



2011–2012 Open Enrollment

The Time Is Here!

The Arizona Public Employers Health Pool (APEHP) open enrollment period is the designated time each year during which you can: (1) make changes to your existing coverage; and (2) elect or change coverage for your spouse, domestic partner, and/or dependents.

Your 2011–2012 open enrollment period is April 20 to May 31, 2011.

If you anticipate that your or your family's health needs will be changing, now is the time to take action:

- **Review this guide** thoroughly to see what's new, and refresh your knowledge of the different benefit plans.
- **Share this guide** with your family. The amount you pay each month depends on whom you elect to enroll. You can choose the appropriate level of coverage: for yourself, yourself and your spouse or domestic partner, yourself and your children, or your entire family. See "Who's Eligible to Enroll" (page 3).
- **Attend an open enrollment meeting** to ask questions and get answers regarding 2011–2012 benefits. (See page 4.)
- **Learn about** the variety of health-related programs available.
- **Complete and submit an enrollment form** if you plan to make changes to your elections.
 - * If you do *not* submit an enrollment form, you will continue with the same benefits and coverages you had during the 2010–2011 plan year. Please refer to your employer's benefits office for the due date for your open enrollment form(s) changes.
 - * *You MUST reenroll each year to participate in a flexible spending account (FSA) or health savings account (HSA).*

Read this guide carefully. If you do not intend to make any changes to your benefits, you do not need to fill out any new forms. New forms are required, however, if you are planning to:

- change plans,
- participate in a flexible spending account (FSA),
- participate in a health savings account (HSA),
- add or remove a dependent or domestic partner,
- elect or cancel voluntary vision benefits,
- elect or cancel dental benefits,
- increase or change your voluntary life insurance,
- opt out of the insurance plan, or
- enroll in voluntary life insurance for the first time.

NOTE: If a covered individual transfers from one APEHP employer to another, it is the responsibility of the first employer to ensure that benefits coverage ceases for the departing employee. "Double coverage" is not permitted under the plan.

Open Enrollment Basics

What's New for 2011–2012?

In 2010, Congress reformed the U.S. healthcare system by passing the Affordable Care Act (ACA).

The following changes, required by the ACA, will take effect on July 1, 2011:

- Coverage must be made available for dependent children up to age 26, regardless of the child's student or marital status.
- The following insurance plan provisions are prohibited:
 - ◆ pre-existing condition exclusion for individuals under age 19,
 - ◆ lifetime benefit dollar maximum, and
 - ◆ lifetime maximum on the dollar value of essential benefits.
- Coverage may be rescinded in cases of participant fraud or intentional misrepresentation of material facts.
- A new claims and appeals process will be introduced.
- Over-the-counter medications must be prescribed by a physician in order to be eligible for reimbursement through an FSA or HSA plan.
- The penalty for using HSA funds for non-medical or non-medically related expenses will increase from 10% to 20%.

Additionally, APEHP will make the following plan changes effective July 1, 2011:

- Coverage will be increased to allow one physical exam and gynecology exam/pap smear lab test each plan year, payable at 100 percent.
- Prostate screenings will be added as a wellness benefit, payable at 100 percent.
- Any unused orthodontic services balance from a participant's previous plan will be available on the APEHP plan (up to the \$1,500 orthodontia allowance). This applies only to new hires or new members of the group.
- The high-deductible health plan (HDHP) deductible for dependent coverage will increase for the \$1,500 HDHP and the \$2,500 HDHP.
- Basic life insurance coverage will increase to \$2,000 for all dependents.
- The health savings account vendor will change to Health Equity. Refer to page 5 for details.

Special Enrollment for Children Under Age 26

If you have a child who is under age 26 (whether married or unmarried), including a child currently receiving continuation coverage under COBRA, that child may be eligible to enroll in the plan as of July 1, 2011. This one-time, 30-day special enrollment opportunity applies to:

1. children whose previous coverage under the plan has ended;
2. children who were previously denied coverage under the plan; and
3. children who were not previously eligible to enroll in the plan because they: (a) exceeded the then-allowable age for plan eligibility; or (b) failed to meet requirements regarding student or marital status.

In addition, if you are not currently enrolled in the plan, you also have the opportunity to enroll along with your eligible child. You must request special enrollment on behalf of your child beginning April 20, 2011, and no later than June 20, 2011. If you request special enrollment within this date range, coverage will become effective on July 1, 2011.

To request special enrollment or obtain more information, contact your Arizona Public Employers Health Pool representative.

Special Enrollment for Individuals Who Reached the Lifetime Limit

The lifetime limit on the dollar value of benefits under APEHP no longer applies. Individuals whose coverage ended because they reached the lifetime limit under the plan are eligible to reenroll. Individuals have 30 days from the date of this notice to request enrollment. For more information, contact your Arizona Public Employers Health Pool representative.

Open Enrollment Basics

Get Ready to Enroll

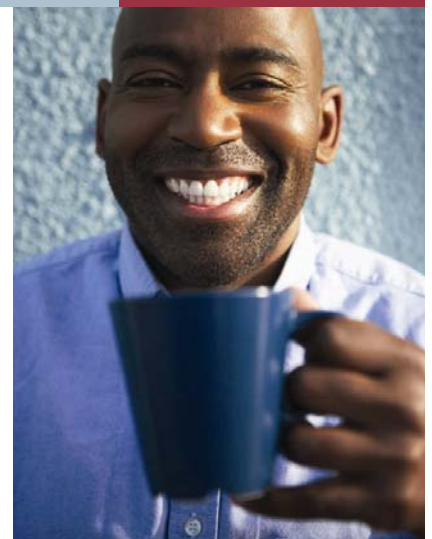
If you want to make changes to your elections, you will need to complete and submit your enrollment form(s) as follows:

- Select a medical program option. (To decline coverage, you must complete the portion of the enrollment form that indicates your desire to opt out of coverage through APEHP.)
- Decide on the tier of coverage you want, depending on who will be covered. If you are adding a domestic partner, you will need to complete the statement of domestic partnership.
- Decide if you want to enroll in the:
 - ♦ Health Care FSA (only available if you elect the Core, Core Plus, or Copay plan), and decide on the annual amount you want to contribute to your FSA,* and/or the
 - ♦ Dependent Care FSA, and decide on the annual amount you want to contribute to your FSA.*
- If you want to enroll in a High Deductible Health Plan (HDHP), be sure you are eligible to enroll, then decide how much you want to contribute to the HSA. Please note that you are not required to contribute to the HSA.*
- Review and/or update your beneficiary designation form for your life insurance benefit.
- Review and decide whether or not to elect supplemental life coverage.
- Fill out the open enrollment form if you want to add or delete vision coverage.
- Sign and date the enrollment form(s).

Please refer to your employer's benefits office for the due date for your open enrollment form(s) changes.

**If enrolling in an FSA or an HSA, you will need to complete additional forms. These will be provided during your open enrollment meeting, and should also be available from your human resources manager.*

If you have questions about eligibility, please contact your human resources department or refer to the Plan Document/Summary Plan Description (SPD).



