs, important plan information, contact addresses, phone numbers, web addresses, and comparison charts. This guide is intended to help you understand your benefits.

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

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

DATES & EVENTS

Ask Questions. Learn More. Get Screened. Would you like to know more about your 2013 benefits? The Benefit Options vendors will be on location to answer your questions. Speak with the benefit vendors face-to-face and participate in a free health screening or get a free flu shot at a Benefit Expo near you. This year we have added a special A1c diabetes screening as part of our wellness initiative. All Benefit Expo dates, times, and locations are listed below.

Phoenix
October 20, 2012 9am-3pm
Phoenix Convention Center
North Building
100 N. 3rd St., Phoenix, AZ 85004
Parking: East Garage (on 601E. Washington Street). Parking pass will be provided at the expo for all attendees.

Phoenix
October 22, 2012 9am-3pm
Senate Lawn
1700 W. Washington, Phoenix, AZ 85007
(17th Ave between Jefferson St and Adams St.)

Flagstaff
October 23, 2012 9am-3pm
Radisson Woodlands Hotel
1175 W. Route 66, Flagstaff, AZ 86001
Parking: Free hotel parking

Phoenix
October 24, 2012 9am-3pm
Phoenix Convention Center
North Building
100 N. 3rd St., Phoenix, AZ 85004
Parking: East Garage (on 601E. Washington Street). Parking pass will be provided at the expo for all attendees.

Glendale
October 25, 2012 9am-3pm
Renaissance Hotel
9495 W. Coyotes Blvd., Glendale, AZ 85305
Parking: The hotel garage is reserved – no parking pass is required. Parking across the street at the jobing.com parking lot is prohibited and is a tow-away zone.

Tucson
October 27, 2012 9am-3pm
Marriott Tucson University Park
880 East 2nd Street, Tucson, AZ 85719
Parking: Covered parking is available in the adjacent University of Arizona parking garage. Please advise parking attendant you are attending the ADOA Benefits Expo upon entering the parking area. Parking pass is required.

DATES & EVENTS
Continued

October & November, 2012

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
15	16	17	18	19	20 Phoenix Convention Center
22 Open Enrollment Starts Phoenix - Senate Lawn	23 Flagstaff Radisson Woodlands	24 Phoenix Convention Center	25 Glendale Renaissance Hotel	26	27 Tucson Marriott Hotel University Park
29	30	31	1	2	3
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OPEN ENROLLMENT INFORMATION

Open Enrollment will begin Monday, October 22, at 8 a.m. and will end Friday, November 16, at 5 p.m. (Arizona time). During the 2013 Open Enrollment, you will have the opportunity to make changes to your benefits for the plan year beginning January 1, 2013.

You must make a selection for dental coverage.

Changes made during Open Enrollment will be effective for the plan year beginning January 1, 2013 and ending December 31, 2013.

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

Benefit Options Wellness will also be offering free screenings and free flu shots as part of your BeWell Benefit. The Benefit Expo dates, times, and locations can be found on the "Dates and Events" pages of this guide (pages 1-2).

Information for Open Enrollment
Your 2013 Open Enrollment benefit elections can be made online using the YES website or by filling out an enrollment form. Instructions are on pages 12-15 of this guide entitled "Where to Enroll."

You will need the following information:

- Your State issued Employee Identification Number (EIN). You can contact the Benefit Services Division at 602.542.5008 to obtain your EIN.
- Dependents' names, dates of birth and Social Security Numbers. You will need this information to add eligible dependents to your benefits coverage.

Other documentation may also be necessary in certain circumstances. Please refer to the Eligibility section of this guide on pages 8-11 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) within 31 days, such as a marriage, divorce, birth, death, or change in employment status for you or your spouse. QLEs are outlined in more detail at *benefitoptions.az.gov.*

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

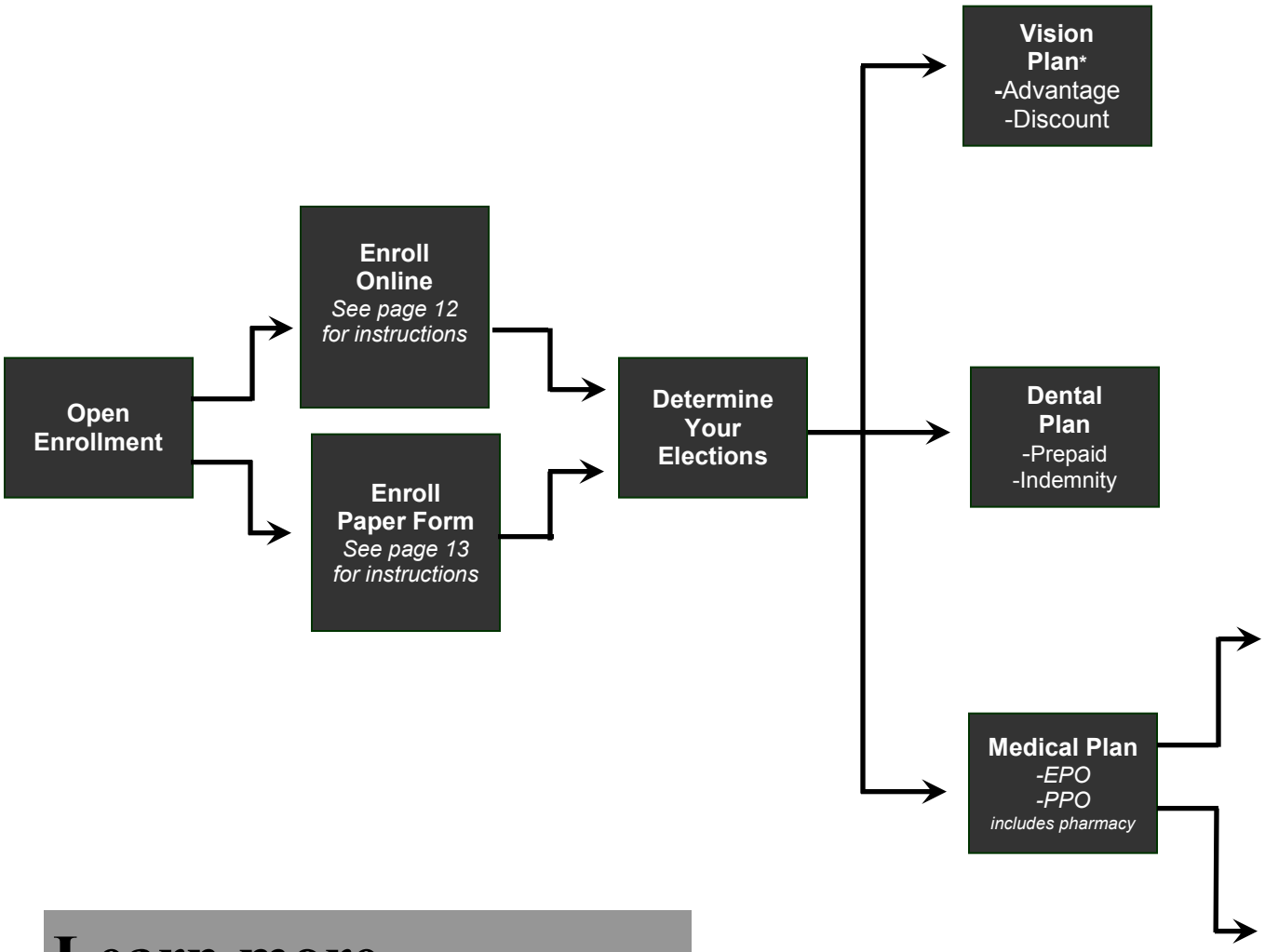
OPEN ENROLLMENT INFORMATION Continued

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 BenefitsIssues@azdoa.gov.

Persons with a disability may request reasonable accommodations by contacting the ADOA Benefit Services Division. If you need this information in an alternate format, please call 602.542.5008, Option 2.

2013 RETIREE



Learn more…

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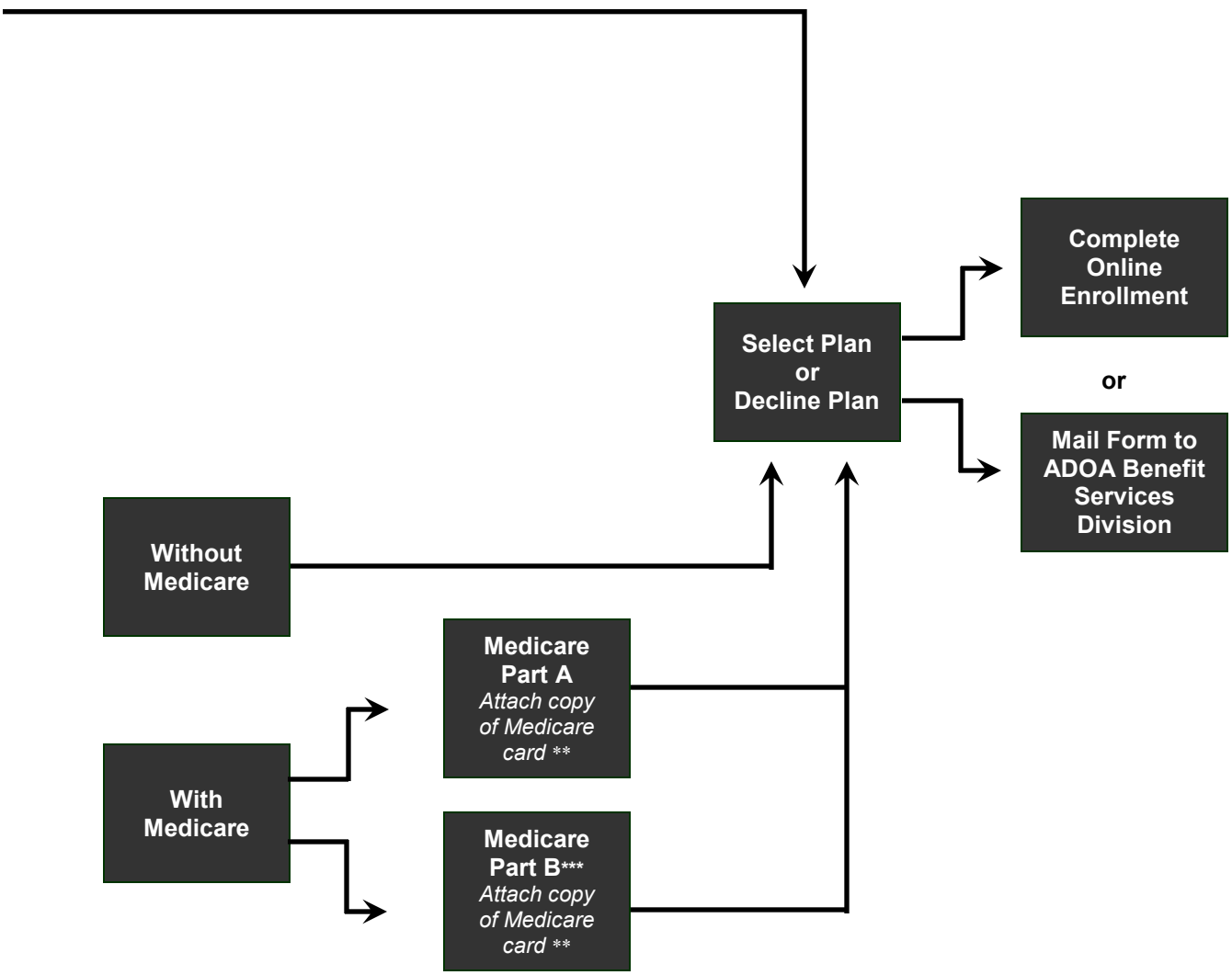
Pharmacy Plan Information	page 39
Dental Plan Information	page 45
Vision Plan Information	page 48

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

ENROLLMENT AT-A-GLANCE



BENEFITS CHANGES FOR PLAN YEAR 2013

Medical Plan Changes

Hearing Aid
Hearing aid services will be limited to $1,500.00 per ear, per plan year.

Compression Stockings
Approved for Lymphedema. Coverage will be limited to two pairs upon diagnosis and four replacements per plan year.

Wigs/Hair Pieces
One wig or hairpiece, up to $150.00, will be covered for members diagnosed with Alopecia as a result of chemotherapy, radiation therapy, second and third degree burns.

Autism Spectrum Disorder
Covered treatment will included short-term rehabilitative therapy included in an outpatient facility or physician's office that is part of a rehabilitation program for treatment of Autism Spectrum Disorder, including physical, speech, and occupational therapy subject to the 60 visit benefit limitations.

Dental Plan Changes

Delta Dental PPO plus Premier (self funded)

- New contract implemented for dental effective 1/1/2013.
- New plan tiers: Retiree, Retiree +Adult, Retiree + Child, and Family.
- Lower rates: Retiree +Adult, Retiree + Child, and Family (single rate remains the same).

Benefit Changes:
There will be a six month waiting period for Major Restorative Class III services if the Delta Dental PPO plus Premier plan is not elected upon the initial enrollment opportunity.

*Class III services include: crowns, dentures, inlays, and orthodontia***.**

Preventive Class I services do not apply to the annual benefit limit of $2,000.

Class I services include: office visits, oral exams, cleaning, fluoride treatment, and x-rays.

Total Dental Administrators Pre-Paid (fully funded)

- New contract implemented for dental effective 1/1/2013.
- New plan tiers: Retiree, Retiree +Adult, Retiree + Child, and Family.
- Lower rates: Retiree, Retiree + Adult, Retiree + Child, and Family.
- No waiting period.
- Continued benefits: Pre-diagnostic tests, implants, adult fluoride, and interim partial dentures.

Co-payment change to include lab fees: Replacement of missing/broken teeth, complete denture base, partial denture.

For additional dental services, please see the Dental Plans Comparison Chart on page 47.

ELIGIBILITY

Domestic Partners

Pursuant to a change in Arizona law, A.R.S. § 38-651(O), domestic partners are not eligible dependents under the State of Arizona's benefit plan. As a result, this Arizona law precludes previously qualified same-sex and opposite-sex domestic partners from receiving benefits that were created by administrative rulemaking in Arizona Administrative Code § R2-5-101(22).

Accordingly, the State of Arizona will not be offering benefits to opposite-sex domestic partners.

The State of Arizona intended that this law apply equally to same-sex domestic partners. However, a United States Federal District Court, in *Diaz v. Brewer, et al.* (2:09-cv-02402 JWS), imposed a preliminary injunction preventing the State of Arizona from implementing A.R.S. § 38-651 (O) as applied to qualified same-sex domestic partners. The case is still in litigation and the State intends to defend its right to fully implement the statute and discontinue offering benefits to all domestic partners.

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

As a result of the U.S. District Court preliminary injunction, the State of Arizona is compelled at this time to continue offering benefits to qualified same-sex domestic partners. Qualified same-sex domestic partners are herein ADVISED and CAUTIONED that the preliminary injunction possibly could be lifted after open enrollment or during the 2013 Plan Year. If that were to occur, the State of Arizona would no longer be compelled by the U.S. District Court injunction and the State of Arizona reserves the right to immediately discontinue offering benefits to same-sex domestic partners during the 2013 Plan Year and thereafter. This also would include dependent children of the non-employee qualified same-sex domestic partner unless those individual(s) were an actual dependent of the State employee as defined under the State's benefit plan. **Qualified same-sex domestic partners and their dependents should not have an expectation that coverage will continue or an expectation that the benefits have vested for an entire plan year because the preliminary injunction may be lifted in the future**.

ELIGIBILITY Continued

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 an Open Enrollment period.

C. If you have a qualified dependent that is not currently enrolled in Arizona Benefit Options, he or she may be added during an Open Enrollment period. Dependents not enrolled during Open Enrollment cannot be added until the next Open Enrollment unless there is a Qualified Life Event (QLE). You have 31 days from the QLE to change your enrollment through 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 same-sex domestic partner subject to the following qualifications and proper documentation:

Important Disclosure and Disclaimer:

The State of Arizona is not offering benefits to opposite-sex domestic partners. As a result of the U.S. District Court preliminary injunction (described in detail on page 8 in the "Eligibility" section of this manual), the State of Arizona is compelled at this time to continue offering benefits to qualified same-sex domestic partners. Qualified same-sex domestic partners are ADVISED and CAUTIONED that the preliminary injunction possibly could be lifted after open enrollment or during the 2013 Plan Year. If that were to occur, the State of Arizona would no longer

ELIGIBILITY Continued

be compelled by the U.S. District Court injunction and the State of Arizona reserves the right to immediately discontinue offering benefits to qualified same-sex domestic partners during the 2013 Plan Year and thereafter. This also would include dependent children of the non-employee qualified same-sex domestic partner unless those individual(s) were an actual dependent of the State employee as defined under the State's benefit plan. **Qualified same-sex domestic partners and their dependents should not have an expectation that coverage will continue or an expectation that the benefits have vested for an entire plan year because the preliminary injunction may be lifted in the future**.