Who's Eligible to Enroll?

Those eligible for benefits include:

- full-time employees working at least 35 hours per week
- part-time employees working a minimum of 20 hours per week, if the employer allows part-time coverage
- active board members or council members, as permitted by their host organizations
- dependents of enrolled employees, including:
 - (1) lawfully married spouse or domestic partner; and
 - (2) dependent children, up to age 26.

Beginning July 1, 2011, you can enroll a dependent child up to age 26. Your child will remain eligible through the end of the month in which he or she turns 26.

NOTE: Participants cannot be covered by more than one APEHP employer's plan for any medical, dental, vision, or life insurance benefits.

Open Enrollment Meetings

Town of Payson

April 27 9:00 a.m.–12:00 p.m.
303 N. Beeline Highway
Payson, AZ 85541

Clarkdale–Jerome School District

May 3 8:45 a.m.–10:45 a.m.
1615 Main Street
Clarkdale, AZ 86324

Cottonwood–Oak Creek School District and City of Cottonwood

May 3 12:15 p.m.–4:00 p.m.
1 N. Willard Street
Cottonwood, AZ 86326

Sedona–Oak Creek School District

May 5 8:30 a.m.–10:00 a.m.
Sedona Red Rock High School
995 Upper Red Rock Loop Road

10:45 a.m.–12:45 p.m.
W. Sedona Elementary School
570 Posse Ground Road

2:00 p.m.–4:00 p.m.
Big Park Community School
25 W. Saddlehorn Road

City of Sedona

May 10 9:30 a.m.–12:30 p.m.
102 Roadrunner Drive
Sedona, AZ 86336

Town of Camp Verde

May 10 2:30 p.m.–4:00 p.m.
646 S. 1st Street
Camp Verde, AZ 86322

Town of Jerome

May 17 1:30 p.m.–2:30 p.m.
600 Clark Street
Jerome, AZ 86331

Clarkdale Fire District

May 17 8:30 a.m.–9:30 a.m.
895 First South Street
Clarkdale, AZ 86324

Town of Clarkdale

May 17 10:00 a.m.–12:00 p.m.
890 Main Street
Clarkdale, AZ 86324

Navajo County Meetings

Wednesday, April 20, 2011

Holbrook Complex, Board Chambers

8:30 a.m.–10:00 a.m.
10:30 a.m.–12:00 p.m.
1:00 p.m.–2:30 p.m.
3:00 p.m.–4:30 p.m.

Jail, Conference Room

5:00 p.m.–6:30 p.m.

Thursday, April 21, 2011

Holbrook Road Yard

6:00 a.m.–7:30 a.m.

Holbrook Complex, Board Chambers

8:30 a.m.–10:00 a.m.
10:30 a.m.–12:00 p.m.

Winslow Complex, Winslow Health Conference Room

2:00 p.m.–3:30 p.m.

Friday, April 22, 2011

Holbrook Complex, Board Chambers

8:00 a.m.–9:30 a.m.
10:00 a.m.–11:30 a.m.

Snowflake Justice Court, Conference Room

1:30 p.m.–2:30 p.m.

Pinetop Justice Court, Conference Room

3:30 p.m.–4:30 p.m.

Monday, April 25, 2011

South County Complex, Frontier Conference Room (Health Building)

8:00 a.m.–9:30 a.m.
10:00 a.m.–11:30 a.m.
1:00 p.m.–2:30 p.m.
3:00 p.m.–4:30 p.m.

Tuesday, April 26, 2011

Show Low Road Yard

6:00 a.m.–7:30 a.m.

South County Complex, Frontier Conference Room (Health Building)

8:00 a.m.–9:30 a.m.

McNeil Complex, Large Conference Room

10:00 a.m.–12:00 p.m.

Mogollon Complex, Large Conference Room

2:00 p.m.–3:30 p.m.

Contact Us

<p>Plan Administration and Employee Advocate</p>	<p>Arizona Public Employers Health Pool (APEHP) Member Services: (800) 718-8328 http://www.apehp.org</p>
<ul style="list-style-type: none"> • Eligibility • Medical Plan Claims • Health Savings Account (HSA) • Flexible Spending Account (FSA) • COBRA 	<p>AmeriBen/IEC Group P.O. Box 7186 Boise, ID 83707 Member Services: (866) 955-1485 https://services.ameriben.com</p>
<p>HSA Administration</p>	<p>Health Equity 15 W. Scenic Pointe Drive, Suite 400 Draper, UT 84020 Member Services: (866) 346-5800 http://www.healthequity.com/apehp</p>
<p>Medical Plan Provider Network</p>	<p>BlueCross BlueShield of Arizona http://www.azblue.com</p>
<p>Mayo Clinic Arizona</p>	<p>Mayo Clinic Arizona Appointment Office: (480) 301-1735 http://www.mayoclinic.org/scottsdale/</p>
<p>Dental Plan</p>	<p>Delta Dental P.O. Box 43026 Phoenix, AZ 85080-3026 Member Services: (800) 352-6132 http://www.deltadentalaz.com</p>
<p>Vision Plan</p>	<p>Vision Service Plan (VSP) Member Services: (800) 877-7195 http://www.vsp.com</p>
<p>Prescription Drugs (Retail and Mail Order)</p>	<p>InformedRx Member Services: (800) 880-1188 https://informedrx.rxportal.sxc.com/rxclaim/portal/preLogin</p>
<p>Pre-certification</p>	<p>American Health Group, Inc. Member Services: (800) 847-7605 http://www.americanhealthgroup.com</p>
<p>Employee Assistance Program (EAP)</p>	<p>EAP Preferred Member Services: (800) 327-3517, ext. 2 http://www.eappreferred.com (User name: EEAP123; Password: eappreferred)</p>
<p>Life Insurance</p>	<p>Sun Life Member Services: (800) 247-6875</p>



Medical Options

APEHP offers a flexible benefits program that lets you choose from among five different preferred provider organization (PPO) medical plan options:

- **Core Plan:** This plan offers lower monthly premiums. In exchange for these lower premiums, you may have higher out-of-pocket medical costs.
- **Copay Plan:** This plan has a higher annual deductible, and you pay copays for office visits and urgent care treatment.
- **Core Plus Plan:** This plan offers lower out-of-pocket medical costs, but you pay more in premiums.
- **\$1,500 and \$2,500 High Deductible Health Plans (HDHP) with health savings accounts (HSA):** These plans have the lowest monthly premiums, but your out-of-pocket medical expenses may be the highest.

The PPO network for each plan is provided through BlueCross BlueShield of Arizona. Additional plan details appear on pages 7 and 8.

Comparing Your Options

Each plan option covers the same range of services. The plans differ, however, in terms of the copay and out-of-pocket medical costs—deductibles and coinsurance—you could incur during the year.

The *annual deductible* is the amount of covered medical expenses that you pay each fiscal year before the plan pays any benefits. Once you meet the deductible, you pay a percentage of covered medical costs (coinsurance), and the plan pays the rest. Once your coinsurance reaches the out-of-pocket maximum for the fiscal year, the plan pays 100 percent of the remaining allowed charges for the rest of the year.