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

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

ELIGIBILITY Continued

b. A person under the age of 26 for whom you or your same-sex domestic partner have court-ordered guardianship;
c. Your or your same-sex domestic partner's foster children under the age of 26;
d. A child placed in your home by court order pending adoption;
e. Your or your same-sex domestic partner's natural, adopted and/or stepchild;
   i. Who was disabled as defined by 42 U.S.C. 1382c before the age of 26;
   ii. Who continues to be disabled as defined by 42 U.S.C. 1382c;
   iii. Who is dependent for support and maintenance upon you or your same-sex domestic partner;
   iv. For whom you or your same-sex domestic partner had custody before the child was 26.

Dependent Documentation Requirements

If your dependent child is approaching age 26 and is disabled, application for continuation of dependent status must be made within 31 days of the child's 26th birthday. You will need to provide verification that your dependent child has a qualifying permanent disability, that occurred prior to his or her 26th birthday, in accordance with 42 U.S.C. 1382c.

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 all amounts paid out on behalf of you, the insured. In the event you, as a Benefit Options member, suffer an injury or illness for which another party may be responsible, such as someone injuring you in an accident, and Benefit Options pays benefits as a result of that injury or illness, Benefit Options has the legal right to recover against the party responsible for your illness or injury or from any settlement or court judgment you may receive, up to the amount of benefits paid out by Benefit Options. As a Benefit Options member you are required to cooperate with the vendors acting on behalf of ADOA the during subrogation process. Failure to do so may result in legal action by the State to recover funds received by you.

Return to Work Retirees

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

WHERE TO ENROLL ONLINE

During the Open Enrollment, October 22, through November 16, 2012, benefit elections 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 October 22 through November 16, 2012 only.

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

6. Save and print your confirmation

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 up to a 6 digit number. If you are unsure of your EIN contact 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

6. Save and print your confirmation

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 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.

Benefit Options
Choice Value Health

STATE OF ARIZONA BENEFIT OPTIONS RETIREE/LTD 2013 ENROLLMENT FORM

1.
☐ NEW RETIREE ☐ NEW LTD PARTICIPANT ☐ ADDRESS CHANGE
☐ QUALIFIED LIFE EVENT ☐ TERMINATE INSURANCE

2.
☐ RETIRED ☐ DISABLED
☐ SURVIVING SPOUSE

Retirement System
☐ ASRS (ZA) ☐ PSPRS, CORP, EORP (ZP) ☐ OPTIONAL (ZT)

EFFECTIVE DATE:	DECEASED MEMBER'S NAME:	DECEASED DATE:

MEMBER IDENTIFICATION

3.

LAST NAME, FIRST NAME, M.I.	EMPLOYEE EIN or SSN	☐ MALE ☐ FEMALE	☐ MARRIED ☐ SINGLE	DATE OF BIRTH

STREET ADDRESS	COUNTY OF RESIDENCE

CITY, STATE, ZIP CODE	E-MAIL ADDRESS (Mandatory)

LAST DAY WORKED	DATE RETIRED	MEDICARE ☐ YES ☐ NO	HOME PHONE NUMBER ( )	AGENCY

4.
Are you enrolling a same-sex Domestic Partner? (circle one) Yes or No

To qualify a same-sex 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*.

5.
DEPENDENTS MUST BE LISTED FOR FAMILY COVERAGE

LAST NAME, FIRST NAME, MIDDLE INITIAL	DATE OF BIRTH *(Required)*	RELATIONSHIP CODE S=Spouse D=Same-Sex 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	ADD OR DELETE	Indicate Plan Type Medical(M) Dental(D) Vision(V)
MEMBER:							☐ M ☐ D ☐ V
SPOUSE OR SAME-SEX DOMESTIC PARTNER:							☐ M ☐ D ☐ V
							☐ M ☐ D ☐ V
							☐ M ☐ D ☐ V
							☐ M ☐ D ☐ V
							☐ M ☐ D ☐ V
							☐ M ☐ D ☐ V

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2. Indicate your current status (RETIRED, DISABLED, or SURVIVING SPOUSE), the effective date and the retirement system with which you are affiliated.

3. Complete the MEMBER IDENTIFICATION section.

4. Answer the question regarding enrollment of a same-sex domestic partner, please read the instructions printed on the enrollment form.

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

Persons with a disability may request reasonable accommodation by contacting the Benefit Services Division. If you need this information in an alternate format, please call 602.542.5008, option 2.

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 DECLINE VISION COVERAGE.

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

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

Benefit Options
Choice Value Health

STATE OF ARIZONA BENEFIT OPTIONS RETIREE/LTD
2013 ENROLLMENT FORM

VISION PLAN SELECTION - ONLY AVAILABLE IF MEDICAL AND/OR DENTAL COVERAGE IS SELECTED

VISION PLAN - MONTHLY PREMIUMS AMOUNT

☐ DECLINE VISION COVERAGE

6.

Select A Plan	Retiree Only	Retiree + One	Retiree & Family
Avesis	☐ $4.83	☐ $13.52	☐ $16.86

DENTAL PLANS - MONTHLY PREMIUMS AMOUNT

☐ DECLINE DENTAL COVERAGE

7.

Select A Plan	Retiree Only	Retiree + Adult	Retiree + Child	Retiree & Family
Delta Dental PPO Plus Premier	☐ $35.94	☐ $75.[illegible]3	☐ $60.48	☐ $118.26
Total Dental Administrators	☐ $8.99	☐ $1[illegible]98	☐ $17.51	☐ $26.97

MEDICAL PLANS - MONTHLY PREMIUMS AMOUNT

☐ DECLINE MEDICAL COVERAGE

8.

Select A Plan	Retiree Only	Retiree + One	Retiree & Family
NON MEDICARE EPO PLANS			
AETNA EPO	☐ $593.00	☐ $1387.00	☐ $1869.00
BCBSAZ/AMERIBEN EPO	☐ $593.00	☐ $1387.00	☐ $1869.00
CIGNA EPO	☐ $593.00	☐ $1387.00	☐ $1869.00
UNITEDHEALTHCARE EPO	☐ $593.00	☐ $1387.00	☐ $1869.00
NON MEDICARE PPO PLANS			
AETNA PPO	☐ $943.00	☐ $2219.00	☐ $3074.00
BCBSAZ/AMERIBEN PPO	☐ $943.00	☐ $2219.00	☐ $3074.00
UNITEDHEALTHCARE PPO	☐ $943.00	☐ $2219.00	☐ $3074.00
NAU Only - Available in ALL regions NON MEDICARE			
BCBS of Arizona PPO	☐ $667.06	☐$1334.12	☐ $1867.79

BENEFIT SERVICES DIVISION USE ONLY

PLAN NAME: _____ PLAN OPTION CODE: _____

FOR MEMBERS WITH MEDICARE, MAKE MEDICAL ENROLLMENT SELECTIONS ON THE FOLLOWING PAGE

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EXAMPLE

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

9. Skip to step 12 on the next page.

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. *Medicare card is required if electing a Medicare Plan with ADOA.*

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

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

Benefit Options

STATE OF ARIZONA BENEFIT OPTIONS RETIREE/LTD
2013 ENROLLMENT FORM

FOR MEMBERS WITH MEDICARE - You are required to attach a copy of your Medicare card

10.

☐ I HAVE MEDICARE PART A	☐ I HAVE MEDICARE PART B

MEDICAL PLANS - MONTHLY PREMIUMS AMOUNT - MEDICARE OPTIONS

☐ DECLINE MEDICAL COVERAGE

11.

Select A Plan	Retiree Only with Medicare	Retiree + ONE: Both with Medicare	Retiree + ONE: One with Medicare, the other without	Retiree & Family With Medicare
EPO PLANS				
AETNA EPO	☐ $442.00	☐ $878.00	☐ $1024.00	☐ $1166.00
BCBSAZ/AMERIBEN EPO	☐ $442.00	☐ $878.00	☐ $1024.00	☐ $1166.00
CIGNA EPO	☐ $442.00	☐ $878.00	☐ $1024.00	☐ $1166.00
UNITEDHEALTHCARE EPO	☐ $442.00	☐ $878.00	☐ $1024.00	☐ $1166.00
PPO PLANS				
AETNA PPO	☐ $789.00	☐ $1576.00	☐ $1740.00	☐ $1980.00
BCBSAZ/AMERIBEN PPO	☐ $789.00	☐ $1576.00	☐ $1740.00	☐ $1980.00
UNITEDHEALTHCARE PPO	☐ $789.00	☐ $1576.00	☐ $1740.00	☐ $1980.00
NAU Only - Available in ALL Regions				
BCBS of Arizona PPO	☐ $543.[illegible]	☐ $1086.39	☐ $1210.12	☐ $1492.95

EXAMPLE

If you decline or cancel both medical and dental coverages you will NOT be able to re-enroll with ADOA in the future. If you choose to keep medical or dental coverage through ADOA, you may elect medical and/or dental coverages during future Open Enrollment periods.

12.

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. I hereby acknowledge, I have received the Summary of Benefits and Coverage Documents as part of The Affordable Care Act (ACT).

Signature: _____ **Date:** _____

Return form to: ADOA Benefit Services Division, 100 N. 15th Ave., Suite 103
Phoenix, AZ 85007 or Fax 602-542-4744

***** BENEFIT SERVICES DIVISION USE ONLY *****

PLAN NAME: _____ **PLAN OPTION CODE:** _____

Revised 09/24/2012 Page 3 of 3

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 BenefitsIssues@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, guardianship, death, or dependent eligibility due to age.
C. Changes in employment status or work schedule that affect benefits eligibility for you, your spouse, and/or dependent.

Submitting a Change Request

Requested benefit changes must be submitted in writing to ADOA 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

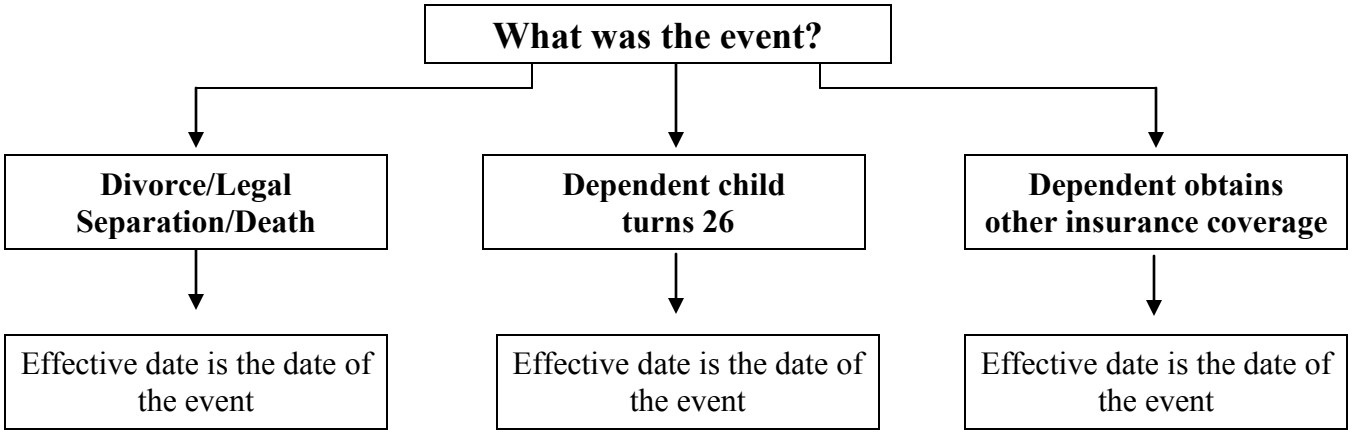
Any change in premiums due to a QLE will be in effect the first of the month following the receipt of all QLE documentation.

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

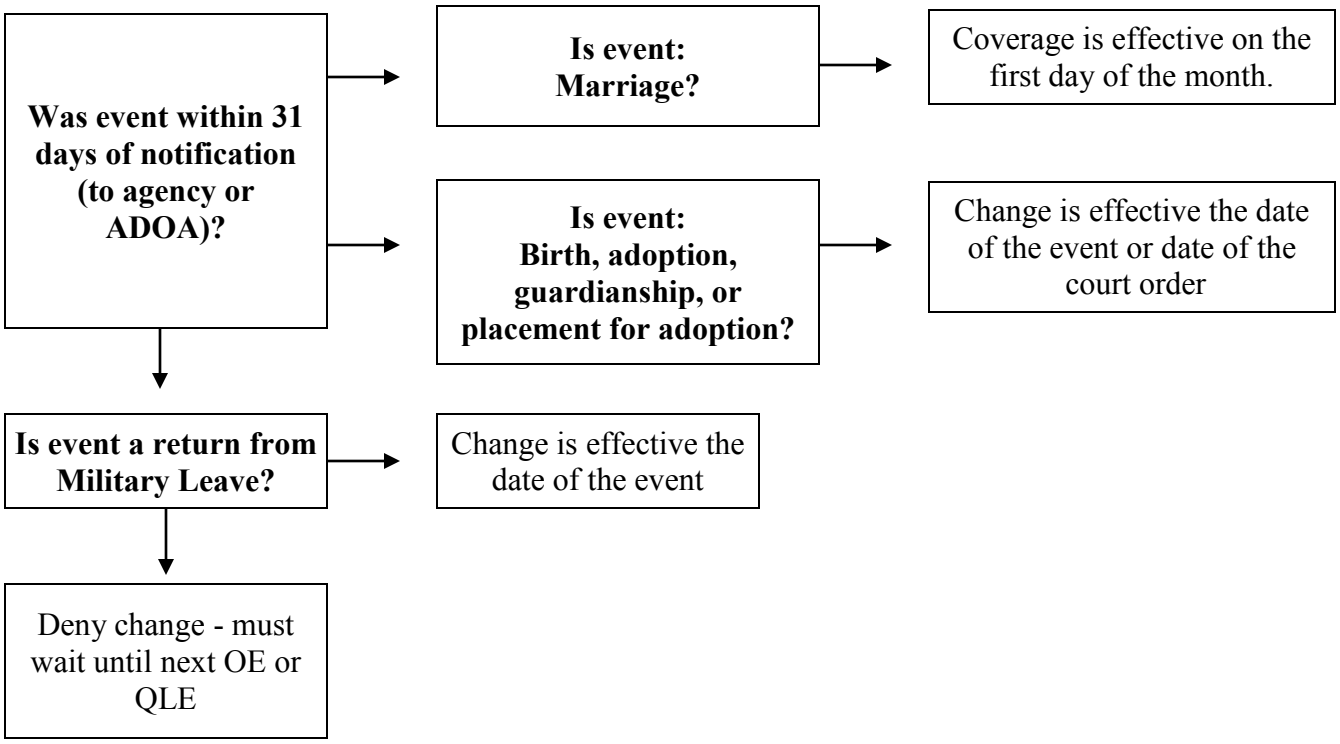
CHANGING YOUR BENEFITS FLOW CHART

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

LOSING YOUR BENEFITS



ADDING YOUR BENEFITS



SUMMARY OF MONTHLY INSURANCE PREMIUMS

Monthly Medical Premiums (Without Medicare)

		Premium Payment
EPO (Aetna, BCBSAZ/AmeriBen*, CIGNA, UnitedHealthcare)	Retiree only	$593
	Retiree +1	$1,387
	Family	$1,869
PPO (Aetna, BCBSAZ/AmeriBen*, UnitedHealthcare)	Retiree only	$943
	Retiree +1	$2,219
	Family	$3,074

Monthly Medical Premiums (With Medicare)

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

For the NAU Blue Cross Blue Shield plan rates visit: http:/hr.nau.edu and choose "Benefits, Health Insurances, Medical (General Health)."

**Blue Cross Blue Shield of Arizona network administered by AmeriBen. Blue Cross Blue Shield, an independent licensee of the Blue Cross Blue Shield Association, provides network access only and does not provide administrative or claims payment services and does not assume any financial risk or obligation with respect to claims. AmeriBen has assumed all liability for claims payment. No network access is available from Blue Cross Blue Shield Plans outside of Arizona.* *See page 38.*

SUMMARY OF MONTHLY INSURANCE PREMIUMS Continued

Monthly Dental Premiums

		Premium Payment
Total Dental Administrators Prepaid	Retiree only	$8.99
	Retiree +adult	$17.98
	Retiree +child	$17.51
	Retiree +family	$26.97
Delta Dental PPO plus Premier	Retiree only	$35.94
	Retiree +adult	$75.63
	Retiree +child	$60.48
	Retiree +family	$118.26

Monthly Vision Premiums

		Premium Payment
Insured plan (Avesis)	Retiree only	$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.

NET MONTHLY HEALTH INSURANCE COST WORKSHEET

Your monthly medical plan premium from page 18			**A**
	+		
Your monthly dental plan premium from page 19			**B**
Total Premium **(A plus B)**			**C**
Your Basic Premium Benefit Subsidy (See chart on page 22)	-		**D**
Your Net Premium (C minus D)	=		**E**

UNDERSTANDING YOUR INSURANCE COST Continued

What You Should Know About Premium Payments

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

- If you are an LTD member or Surviving Spouse not receiving a pension 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 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 twenty-fifth day 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."