Unless you are enrolled in the Copay Plan, you should not be required to pay anything out-of-pocket at the point of service—with the exception of pharmacy copays. (Visit the APEHP Web site at <http://www.apehp.org> for a detailed list of medications that are exempt from this rule under the HDHP.)

Example:

1. You are covered under the Core Plan with employee-only coverage. You go to an in-network physician for a non-preventive wellness visit. At the time of service, you should not be required to pay anything.
2. The physician submits a bill to AmeriBen for \$150. AmeriBen reviews the claim and reduces it to the BCBS contracted fee. Assume in this scenario that the bill is reduced to \$100.
3. Because your deductible has not yet been met for the year, you are responsible for paying the \$100 to the physician. The \$100 will be applied to your \$500 deductible.
4. For the remainder of the year, you must pay \$400 in additional eligible out-of-pocket expenses before the plan begins paying for services at 80 percent.
5. Once the deductible is met, you will pay 20 percent of the allowed amount, to a maximum of \$3,500 (your out-of-pocket maximum).
6. When you reach the \$3,500 out-of-pocket maximum, the plan will pay 100 percent of services through the end of the year. (Copays for prescriptions will still apply.)

Please note: Your contributions to the deductible and the out-of-pocket maximum are reset to zero on July 1 of each year.

Prescription Drug Coverage



All medical options include the prescription drug coverage listed in the 2011–2012 medical benefits chart. (See pages 7 and 8.)

The HDHPs, however, require that the deductible be met before prescription drug benefits can begin.

Prescription drug benefits are paid based on a formulary, which is a list of drugs that are covered under the plan. The medicines that are covered fall under three categories: generic, preferred brand name, and non-preferred brand name.

Prescription Drug Programs

InformedRx is the pharmacy benefit manager for APEHP. All major pharmacy chains are available through the InformedRx network.

Getting the Most from Your Prescription Benefit

The following tips can help reduce the amount of money you pay for prescriptions:

- **Generic medications** are a less expensive option than brand name drugs. Before you fill a prescription, ask your doctor if you can substitute a generic drug for the brand medication you are currently taking.
- **Pill splitting** can help save money without sacrificing drug effectiveness or safety. Some tablets are available at double the dose and at the same or nearly the same cost as lower doses. By splitting the larger doses, you can essentially get two doses for the price of one. There are limitations, however, on the types of pills you can split. Time-release medications and medications in capsule form, for example, cannot be split. Ask your doctor and pharmacist if your medication is available in larger doses, and if it can be split.
- **Ask your doctor if there is an over-the-counter alternative to your prescription.** Remember that over-the-counter medications usually come in lower strengths; therefore, you should ask your doctor about appropriate dosing.
- **Buy medications through the mail.** Ask your doctor for a 90-day prescription, and take advantage of the mail order program. You can save money on copays by getting medications through the mail, and enjoy the convenience of having them delivered directly to your home. **Note:** You will need a new prescription to start home delivery with InformedRx.
- **Ask your doctor for samples.** Doctors get free samples from pharmaceutical sales representatives. Don't be afraid to ask if samples are available.
- **Shop around for your medications.** As with everything else you buy, medication prices vary depending on where you purchase them. Call around to different pharmacies, and don't forget warehouse stores, which can sometimes offer better prices than traditional pharmacies.

Medical Benefits for 2011-2012

Each plan option covers the same range of services. The plans differ, however, in terms of the out-of-pocket medical costs—deductibles and coinsurance—you could incur for the year, as well as the premium. The Core Plan, Copay Plan, and HDHP options offer lower monthly premiums in exchange for higher out-of-pocket costs for deductibles and coinsurance.

Overview	Core Plan		Core Plus Plan		Copay Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible ⁽¹⁾	<ul style="list-style-type: none"> • \$500/person • \$1,000/family of 2 • \$1,500/family of 3+ 	<ul style="list-style-type: none"> • \$1,000/person • \$2,000/family of 2 • \$3,000/family of 3+ 	<ul style="list-style-type: none"> • \$250/person • \$500/family of 2 • \$750/family of 3+ 	<ul style="list-style-type: none"> • \$500/person • \$1,000/family of 2 • \$1,500/family of 3+ 	<ul style="list-style-type: none"> • \$750/person • \$1,500/family of 2 • \$2,250/family of 3+ 	<ul style="list-style-type: none"> • \$1,500/person • \$3,000/family of 2 • \$4,500/family of 3+
Annual Out-of-Pocket Limit	\$3,500/person \$7,000/family of 2+	\$5,000/person \$10,000/family of 2+	\$2,500/person \$5,000/family of 2+	\$5,000/person \$10,000/family of 2+	\$3,500/person \$7,000/family of 2+	\$5,000/person \$10,000/family of 2+
Office Visit	Plan pays 80%	Plan pays 60%	Plan pays 80%	Plan pays 60% No deductible	\$20 copay primary care physician; \$40 copay specialist	Plan pays 60%
Well Adult Care	Plan pays 100% No deductible	Plan pays 60% No deductible	Plan pays 100% No deductible	Plan pays 60% No deductible or copay	Plan pays 100% No deductible	Plan pays 60% No deductible
Well Child Care	Plan pays 100% No deductible	Plan pays 60% No deductible	Plan pays 100% No deductible	Plan pays 60% No deductible or copay	Plan pays 100% No deductible	Plan pays 60% No deductible
Outpatient Lab and x-ray (including MRI, PET & CT scans)	Plan pays 80%	Plan pays 60%	Plan pays 80%	Plan pays 60%	Plan pays 80%	Plan pays 60%
Urgent Care	Plan pays 80%	Plan pays 60%	Plan pays 80%	Plan pays 60%	\$40 copay	Plan pays 60%
Emergency Room	Plan pays 80%	Plan pays 80%	Plan pays 80%	Plan pays 80%	Plan pays 80%	Plan pays 80%
Inpatient Hospital	Plan pays 80%	Plan pays 60%	Plan pays 80%	Plan pays 60%	Plan pays 80%	Plan pays 60%
Outpatient Hospital	Plan pays 80%	Plan pays 60%	Plan pays 80%	Plan pays 60%	Plan pays 80%	Plan pays 60%
Outpatient Behavioral Health Visits	Plan pays 80%	Plan pays 60%	Plan pays 80%	Plan pays 60%	\$20 copay/visit No deductible	Plan pays 60%
Retail Prescription Drugs (30-day supply)	You pay: <ul style="list-style-type: none"> • Generic: Greater of \$10 or 25% • Preferred brand: Greater of \$20 or 30% (maximum of \$45) • Non-preferred brand: Greater of \$30 or 50% (maximum of \$90) 		You pay: <ul style="list-style-type: none"> • Generic: Greater of \$10 or 25% • Preferred brand: Greater of \$20 or 30% (maximum of \$45) • Non-preferred brand: Greater of \$30 or 50% (maximum of \$90) 		You pay: <ul style="list-style-type: none"> • Generic: Greater of \$10 or 25% • Preferred brand: Greater of \$20 or 30% (maximum of \$45) • Non-preferred brand: Greater of \$30 or 50% (maximum of \$90) 	
Mail Order Drugs (90-day supply)	You pay: <ul style="list-style-type: none"> • Generic: \$25 copay • Preferred brand: \$50 copay • Non-preferred brand: \$90 copay 		You pay: <ul style="list-style-type: none"> • Generic: \$25 copay • Preferred brand: \$50 copay • Non-preferred brand: \$90 copay 		You pay: <ul style="list-style-type: none"> • Generic: \$25 copay • Preferred brand: \$50 copay • Non-preferred brand: \$90 copay 	

⁽¹⁾ The deductible must be met before benefits are payable under the Core and Core Plus plans. All benefits are subject to the deductible, unless otherwise noted. The medical plan deductible need not be met for outpatient retail and mail order prescription drugs. Under the Copay Plan, certain services are covered by a copay; all other benefits are subject to the deductible, unless otherwise noted.