New Retirees/LTD Members

- Depending on when the Retirement System receives your benefit elections, you may owe one or more months of health and/or dental premiums. After enrolling, check your pension 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.

Vision Premium Payments

If you elect vision coverage, you will be billed directly from Avesis. Vision premiums are NOT deducted from any pension checks.

UNDERSTANDING YOUR INSURANCE COST Continued

Calculating Your Premium Benefit Subsidy

The Arizona State Retirement System (ASRS), the Public Safety Personnel Retirement System (PSPRS), the Elected Officials Retirement Plan (EORP) and the Corrections Officer Retirement Plan (CORP) may provide payment toward insurance premiums for eligible members and dependents who elect health coverage through the ADOA Benefit Services Division. The chart below reflects the maximum monthly premium benefit available for eligible members and their qualified dependents.

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

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

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

Basic Premium Benefit Amounts

	WITHOUT MEDICARE		WITH MEDICARE A & B		COMBINATIONS	
Years of Service	Retiree Only	Retiree & Dependents	Retiree Only	Retiree & Dependents	Retiree & Dependents One with Medicare, the other(s) without	Retiree & Dependent with Medicare, other dependents without
Arizona State Retirement System (ASRS) Members						
5.0–5.9	$75.00	$130.00	$50.00	$85.00	$107.50	$107.50
6.0–6.9	$90.00	$156.00	$60.00	$102.00	$129.00	$129.00
7.0–7.9	$105.00	$182.00	$70.00	$119.00	$150.50	$150.50
8.0–8.9	$120.00	$208.00	$80.00	$136.00	$172.00	$172.00
9.0–9.9	$135.00	$234.00	$90.00	$153.00	$193.50	$193.50
10.0+	$150.00	$260.00	$100.00	$170.00	$215.00	$215.00
Elected Officials' Retirement Plan (EORP) Members						
5.0–5.9	$90.00	$156.00	$60.00	$102.00	$129.00	$129.00
6.0–6.9	$112.50	$195.00	$75.00	$127.50	$161.25	$161.25
7.0–7.9	$135.00	$234.00	$90.00	$153.00	$193.50	$193.50
8.0+	$150.00	$260.00	$100.00	$170.00	$215.00	$215.00
Corrections Officer Retirement Plan (CORP) Members						
not applicable	$150.00	$260.00	$100.00	$170.00	$215.00	$215.00
Public Safety Personnel Retirement System (PSPRS)						
not applicable	$150.00	$260.00	$100.00	$170.00	$215.00	$215.00

UNDERSTANDING YOUR INSURANCE COST Continued

Your Pension Check

Pension checks are issued by ASRS or PSPRS. 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. ASRS or PSPRS will apply remaining money to pay for your medical premium.

- If your pension is large enough to cover the cost of both your dental and medical premiums, you will 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.

Below is an example of an ASRS summary statement. Please note, under the Payment Sources column, the inclusion of additional monies reflected in the premium benefit (HI PREM BENEFIT). This amount is the premium benefit to which you may be entitled and it reduces the full monthly medical and/or dental premiums you pay. Also note, under the deductions column, the full health insurance premium for your medical and/or dental coverage (HLTH INS PREM). Though the total premium for health insurance is shown, you are only paying the net premium after the premium benefit is applied.

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

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

Bob Employee
1234 Main Street
Phoenix, AZ 85012

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

CRP16 PQ001 MNT

PAYEE INFORMATION

PAYMENT DATE	CHECK NUMBER	SOCIAL SECURITY NUMBER	NET PAYMENT
MARCH 01, 2010	0000000000	123-45-6789	821.78

PAYMENT DETAIL 01/01/09

PAYMENT SOURCES	CURRENT	YEAR-TO-DATE	DEDUCTIONS	CURRENT	YEAR-TO-DATE
ANNUITY	562.86	1,688.58	FEDERAL TAX	5.00	15.00
PBI/EPBI	312.88	938.64	STTAX-AZ	1.00	3.00
NONTAX EXCLU	10.04	30.12	HLTH INS PREM	158.00	474.00
HI PREM BENEFIT	100.00	300.00			
GROSS PAYMENT	**985.78**	**2,957.34**	**TOTAL DEDUCTIONS**	**164.00**	**492.00**

W/H ELECTIONS: FED CALCULATED - M/0+5.00
STATE FLAT PERCENTAGE - 11%

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

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

MEDICARE PART A & B

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 PSPRS) as soon as possible. If your enrollment is not processed until after the third of the month, it is possible the correct premiums will not be deducted from your pension check until the month following the effective date of your enrollment or change.

Eligibility

Medicare is health insurance available to people who are:

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

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

Eligibility Notification

If you become eligible to receive Medicare due to a disability, receive your Medicare Card prior to your 65th birthday, or there is a change in your Medicare status, you must contact 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 healthcare

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 26)

Medicare Part C (Medicare Advantage Plans)

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

Medicare Part D (Prescription Drug Coverage)

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

***If you enroll in either Medicare Part C or Part D plan, you will not be eligible for Benefit Options Medical Coverage. (Example: if you enroll in the Humana Part D Plan, you are not eligible to Enroll with any of the ADOA Medical Plans.)**

MEDICARE PART A & B Continued

Medicare Payments

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

ADOA Benefit Options does not pay for Medicare Part B claims. If you decline or disenroll from Medicare Part B, you will be financially responsible for ALL Part B claims.

Medicare and ADOA

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

Medicare Primary

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

- Medicare is primary coverage
- Benefit Options is secondary coverage

How it Works

Medicare A and B will only pay 80% of covered charges once you have met your deductible. Doctors often charge patients the remaining portion of the bill that Medicare has not paid. If you enroll in the Benefit Options plan the remaining portion less copays (20%) will be covered since Benefit Options becomes the secondary payor. The Benefit Options will pay up to the total allowable amount less copays as determined by the Plan. 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. See page 44 for pharmacy benefits.

Copays

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

Medicare Crossover Program

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

MEDICARE PART A & B Continued

Preventative Services Checklist

Use this checklist to consult with your doctor or other healthcare 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		
Hepatits 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.

The ADOA Benefit Options Medical Plan offers a prescription plan which is expected to pay out as much as standard Medicare prescription coverage pays, and is therefore considered Creditable Coverage.

You are not required to enroll in Medicare Part D.

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 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.

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

MEDICAL PLAN INFORMATION

Understanding Your Options

For the plan year beginning January 1, 2013 retirees have the option of two plans and four networks. The word "network" describes the company contracted with the State to provide access to a group of providers (e.g., doctors, hospitals). Certain providers may belong to one network but not another. Plans are loosely defined as the structure of your insurance policy: the premium, deductibles, copays, and out-of-network coverage associated with your medical benefit.

	EPO	PPO
Aetna	X	X
BCBSAZ/AmeriBen*	X	X
CIGNA	X	
UnitedHealthcare	X	X

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

How the Plans Work

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

The EPO Plan

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

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

The PPO Plan

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

Choosing the Best Plan for You and Your Family

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

1. Assess the costs you expect in the coming year including: monthly premiums, copays, and out-of pocket. Refer to pages 18-19 for monthly premiums and page 34 for the plan comparisons to help determine cost.

2. Determine if your doctors and specialists are contracted with the network you are considering. Each medical network has a

website or phone number (under Contacts) for you to determine if your doctor is contracted.

3. Once you have selected which plan best suits your needs and your budget, make your benefit elections by completing the 2013 Enrollment Form.

Transition of Care (TOC)

If you are undergoing an active course of treatment with a provider who is not contracted with one of the new networks, you can apply for transition of care. If you are approved, you will receive in-network benefits for your current provider during a transitional period after January 1, 2013. 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

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

If you do not make changes to your current benefits, you can continue to use your current ID card, a new card will not be sent.

Contacts

Aetna:
1.866.217.1953
aetna.com

Blue Cross Blue Shield of Arizona network administered by AmeriBen:
1.866.955.1551
myAmeriBen.com

CIGNA:
1.800.968.7366
cigna.com/stateofaz

UnitedHealthcare:
1.800.896.1067
welcometouhc.com/stateofaz

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)
During Open Enrollment visit:
aetnastateaz.com

DocFind
You can find out if your physician or hospital is contracted with Aetna.

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

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

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

Contact and E-mail
Access contact information for Aetna Member Services as well as Aetna's 24/7/365 NurseLine. Chat live with member service representatives by using Live Help feature .

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

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

Smart Source
Access information and resources on a variety of health and wellness topics and learn more about programs and services.

Personal Health Record
Access and print historical claims information.

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

Blue Cross Blue Shield of Arizona Network Administered by AmeriBen

Non-member: *www.myameriben.com/arizona2.htm*
Existing member: *MyAmeriBen.com*

Blue Cross® Blue Shield® of Arizona (an independent licensee of the Blue Cross and Blue Shield Association) provides network access only and provides no administrative or claims payment services and does not assume any financial risk or obligation with respect to claims. No network access is available from Blue Cross and Blue Shield plans outside of Arizona.

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

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

HealthGrades
Perform research on over 5,000 hospitals nation-wide. Access easy to understand ratings for recoveries, complications, and survival rates.

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

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

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

Coverage Inquiry
Verify eligibility for you and your dependents.

Wellness Tools
You can 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

MEDICAL ONLINE FEATURES
Continued

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

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

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

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

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

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

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

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

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

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

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

Note: All Mayo Clinic Primary Care Physician (PCP) are contracted with Cigna HealthCare as specialists, therefore all primary care services administered by Mayo PCPs will be subject to the $30 specialist copayment.

MEDICAL ONLINE FEATURES
Continued

UnitedHealthcare

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

Visit your support site: welcometouhc.com/stateofaz

From this site you can access benefit information, learn about available tools, resources and programs, view open enrollment materials and more.

- View and compare benefit plan options
- Learn about specialized benefits
- Search for physicians and facilities
- And, access our site for members, myuhc.com

Use your own private website at myuhc.com

Once you become a member you can access myuhc.com.

- Look up your coverage and eligibility details including deductibles, and out-of-pocket costs
- View your current claims and claims history
- Find a network doctor or pharmacy
- Tools and resources, including myHealthcare Cost Estimator, price a medication and a Personal Health Record
- Connect with a nurse through live, one-to-one online Nurse Chats.

Personalized online support

Continuous access to your health and benefits information through our online tools.

UnitedHealthcare Health4Me℠

Once you are a member, the Health4Me app provides you with confidential features that include:

- Single-registration — you can register with myuhc.com to enable both the mobile and online app functionality
- Search for physicians or facilities
- View claims, account balances, benefit plan details and your health plan ID card
- Have an Easy Connect representative contact you to answer any questions and connect you with an registered nurse 24/7

DocGPS®

Find a doctor or hospital wherever you are:

- Search for network doctors, clinics and hospitals
- Get directions and more compatible with select BlackBerry®, Android™ and iPhone® devices

OptumizeMe®

With this social networking app you can:

- Create and join fitness and nutrition challenges
- Compete and collaborate with friends

MEDICAL PLANS COMPARISON CHART

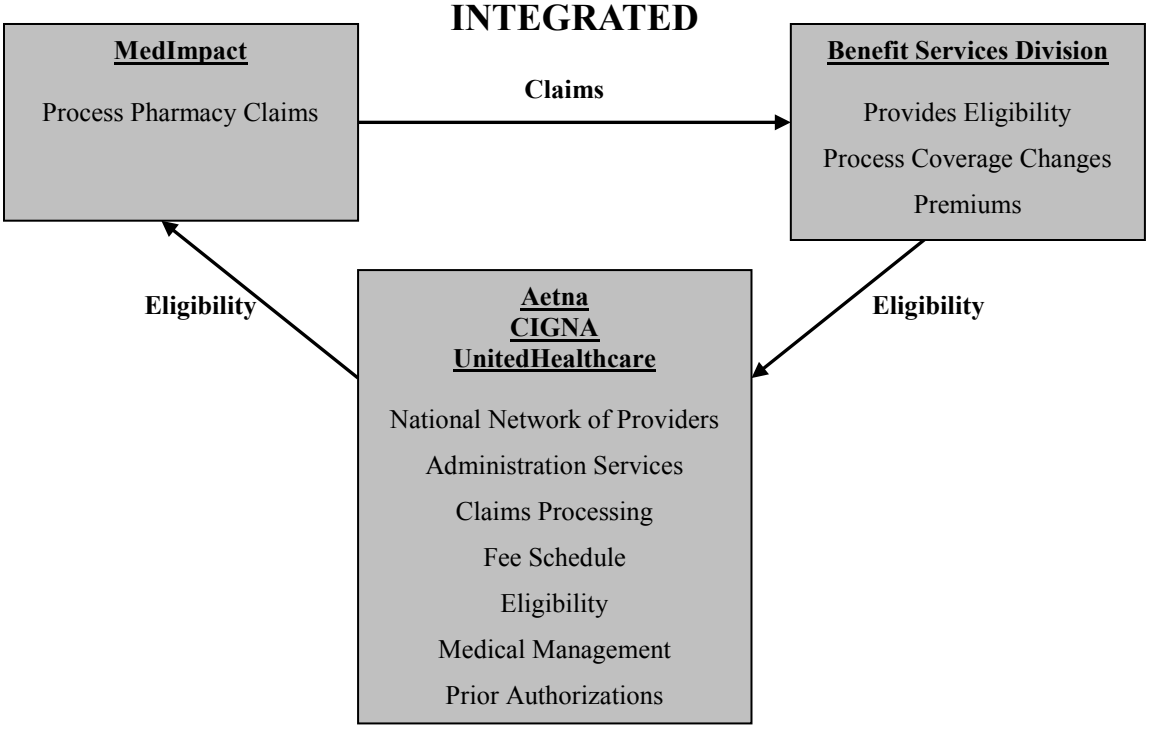
	EPO	PPO	PPO
Available Plans	☑*Aetna* ☑*BCBSAZ/AmeriBen** ☑*CIGNA* ☑*UnitedHealthcare*	☑*Aetna* ☑*BCBSAZ/AmeriBen** ☑*UnitedHealthcare*	☑*Aetna* ☑*BCBSAZ/AmeriBen** ☑*UnitedHealthcare*
	IN-NETWORK	**IN-NETWORK**	**OUT-OF-NETWORK**
Plan year deductible Single retiree	none	$500**	$1,000**
Retiree+adult, retiree+child, family	none	$1,000** +	$2,000**
Out-of-pocket max Single retiree	none	$1,000** +	$4,000**
Retiree+adult, retiree+child, family	none	$2,000**	$8,000**
Lifetime max	none	none	No maximum
	RETIREE 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	$125
Urgent care	$40	$40	50% after deductible
Home health services Maximum visits per year	42	42	
Hospital admission (Room and Board)	$150	$150	50% after deductible
Mammography	$0	$0	50% after deductible
Office visits PCP	$15	$15	50% after deductible
Max of 1 copay/day/provider Specialist	$30	$30	50% after deductible
Preventative	$15	$15	50% after deductible
OB/GYN	$10	$10	50% after deductible
Outpatient services Freestanding ambulatory facility or hospital outpatient surgical center	$50	$50	50% after deductible
Radiology	$0	$0	50% after deductible

**Blue Cross Blue Shield of Arizona network administered by AmeriBen.*
***Copays apply to out-of-pocket maximum after deductible is met for PPO plans. The plan pays 100% after out-of-pocket maximum is met.*
+ PPO in-network deductible must be met before copay applies.