HDHP Medical Benefits for 2011-2012

Overview	\$1,500 HDHP with HSA		\$2,500 HDHP with HSA	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible ⁽¹⁾	\$1,500/person \$3,000/family of 2+*	\$2,500/person \$5,000/family of 2+*	\$2,500/person \$5,000/family of 2+*	\$5,000/person \$10,000/family of 2+*
Annual Out-of-Pocket Limit	\$3,500/person \$7,000/family of 2+	\$5,000/person \$10,000/family of 2+	\$3,450/person \$6,900/family of 2+	\$5,000/person \$10,000/family of 2+
Office Visit	Plan pays 80%	Plan pays 60%	Plan pays 80%	Plan pays 60%
Well Adult Care	Plan pays 100% No deductible	Plan pays 60% No deductible	Plan pays 100% No deductible	Plan pays 60% No deductible
Well Child Care	Plan pays 100% No deductible	Plan pays 60% No deductible	Plan pays 100% No deductible	Plan pays 60% No deductible
Outpatient Lab and x-ray (including MRI, PET & CT scans)	Plan pays 80%	Plan pays 60%	Plan pays 80%	Plan pays 60%
Urgent Care	Plan pays 80%	Plan pays 60%	Plan pays 80%	Plan pays 60%
Emergency Room	Plan pays 80%	Plan pays 80%	Plan pays 80%	Plan pays 80%
Inpatient Hospital	Plan pays 80%	Plan pays 60%	Plan pays 80%	Plan pays 60%
Outpatient Hospital	Plan pays 80%	Plan pays 60%	Plan pays 80%	Plan pays 60%
Outpatient Behavioral Health Visits	Plan pays 80%	Plan pays 60%	Plan pays 80%	Plan pays 60%
Prescription Drugs (30-day supply) After deductible**	You pay: • Generic: Greater of \$10 or 25% • Preferred brand: Greater of \$20 or 30% (maximum of \$45) • Non-preferred brand: Greater of \$30 or 50% (maximum of \$90)		You pay: • Generic: Greater of \$10 or 25% • Preferred brand: Greater of \$20 or 30% (maximum of \$45) • Non-preferred brand: Greater of \$30 or 50% (maximum of \$90)	
Mail Order Drugs (90-day supply) After deductible**	You pay: • Generic: \$25 copay • Preferred brand: \$50 copay • Non-preferred brand: \$90 copay		You pay: • Generic: \$25 copay • Preferred brand: \$50 copay • Non-preferred brand: \$90 copay	

(1) The deductible must be met before the HDHP plan pays benefits. All benefits are subject to the deductible, unless otherwise noted.

* The family deductible must be met before claims are paid for any member of the family.

** You must meet the annual deductible before the HDHP plan pays a prescription drug benefit, with the exception of certain preventive medications and medical services not subject to the deductible. In the back pocket of this guide you will find a detailed list of medications that are exempt from this rule under the HDHP plans.

Dental and Life Insurance

Dental Benefit Overview	Employer-Paid Dental
Plan Year Deductible	\$50/single; \$150/family
Plan Year Maximum	\$1,500/member
Orthodontia Lifetime Maximum (children under 17)	\$1,500/member
Routine Services	100% No deductible (includes exams, x-rays, routine cleaning, fluoride treatment up to age 18, and space maintainers)
Basic Services	80% (includes restorative/fillings, oral surgery, periodontics, endodontics, and emergency treatment)
Major Services	50% after deductible (includes restorative/crowns, implant, bridges, and denture/bridge repair)
Orthodontics (braces need to be banded by age 17)	50% after deductible



Delta Dental

You have a choice between the Employer-Paid Dental Plan and the Voluntary Dental Plan (based on your employer's election).

The pool's dental coverage offers you and your family a large network of Delta Dental Premier Network dentists. By using a Premier provider, you will pay less out of your own pocket.

You also have the option of using a dentist outside of the Delta Dental network. However, if you receive services from an out-of-network provider, you will have to pay the difference between your dentist's charges and Delta Dental's allowable fee, in addition to your normal percentage of the cost.

For a list of participating providers in the Delta Dental Premier Network, visit: <http://www.deltadentalaz.com>.



Basic Life and AD&D Insurance (Sun Life)

APEHP's life insurance and accidental death and dismemberment (AD&D) insurance benefit will continue to be provided through Sun Life. The coverage amounts will remain at:

- \$50,000 of basic group life insurance; and
- \$50,000 of AD&D insurance.

The monthly premium for this benefit is paid entirely by your employer.

Employees may change their beneficiary information at any time during the year. To update your beneficiary information, please contact your human resources department.

NOTE: If you do not elect coverage for new dependent children when they first become eligible (birth, date of adoption, etc.) you must provide evidence of insurability (EOI) when you do elect coverage.

Voluntary Products

Vision Benefits

The pool provides voluntary vision benefits through the Vision Service Plan (VSP). If you elect this coverage, you can see a VSP provider and receive coverage for eye exams, lenses, and frames. The chart on the right provides highlights of the vision benefits.



Benefit Overview	PPO Vision Plan	
Monthly Premium	Employee Only	\$9.21
	Employee + Spouse/ Domestic Partner	\$13.90
	Employee + Child(ren)	\$14.88
	Employee + Family	\$23.78
	In Network VSP Provider	Out-of-Network Reimbursement
Exam (one every 12 months)	\$10 copay	Up to \$45
Lenses (one every 12 months)	\$25 copay	
Single Vision	Plan pays 100%	Up to \$30
Bifocal	Plan pays 100%	Up to \$50
Trifocal	Plan pays 100%	Up to \$65
Progressive	Plan pays 100%	Not covered
Eyeglass frames (one set every 24 months)	\$130 max	\$70
Contact lenses (one prescription every 12 months)	\$130 max	\$105 max

Sun Life Voluntary Life

To supplement APEHP's employer-paid life insurance and AD&D coverage, the pool offers you the opportunity to buy voluntary life and AD&D insurance, through Sun Life, for yourself, your spouse/domestic partner, and your children.