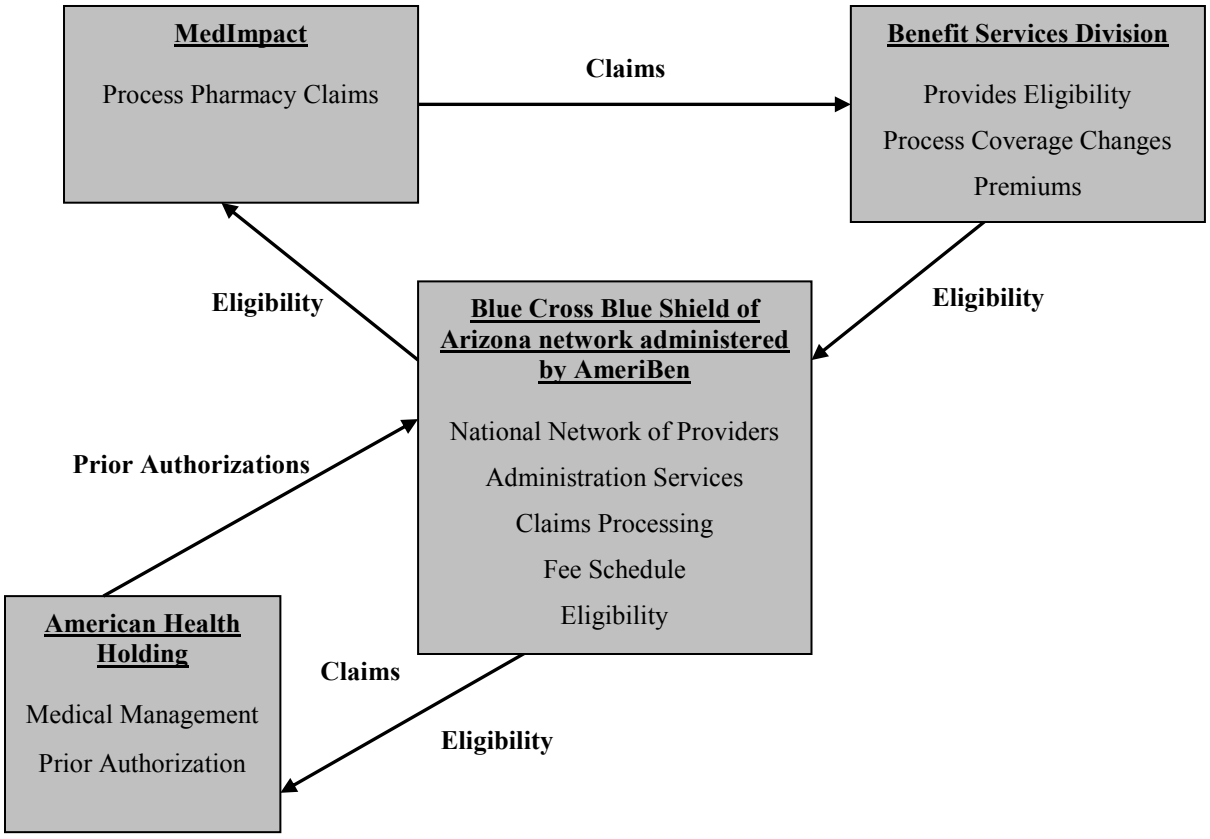
For the NAU only BCBS PPO plan details, go to http://hr.nau.edu/m and choose Benefits, Health Insurances, Medical (General Health), BCBS Plan Book.

INTEGRATED & NON-INTEGRATED

INTEGRATED



NON-INTEGRATED



MEDICAL MANAGEMENT

Services Available

When you choose Benefit Options medical insurance you get more than basic healthcare coverage. **You get personalized medical management programs at no additional cost**. Under the Benefit Options health plan, there are four medical management vendors: American Health Holding (AHH), Aetna, CIGNA, and UnitedHealthcare. Each vendor serves their specific members based on which medical network you select during enrollment.

The four vendors provide medical management services as follows:

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

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

Utilization Management

AHH, Aetna, CIGNA, and UnitedHealthcare provide prior authorization and utilization review for the ADOA Benefit Options plan 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. Please refer to your Plan Document posted at *benefitoptions.az.gov* for the specific list of services that require prior authorization. Each vendor has a dedicated line to accept calls and inquiries:

American Health Holding 1.866.244.8977

Aetna 1.800.333.4432

CIGNA 1.800.968.7366

UnitedHealthcare 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 the Benefit Options plan.

Disease Management

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

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

- Asthma
- Diabetes

MEDICAL MANAGEMENT Continued

- Chronic Obstructive Pulmonary Disease
- Congestive Heart Failure
- Pregnancy/Maternity
- 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 American Health Holding, Aetna, CIGNA, and UnitedHealthcare identify and reach out through phone calls and/or mail to members who may need help managing their health conditions. The disease management companies work with the Benefit Options plan to provide this additional service.

Participation is optional, private, and tailored to your specific needs. Also, members of the Benefit Options plan who are concerned about a health condition and would like to enroll in one of the covered programs can contact their respective disease management vendors directly to self enroll. Please refer to the your medical management vendor's phone number on page 36 if you or your dependent is interested.

NurseLine

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

American Health Holding
1.866.244.8977

CIGNA 1.800.968.7366

Aetna 1.800.556.1555

UnitedHealthcare 1.800.401.7396

NETWORK OPTIONS OUTSIDE OF ARIZONA

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

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

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

**Blue Cross Blue Shield of Arizona network 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.

PHARMACY PLAN INFORMATION

MedImpact

If you elect any Benefit Options medical plan, MedImpact will be the network you use for pharmacy benefits. Enrollment is automatic when you enroll in a medical plan and there is no separate cost.

MedImpact currently services 33 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 on page 44. 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, so your choice of generics can help keep the Plan's costs down and benefits high.

PHARMACY PLAN INFORMATION Continued

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.

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 medication.

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*.

PHARMACY PLAN INFORMATION Continued

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 *WalgreensHealth.com* or via phone at 1.866.304.2846.

Have your insurance card ready when you call!

Choice90

With this program, retirees who require medications for an on-going health condition can obtain a 90-day supply of medication at a local retail pharmacy for **two and a half copays.**

For more information contact MedImpact Customer Care Center at 1.888.648.6769.

Limited Prescription Drug Coverage

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

Non-Covered Drugs

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

Extended Vacation or Working Abroad

Whether you go to a retail pharmacy or use mail order for your prescriptions, you will need to notify MedImpact in writing of why

PHARMACY PLAN INFORMATION Continued

you are requesting an additional supply of medication, the date when you are leaving, and how long you plan to be gone. MedImpact will be able to authorize a VACATION OVERRIDE allowing you to have the extra medication you will need *providing you have the appropriate number of refills remaining.*

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

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

If you are already out of town and need a prescription call MedImpact. Tell the representative you are out of town and need to find a participating pharmacy in the area where you are. You will need the zip code where you are visiting. In most cases you will have several choices. If your medication is lost, stolen, or damaged, replacement medication is not covered.

Contacts

	Phone
MedImpact	
Customer Care Center and Prior Authorization	1.888.648.6769
Walgreens	
Mail Order	1.866.304.2846
Specialty Pharmacy	1.888.782.8443

NAU Retiree BCBS Member only

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

The BCBSAZ Prescription Medication Guide can be used to determine your copay and this guide can be found on the BCBS website at *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 Walgreens Prescription Drug Mail-Order Program. Maintenance drugs are drugs you take consistently. The copay for the 90-day supply is equivalent to one month's copay.

PHARMACY PLAN ONLINE FEATURES

Members can view pharmacy information located at *benefitoptions.az.gov*. Click on the pharmacy link and then click "MedImpact Pharmacy Website".

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

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

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

Prescription History
View your prescription history, including all of the medications received by each member, under PersonalHealth Rx. Your prescription history can be printed for annual tax purposes.

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

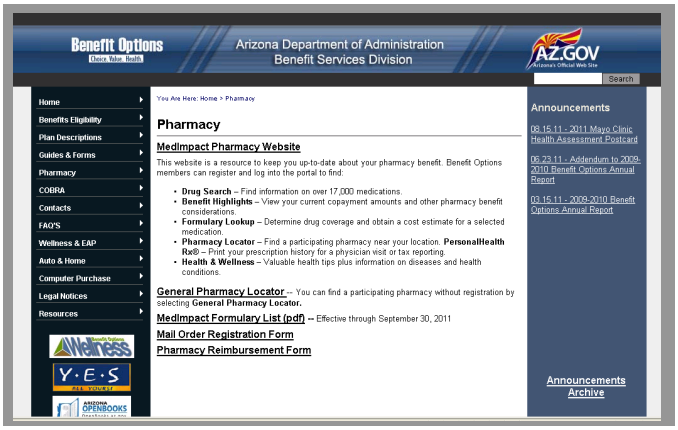
Health & Wellness
Learn valuable tips and information on diseases and health conditions.

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

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

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

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



NAU Retirees only Blue Cross/Blue Shield Members

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

PHARMACY BENEFITS SUMMARY

	ADOA Benefit Options (Aetna, Blue Cross Blue Shield of Arizona network 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	$10 copay
Preferred Brand*	$20 copay	$25 "brand"
Non-Preferred Brand*	$40 copay	$45 for non-preferred brand "A" $85 for non-preferred brand "B"
Annual Maximum	None	None

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

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

DENTAL PLAN INFORMATION

Dental Plan Options

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

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

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

Each family member may choose a different general dentist. You can select or change your dentist by contacting TDAHP by telephone or using the "change my dentist" function on the website *TDAdental.com/adoa*. Members may self-refer to dental specialists within the network.

Specialty care copays are listed in the plan booklet. Specialty services not listed are provided at a discounted rate. This discount includes services at a Pedodontist, Prosthodontist, and TMJ care.

Indemnity/PPO Plan – Delta Dental PPO plus Premier

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

To find a Delta Dental dentist near you, please visit *deltadentalaz.com/find*.