If you enroll in voluntary life insurance, you are automatically enrolled in voluntary AD&D at no additional cost.

If you wish to enroll this year for additional life insurance, you must complete a medical evidence of insurability (EOI) form from Sun Life. EOI is also required for new participants if the amount of life insurance is in excess of the guaranteed issue amount.

Optional coverage can be purchased as follows:

Employee—in increments of \$10,000, to a maximum of \$750,000, not to exceed five times salary. Unless you are a new employee, any additional amount you apply for requires an EOI (guaranteed issue amount: \$150,000).

Spouse—in increments of \$10,000, and not to exceed 100% of the employee's amount. Unless you are a new employee, any additional amount you apply for requires an EOI (up to \$200,000; guaranteed Issue amount: \$30,000).

Child(ren)—in increments of \$5,000, not to exceed \$10,000 (no EOI required; guaranteed issue amount: \$10,000).

Rates for voluntary insurance are based on the employee's age and the coverage amount. Please refer to the table to the right and/or to your voluntary life and AD&D summary of benefits for information on costs.

Employees will automatically be the beneficiary for all dependent life insurance.

Rate Per \$10,000 of Coverage		
Age	Employee	Spouse
<20	\$0.66	\$0.66
20–24	\$0.66	\$0.66
25–29	\$0.76	\$0.76
30–34	\$0.96	\$0.96
35–39	\$1.06	\$1.06
40–44	\$1.16	\$1.16
45–49	\$1.66	\$1.66
50–54	\$2.46	\$2.46
55–59	\$4.46	\$4.46
60–64	\$6.79	\$6.79
65–69	\$12.86	\$12.86
70+	\$20.66	Not available
Child		
Rate	Coverage Elections	
\$0.70	\$5,000.00	
\$1.39	\$10,000.00	

Flexible Spending Accounts (FSA)

How FSAs Work

When you elect to contribute to a Health Care or Dependent Care FSA, you decide, in advance, how much to contribute each fiscal year, subject to certain maximums (discussed below). The dollar amount you specify is taken from your paycheck in the form of a pre-tax deduction, which is deposited into your FSA account. You can then pay for eligible medical expenses using FSA dollars. Please note, however, that expenses for a domestic partner or dependent of a domestic partner do not qualify for the Health Care FSA.

Flexible spending accounts allow you to maximize the dollars you use to pay certain expenses for health care and dependent care. Because you bypass most taxes, you save money. Let's say that 30 percent of your paycheck normally goes to taxes. If you use after-tax dollars to pay for your medical expenses, you have only \$70 available for every \$100 you earn. But with an FSA and the pre-tax dollars you deposit in it, you have the full \$100 to apply to your medical expenses. Plus, your FSA contributions can be made through the convenience of direct deposit from your paycheck.

There are two types of flexible spending accounts, or FSAs: Health Care and Dependent Care:

▪ **Health Care FSA:** When you enroll in the Core, Core Plus, or Copay medical options, you may contribute a maximum of \$2,400 per year to the Health Care FSA. Money in this account can be used to pay for a long list of IRS-approved medical, dental, and vision expenses incurred by you or your family during the fiscal year, from July 1 through June 30.

▪ **Dependent Care FSA:** This account can be used to pay for eligible dependent child or elder care expenses for your qualified dependents. Eligible expenses are defined by the IRS, based on the tax code. (See the discussion on the right side of this page.)

If you are covered under an HDHP, you may not enroll in an Health Care FSA. However, you may still contribute to the Dependent Care FSA.

Because FSAs offer tax savings, the IRS has established guidelines regarding the amount you can contribute and what expenses are eligible for reimbursement. As one example, if your spouse is a full-time student or is incapable of self-care and you are utilizing the Dependent Care FSA, your payments are limited to the smallest of the following amounts:

- \$5,000 (\$2,500 if you are married but filing separately);
- your earned income; or
- your spouse's earned income if you are married at the end of the taxable year.

To enroll in an FSA, complete and submit the appropriate form(s) included in this enrollment packet.

Please note that as a result of federal health care reform, employees may receive FSA reimbursement for eligible expenses incurred by adult children under the age of 26.

Plan Carefully!

Plan your expenses carefully. You are not permitted to change the amount of your deductions or terminate participation during the year.

When estimating your expenses, remember:

- You are estimating expenses you will incur *during* the fiscal year.
- Try not to overestimate; you will forfeit any money not spent before June 30, 2012.
- You will have until September 30, 2012 to submit claims for FSA-eligible expenses you incurred during the previous (2011–2012) fiscal year.

NOTE: The FSA will only reimburse the cost of over-the-counter medications if a health care provider prescribes them with a written prescription. (Insulin is excepted from this rule.)

Eligible Health Care Expenses Under an FSA

Eligible health care expenses are defined under Section 213 of the Internal Revenue Code. IRS Publication 502 also has a complete list of eligible expenses. (See <http://www.irs.gov>.) Generally, reimbursable expenses are those you could claim as a deduction on your federal income tax return.

Eligible Dependent Care Expenses Under an FSA

Eligible dependent care expenses are those incurred for dependent care that is necessary for you or your spouse to be gainfully employed. IRS Publication 503 has a complete list of eligible dependent care expenses. (See <http://www.irs.gov>.) Dependent care can be for any member of your household who is under age 13 and whom you could claim as a dependent on your federal income tax return, or any adult who lives with you at least eight hours a day, who is physically or mentally unable to care for him/herself, and whom you could also claim as a dependent on your federal income tax return (a spouse or elderly parent, for example).

Eligible services may be provided in your home or another location, but must be incurred for dependent care, whether for a child or an adult, when that care enables you or your spouse to remain gainfully employed. The care must also be rendered by someone who is not your dependent, your spouse, or your child, and who is not under the age of 19.

Getting Reimbursed

To receive tax-free reimbursement from your FSA(s), simply submit a claim form and the receipts for your eligible expenses, or use your FSA debit card. Claim forms are available from AmeriBen (see Contact Us, page 5), and from APEHP online at <http://www.apehp.org>.

For the Health Care FSA, you will be reimbursed the full amount of every eligible claim you file, up to the total amount you elect to contribute for the year. For the Dependent Care FSA, you will be reimbursed in full *only* if sufficient money is in your account. Otherwise, you will receive reimbursement for the amount in your account at the time you submit the claim, and the balance when additional contributions are made to your account.

Flexible Spending Accounts (FSA)

Tax Considerations

The IRS determines the types of health care and dependent care expenses that are eligible for reimbursement from your FSA. To see a complete list of allowable health care and dependent care expenses, visit the IRS Web site at <http://www.irs.gov>. (See Publications 502 and 503, respectively.)

Please note that you may not claim a tax deduction for any health care expense reimbursed from your Health Care FSA or Dependent Care FSA.

FSA Plan Document

Further details on how the FSA plan works are provided in the FSA Plan Document/Summary Plan Description.

For a copy, please contact the pool at (800) 718-8328, or visit <http://www.apehp.org>.

The example below illustrates how an FSA may help you save money on taxes, leaving more dollars in your pocket:

Example		
	With the FSA	Without the FSA
Adjusted Gross Income	\$20,000	\$20,000
Health Care FSA Contribution	-1,500	-0
Dependent Care FSA Contribution	-0	-0
Taxable Income	\$18,500	\$20,000
Taxes (federal income & FICA)*	-2,760	-3,010
After-tax Income	\$15,740	\$16,990
Reimbursements from the FSA(s)	+1,500	+0
“Spensible Income”	\$17,240	\$16,990
Savings with the FSA	\$250	\$0

**This example and the estimated tax rates are for illustrative purposes only. The example does not include state taxes; thus, your individual tax savings may differ. Please consult with a tax professional regarding your specific situation.*

Health Care Expense Estimator

While health care needs can't always be foreseen, many health care expenses occur regularly, such as copayments for routine doctor visits and prescription drugs. Other regular expenses include amounts spent on eligible health care items not covered (or only partially covered) by your health care plans, such as prescription sunglasses, chiropractic treatment, etc.

Review your health care expenses from the past several years, as they could help you predict future expenses. You can also use the worksheet below to help estimate your costs.

2011–2012 Eligible Health Care Expenses

Deductibles	\$
Copayments and coinsurance amounts	+
Charges above the amounts payable by your health care plans	+
Medical, dental, orthodontia, and vision care expenses not covered by your health care plans	+
Prescription drug copayments and expenses	+
Other eligible expenses	+
Total Estimated Health Care Expenses	=
Maximum annual contribution amount	\$2,400
Your 2011–2012 annual contribution amount*	\$

**Write this amount on your FSA enrollment form.*

Health Savings Account (HSA)

A health savings account (HSA) is available only when you enroll in one of the HDHP medical plans. HSAs are designed to allow individuals to use tax-favored contributions to pay for eligible health care expenses.

How HSAs Work

When you elect coverage under one of the HDHP options, an HSA will be established for you. This account will help you pay for certain eligible health care expenses, along with expenses not covered by the plan, such as your deductible. You can use your HSA debit card to make qualifying purchases (see information to the right).

For 2011–2012, if you are an active employee, you may contribute pre-tax dollars up to \$3,050 for individual coverage, and \$6,150 for family coverage (less any contributions made by your employer). You can also make an additional \$1,000 “catch-up” contribution if you are 55 or older. All money deposited into your account, either by you or your employer, will earn interest just like a savings account, but on a tax-free basis. And, unlike an FSA account, your money is not lost if you do not spend it by the end of the year. The HSA balance rolls over to the next year.

If you elect an HDHP, you must meet the annual deductible before the plan pays benefits, with the exception of certain preventive medications and medical services not subject to the deductible. You will find a detailed list of medications that are exempt from this rule under the HDHP on the Arizona Public Employers Health Pool Web site at <http://www.apehp.org>.

Special Note: There are certain HSA eligibility requirements, restrictions, and tax considerations dictated by federal law. For more information, call the HSA administrator, Health Equity, at (866) 346-5800.

Eligible Health Care Expenses

An HSA helps you pay for certain health care expenses that are not otherwise covered by the plan, including your annual deductible. In general, eligible health care expenses include any non-reimbursed medical, dental, or vision expense that can be deducted on your individual tax return if you itemize deductions. (Eligible deductions are described in IRS Publication 502.) Some examples include:

- copayments and coinsurance amounts;
- prescription drugs;
- additional amounts you pay when you do not use an in-network provider (for example, amounts over the plan’s allowed amount); and
- Medicare premiums (including Part A, Part B, Part D, and Medicare managed care) or employer-sponsored health coverage premiums, including premiums for post-employment COBRA coverage.

To see a complete list of allowable expenses, visit the IRS Web site at <http://www.irs.gov> and review Publication 502.

How to Enroll in an HSA

If you are electing an HDHP medical option for the first time, you will need to complete an additional enrollment form in order to establish your HSA. Please check with your employer’s benefit office or attend an open enrollment meeting.

What’s New?

- The health savings account vendor is Health Equity.
- One debit card is issued to all participants; however, two additional cards can be requested at no charge.
- ATM access will not be permitted through Health Equity.

Paying Expenses from Your HSA

When you enroll in an HDHP, you will receive more information on how to make HSA contributions, and how you can access the money in your HSA to pay for eligible health care expenses. In many instances, paying for eligible expenses is as easy as using your HSA debit card. However, the amount available to you to pay eligible expenses can never exceed the amount in your HSA at the time of withdrawal.

If you pay expenses through your HSA, you cannot deduct those expenses on your individual tax return. Also, if you use the money in your HSA for non-eligible expenses, that distribution will be taxed, generally with a 20 percent penalty. But once money is deposited in your HSA, it’s yours—even when you are no longer eligible for coverage under the plan. If you don’t use all of the money in your account, your account balance will continue to grow each year, and you won’t have to pay taxes on any interest earned. This money can be used in years when you have greater-than-expected health care expenses. Or, at retirement, you can use the money to help pay for retiree health expenses. There is no “use-it-or-lose-it” provision; the money remains in your account **until you choose to use it, even if you change employers.**

Tax Considerations

With an HSA, you are responsible for determining whether or not an expense is eligible to be paid from your account. In addition, you cannot claim a tax deduction for any health care expense reimbursed from your HSA. The IRS determines the types of health care expenses that are permitted for reimbursement from an HSA.

To see a complete list of allowable expenses, visit the IRS Web site at <http://www.irs.gov>, and review Publication 502.

Special Note: In order to open an HSA and make tax-free contributions to that account, you must be “HSA eligible.” IRS guidelines define an HSA-eligible individual as a person who:

- is covered under an HDHP,
- has no other health coverage (except as permitted by the IRS),
- is not enrolled in Medicare, and
- cannot be claimed as a dependent on someone else’s tax return.

For more information, call the HSA administrator, Health Equity, (866) 346-5800.

Health Savings Account Examples

Here are two examples illustrating how you can use an HSA to help pay for deductibles and other qualified medical expenses:

Example One

Joe elects individual coverage in the \$1,500 HDHP. On July 1, he puts the maximum (set by the IRS) of \$3,050 in his HSA. Here are Joe's in-network medical expenses for 2011–2012:

Service/benefit	Amount	What's covered	HSA Balance
			\$3,050
Annual physical	\$ 300	Plan pays 100% (because it's well adult care)	\$3,050
Hospital visit	\$ 750	Plan does not begin to pay coinsurance (80%) until deductible has been met. HSA pays \$750.	\$2,300
Prescriptions	\$ 200	HSA pays \$200.	\$2,100
X-rays, MRI	\$2,000	HSA pays \$550. Joe has now met his \$1,500 deductible. The plan pays 80% of the remaining balance of \$1,450, or \$1,160; the HSA pays the remaining \$290 (20%).	\$ 1,260

At year-end, Joe received \$3,250 in services/benefits; his HSA paid for \$1,790, and the plan paid for \$1,460. Joe has \$1,260 remaining in his HSA that "rolls over" in 2012–2013.