How to Choose the Best Dental Plan for You

When choosing between a prepaid/DHMO plan and an indemnity/PPO plan, you should consider: dental history, level of dental care required, costs/budget and provider in the network. If you have a dentist, make sure he/she participates on the plan (prepaid/DHMO plan -TDAHP or indemnity/PPO - Delta Dental PPO plus Premier) you are considering.

DENTAL PLAN INFORMATION & ONLINE FEATURES Continued

For a complete listing of covered services for each plan, please refer to the plan description located on *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.

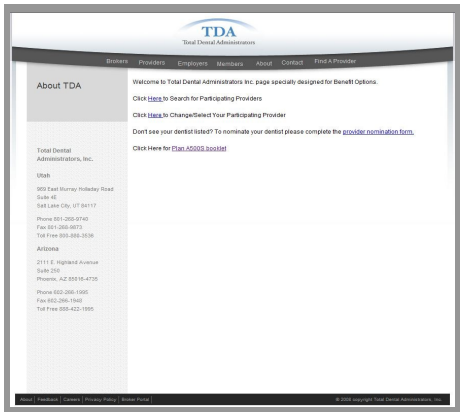
If you are enrolling with **TDAHP**, go to *TDAdental.com/adoa* to access the online features described below.

Participating Providers
You can search for a specific dentist contracted under this plan (DHMO/Prepaid) by visiting *TDAdental.com/adoa.*

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

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

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



Delta Dental PPO plus Premier

Your Delta Dental plan comes with a range of online features designed to make using and managing your benefits easy and convenient. After the benefit year begins on January 1, please visit *deltadentalaz.com* to create your ID and password in the **Member Connection**, a secure online environment that gives you access to the following tools and materials:

- State of Arizona **PPO plus Premier Plan** information.
- View and/or print your **benefits and eligibility**.
- Sign up for **electronic Explanation of Benefits** (EOBs).
- **24/7 claims information**
- View **instructional videos**.
- **Find a Dentist** tool allows you to search the national directory by zip code.
- **Nominate your dentist** to be a contracted dentist if they aren't.
- Preventive dental health and wellness information and tips: Ask the Expert, Assess your risk for **Dental Disease Tool**.

DENTAL PLANS COMPARISON CHART

	TDAHP Total Dental Administrators	Delta Dental
PLAN TYPE	Prepaid/DHMO	Indemnity/PPO
DEDUCTIBLES	None	$50/$150
PREVENTATIVE CARE CLASS I		
Office Visit	$0	$0 - Deductible Waived*
Oral Exam	$0	$0 - Deductible Waived*
Prophylaxis/Cleaning	$0	$0 - Deductible Waived*
Fluoride Treatment	$0 (to age 15)**	$0 - Deductible Waived* (to age 18)
X-Rays	$0	$0 - Deductible Waived*
BASIC CLASS II SERVICES		
Office Visit	$0	$0
Sealants	$10 per tooth (to age 17)	20% (to age 19)
Fillings	Amalgam: $10-$37	20%
	Resin: $26-$76	
Extractions	Simple: $30 Surgical $60	20%
Periodontal Gingivectomy	$225	20%
Oral Surgery	$30 - $145	20%
BASIC CLASS III SERVICES* **		
Office Visit	$0	$0
Crowns	$270 + $185 Lab Fee ($455)	50%
Dentures	$300 + $275 Lab Fee ($575)	50%
Fixed Bridgework	$270 + $185 Lab Fee ($455) per unit	50%
Crown/Bridge Repair	$75	50%
ORTHODONTIA* **		
Child	$2800 - $3400	See lifetime
Adult	$3200 - $3700	
TMJ SERVICES		
Exam, services, etc.	20% Discount	
MAXIMUM BENEFITS		
Annual Combined Preventive, Basic and Major Services	No Dollar Limit	$2000 per person
Orthodontia Lifetime	No Dollar Limit	$1500 per person

**Routine visits and exams are covered two times per plan year at 100%.*
***Fluoride treatment covered 100% once per plan year up to age 15. Additional treatment subject to applicable copayments.*
****Six month waiting period if Delta Dental not elected upon initial enrollment opportunity.*
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 the voluntary Avesis Advantage Program or the Avesis Discount Program.

Avesis Advantage Program

Retirees 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

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 nonparticipating 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.

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

VISION PLAN ONLINE FEATURES

Online Features

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

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

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

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

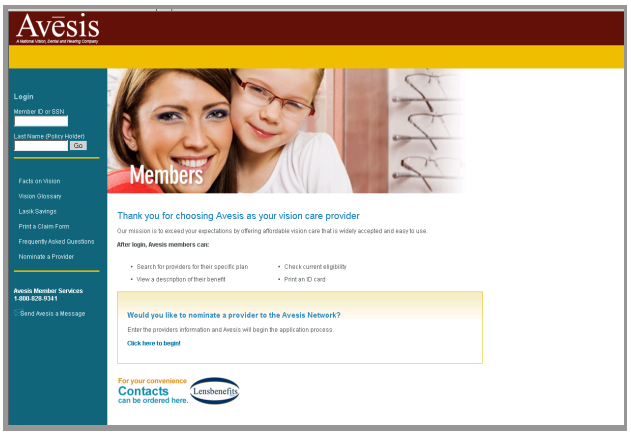
Print an ID Card
If you lose or misplace your ID card, you can print a new one.

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

Glossary
You can learn about vision terminology.

Facts on Vision
Learn about different vision facts.

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



VISION PLANS COMPARISON CHART

IN-NETWORK BENEFITS		
	Advantage Vision Care Program	**Discount Vision Care Program***
Examination Frequency	Once every 12 months	Once per 12 months
Lenses Frequency	Once every 12 months	Once per 12 months
Frame Frequency	Once every 12 months	Once per 12 months
Examination Copay	$10 copay	No more than $45
Optical Materials Copay (Lenses & Frame Combined)	$0 copay	Refer to schedule below Once per 12 months
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
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

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	
EPO Plans	
Aetna	Emergency & Urgent Only
BCBSAZ/AmeriBen*	Emergency & Urgent Only
CIGNA	Emergency & Urgent Only
UnitedHealthcare	Emergency & Urgent Only
PPO Plans	
Aetna	Emergency & Urgent Only at In-Network Benefit Level**
BCBSAZ/AmeriBen*	Emergency & Urgent Only at In-Network Benefit Level**
UnitedHealthcare	Emergency & Urgent Only at In-Network Benefit Level**
NAU Only	
Blue Cross Blue Shield PPO	For assistance with locating a provider and submitting claims call 1.800.810.2583 or 1.804.673.1177. For an international claim form, go to *www.bcbs.com/blue cardworldwide/index*
PHARMACY	
MedImpact	Not covered
DENTAL CARE	
Prepaid/DHMO Plan	
Total Dental Administrators Health Plan, Inc.	Emergency Only
PPO Plan	
Delta Dental PPO plus Premier	Coverage is available under non-participating provider benefits
VISION CARE	
Avesis	Covered as out-of-network and will be reimbursed based on the Avesis reimbursement schedule

*Blue Cross Blue Shield of Arizona network administered by AmeriBen.
**All other services covered at out-of-network benefit level.

LONG-TERM DISABILITY MEMBERS

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

No Longer Eligible for LTD Benefits and Not Able to Retire

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

Returning to Work

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

Waiver of Premiums

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

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

Disability Benefits from Social Security and Eligibility for Medicare

If you have been receiving disability benefits from Social Security or the Railroad Retirement Board for 24 months, you will be automatically entitled to Medicare Part A and Part B beginning the 25th month of the disability benefit entitlement. You will not need to do anything to enroll in Medicare.

Your Medicare card will be mailed to you about 3 months before your Medicare entitlement date. You must mail a copy of your Medicare card to the ADOA 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.

LEGAL NOTICES

Legal Notices regarding the Benefit Options Program may be found under the **"Legal Notices"** tab of the member website: ***benefitoptions.az.gov.***

These notices include:

Health Insurance Portability & Accountability Acct (HIPAA)
This notice protects the privacy of individually identifiable health information, and establishes who can use the personal health information and how it can be used.

Medicare Notice of Creditable Coverage
This notice has information about the prescription drug coverage through the Benefit Options program for people with Medicare. It explains the options you have under Medicare prescription drug coverage (Medicare Part D) and can help you decide whether or not you want to enroll.

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

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

Privacy Policy

GLOSSARY

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

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

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

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

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

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

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

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

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

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

Deductible
Fixed dollar amount a member pays before the health plan begins paying for covered medical services. Copays and/or coinsurance amounts may or may not apply (see comparison chart on page 34).

GLOSSARY Continued

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

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

Domestic Partner
Refer to pages 8-11 for eligibility requirements.

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

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.

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

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.

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.