Example Two

Fred and Sally elect family coverage (for themselves and their two children) in the \$2,500 HDHP. The family deductible is \$5,000. On July 1, they put the maximum (set by the IRS) of \$6,150 in their HSA. Here are the family medical expenses for 2011–2012:

Service/benefit	Amount	What's covered	HSA Balance
			\$6,150
Annual physicals	\$1,000	Plan pays 100% (because it's well adult and well child care)	\$6,150
Hospital visits	\$4,000	Plan does not begin to pay coinsurance (80%) until deductible has been met. HSA pays \$4,000	\$2,150
Prescriptions	\$ 400	HSA pays \$400	\$1,750
Office visits (colds, flu)	\$ 500	Plan does not begin to pay coinsurance (80%) until deductible has been met. HSA pays \$500	\$1,250

At year-end, Fred and Sally received \$5,900 in services/benefits; their HSA paid for all of it (with the exception of the physical examinations, which are covered by the plan at 100%). Because they did not meet their \$5,000 family deductible, the plan's coinsurance did not apply. Fred and Sally have \$1,250 remaining in their HSA that will "roll over" in 2012–2013.



We want to help you stay healthy. Make this the year you really focus on your health and well-being!

Note: Your physician must use wellness codes when billing these services to the plan, or they will not be recognized as wellness and will not be covered at 100%.

Wellness Benefits for 2011–2012

The following benefits are covered 100% per plan year, no deductible, in-network:

- **Female adult physical exams and annual well woman exams (new benefit)**
- **Prostate screenings (new benefit)**
- Adult physical exam, expanded to cover blood pressure, weight, personal and family history, general physical exam, breast exam, testicular exam, and skin cancer exam
- Annual screening pap smear and lab work
- Cholesterol or lipid panel screening
- Screening for sexually transmitted diseases (STDs), including chlamydia, syphilis, and gonorrhea infections (annually for sexually active women ages 25 and younger, and other women at-risk)
- FOBT: Fecal occult blood test, a take-home lab test (e.g., Guaiac lab test or newer Fecal Immunochemical Test (FIT) such as InSure to take home, collect specimen, and return to lab)
- Screening abdominal ultrasound (once for men ages 65 to 75 who have ever smoked)
- Adult immunizations for MMR, meningitis, polio, hepatitis A and B, and chickenpox (varicella)
- Blood glucose screening lab work
- Hearing exam (also called an audiometry exam)
- Screening mammogram (covered 100 percent in-network once per year beginning at age 35, no deductible)
- HPV immunization (e.g., Gardasil, covered 100 percent in-network for females ages 9-26; for females younger than 18, benefit is not covered out-of-network)
- Annual flu shot
- Screening Prostate Specific Antigen (PSA) blood test
- Screening colonoscopy (Covered 100 percent in-network with no deductible. Not covered out-of-network. Payable once every 10 years starting at age 50. May be payable at a younger age, or more frequently with proof of first-degree relative with a history of colorectal cancer or familial adenomatous polyposis or hereditary non-polyposis colorectal cancer.)
- Well child exam visit
- Well child exam visits and immunizations from birth to age two
- Well child physical exam for sports
- Prenatal vitamins, payable under the prescription plan (see retail/mail order prescription drug benefit)

Employee Assistance Program (EAP)

APEHP continues to offer access to an employee assistance program (EAP). Under the EAP, both you and your family can receive a variety of services to help identify and address problems that impact the workplace—all at no additional cost to you.

Counseling (up to six visits per situation) is available, and all information that you share with the EAP counselor will be kept confidential. EAP counselors are state licensed or certified master's- or doctoral-level clinicians with years of counseling experience. In addition, many are certified employee assistance professionals, which means that they have special knowledge of workplace issues. They can assist with personal, family, and employment problems, such as work-related stress, substance abuse, relationship or marital conflict, parent-child conflict, depression, anxiety, unresolved grief, and domestic violence. Counselors can also help with referrals to doctors and to sources of legal or financial assistance.



For more information, log on to the EAP Web site at <http://www.eappreferred.com> and click on the link to My Life Values. Your user name is **EAPP123**; your password is **eappreferred**. For an appointment or additional information, call: **(800) 327-3517, ext. 2**.



Special Plan Notices

Mid-Year Changes to Your Medical Plan Elections

IMPORTANT: After the current open enrollment period is completed, you generally will not be permitted to change your benefit elections or add/delete dependents until next year's open enrollment, unless you experience a "Special Enrollment Event" or a "Mid-year Change in Status."

Special Enrollment Event: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for your other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within **31 days** after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you gain a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within **31 days** after the marriage, birth, adoption, or placement for adoption.

You and your dependents may also enroll in this plan if:

- you (or your dependents) have coverage through Medicaid or the state Children's Health Insurance Program (CHIP) and lose eligibility for that coverage; however, you must request enrollment within **60 days** after the Medicaid or CHIP coverage ends; or
- you (or your dependents) become eligible for a premium assistance program through Medicaid or CHIP; however, you must request enrollment within **60 days** after you (or your dependents) are determined to be eligible for such assistance.

To request special enrollment or obtain more information, contact the Arizona Public Employers Health Pool at (800) 718-8328.

Mid-year Change in Status Event: The following events may allow certain changes in benefits mid-year, if permitted by the Internal Revenue Service:

- change in legal marital status (e.g., marriage, divorce/legal separation, death)
- change in number or status of dependents (e.g., birth, adoption, death)
- change in employee/spouse/dependent's employment status, work schedule, or residence that affects eligibility for benefits
- coverage of a child due to a qualified medical child support order (QMCSO)
- eligibility or loss of eligibility for Medicare or Medicaid
- certain changes in the cost or composition of coverage, or curtailment of coverage, of the employee's or spouse's plan
- changes consistent with special enrollment rights and FMLA leaves

You must notify the plan in writing within **31 days** of the mid-year change in status event by contacting the Arizona Public Employers Health Pool and requesting a copy of the necessary form. The number is (800) 718-8328.

The pool will determine whether your change request is permitted. If so, changes become effective on the first day of the month following the approved change in status event (except for newborn and adopted children, who are covered retroactively to the date of birth, adoption, or placement for adoption).

Medicare Notice of Creditable Coverage

If you or your eligible dependents are currently Medicare eligible, or will become Medicare eligible during the next 12 months, be sure to determine whether the prescription drug coverage that you elect through the pool is or is not creditable with (as valuable as) Medicare's prescription drug coverage. To determine whether the prescription drug coverage under the plan options offered by the pool is or is not creditable, you should review the plan's Medicare Part D Notice of Creditable Coverage, which is available from the Arizona Public Employers Health Pool representative.

This open enrollment guide is intended only as a brief description of your plan benefits. It attempts to describe important details and changes to the plans in a clear, simple, and concise manner. If there is a conflict between this guide and the wording of plan documents, the plan documents will govern. The pool retains the right to change, modify, suspend, interpret, or cancel some or all of the benefits or services at any time.

Special Plan Notices (continued)

Privacy Policy

The 1996 Health Insurance Portability and Accountability Act (HIPAA) privacy rules apply to providers of medical services, including hospitals and doctors, HMOs, insurance companies, and health plans. These rules are intended to protect your personal information from being inappropriately disclosed. They also establish additional rights concerning the use of your healthcare information.

The pool's HIPAA privacy statement is available by calling (800) 718-8328 and requesting a copy from the Arizona Public Employers Health Pool representative.

COBRA Coverage

In compliance with a federal law referred to as COBRA, this plan offers its eligible employees and their covered dependents (known as qualified beneficiaries) the opportunity to elect temporary continuation of their group health coverage when that coverage would otherwise end because of specific events (called qualifying events).

Qualified beneficiaries are entitled to elect COBRA when qualifying events occur, and, as a result of the qualifying event, coverage for that qualified beneficiary ends. Qualified beneficiaries who elect COBRA continuation coverage must pay for it at their own expense.

Qualifying events include termination of employment, reduction in hours of work that make the employee ineligible for coverage, death of the employee, divorce/legal separation, or a child ceasing to be an eligible dependent. The maximum period of COBRA coverage is generally either 18 months or 36 months, depending on which qualifying event occurred.

In order to have the option of electing COBRA coverage after a divorce/legal separation, or after a child ceases to be a dependent under the plan, **you and/or a family member must inform the plan in writing of that event no later than 60 days after the event occurs.** The notice should be sent to the Arizona Public Employers Health Pool via first class mail, and should include the employee's name, the qualifying event, the date of the event, and the appropriate documentation in support of the qualifying event (such as divorce documents).

If you have questions about COBRA, contact the Arizona Public Employers Health Pool at (800) 718-8328 and ask to speak with a representative.



Pre-existing Condition Exclusion

This plan has a pre-existing condition exclusion. This means that if you have a pre-existing medical condition before joining the Arizona Public Employers Health Pool, you may have to wait a fixed period before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a **three-month period before becoming eligible for coverage under this plan.** Generally, this three-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the three-month period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy, or to individuals under the age of 19.

The pre-existing condition exclusion may last up to 6 months (or 12 months for dependents) from your first day of coverage, or if you were in a waiting period, from the first day of your waiting period. **However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage."**

Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not had a break in coverage of at least 63 days. To reduce the six-month exclusion period (or 12-month exclusion period for dependents) by the length of your creditable coverage, you must provide a copy of any certificates of creditable coverage you have.

If you do not have a certificate but you do have prior health coverage, the pool can help you obtain a certificate from your prior plan or issuer. There are other ways of demonstrating that you have creditable coverage as well; please contact the plan administrator if you need help.

Questions about the pre-existing condition exclusion and creditable coverage should be directed to the Arizona Public Employers Health Pool representative at (800) 718-8328.

Women's Health and Cancer Rights Act of 1998

For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

Plan limits, deductibles, copayments, and coinsurance apply. For more information on these benefits, call (800) 718-8328 and ask to speak with the Arizona Public Employers Health Pool representative.

Notice that Lifetime Limit No Longer Applies, and Related Enrollment Opportunity

The lifetime limit on the dollar value of benefits under the Arizona Public Employers Health Pool no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to reenroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information, contact the Arizona Public Employers Health Pool representative at (800) 718-8328.

Special Plan Notices (continued)

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage To Children And Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP, and you live in a state listed below, you can contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your state Medicaid or CHIP office or dial **(877) KIDS NOW**, or go to <http://www.insurekidsnow.gov> to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan—as long as you and your dependents are eligible, and are not already enrolled in the employer's plan. This is called a "special enrollment" opportunity; you must request coverage within 60 days of being determined eligible for premium assistance.

If you live in one of the following states, you may be eligible for assistance with employer health plan premiums. The following list of states is current as of January 31, 2011. You should contact your state for further information on eligibility.

ALABAMA: Medicaid	CALIFORNIA: Medicaid
Web site: http://www.medicaid.alabama.gov Phone: (800) 362-1504	Web site: http://goo.gl/Ods2a Phone: (866) 298-8443
ALASKA: Medicaid	COLORADO: Medicaid and CHIP
Web site: http://www.hss.state.ak.us/dpa/programs/medicaid/ Phone (outside of Anchorage): (888) 318-8890 Phone (Anchorage): (907) 269-6529	Medicaid Web site: http://goo.gl/EaZyV Medicaid phone (in state): (800) 866-3513 Medicaid phone (out of state): (800) 221-3943 CHIP Web site: http://www.CHPplus.org CHIP phone: (303) 866-3243
ARIZONA: CHIP	
Web site: http://www.azahcccs.gov/applicants/default.aspx Phone (outside of Maricopa County): (877) 764-5437 Phone (Maricopa County): (602) 417-5437	
ARKANSAS: CHIP	FLORIDA: Medicaid
Web site: http://www.arkidsfirst.com/ Phone: (888) 474-8275	Web site: http://www.fdhc.state.fl.us/Medicaid/index.shtml Phone: (877) 357-3268

GEORGIA: Medicaid	MISSOURI: Medicaid
Web site: http://dch.georgia.gov/ ; click on Programs, then Medicaid Phone: (800) 869-1150	Web site: http://goo.gl/8qPx7 Phone: (573) 751-2005
IDAHO: Medicaid and CHIP	MONTANA: Medicaid
Medicaid Web site: http://goo.gl/KnC9U Medicaid phone: (800) 926-2588 CHIP Web site: http://www.medicaid.idaho.gov CHIP phone: (800) 926-2588	Web site: http://goo.gl/lh5NQ Phone: (800) 694-3084

Special Plan Notices (continued)

INDIANA: Medicaid	NEBRASKA: Medicaid
Web site: http://www.in.gov/fssa/2408.htm Phone: (800) 889-9948	Web site: http://www.dhhs.ne.gov/med/medindex.htm Phone: (877) 255-3092
IOWA: Medicaid	NEVADA: Medicaid and CHIP
Web site: http://www.dhs.state.ia.us/hipp/ Phone: (888) 346-9562	Medicaid Web site: http://goo.gl/HvMou Medicaid phone: (800) 992-0900 CHIP Web site: http://nevadacheckup.nv.gov/ CHIP phone: (877) 543-7669
KANSAS: Medicaid	
Web site: https://www.khpa.ks.gov Phone: (800) 792-4884	
KENTUCKY: Medicaid	NEW HAMPSHIRE: Medicaid
Web site: http://chfs.ky.gov/dms/default.htm Phone: (800) 635-2570	Web site: http://www.dhhs.nh.gov/ombp/medicaid/index.htm Phone: (603) 271-4238
LOUISIANA: Medicaid	NEW JERSEY: Medicaid and CHIP
Web site: http://www.lahipp.dhh.louisiana.gov Phone: (888) 342-6207	Medicaid Web site: http://goo.gl/N8QIi Medicaid phone: (800) 356-1561 CHIP Web site: http://www.njfamilycare.org/index.html CHIP phone: (800) 701-0710
MAINE: Medicaid	
Web site: http://goo.gl/uA52G Phone: (800) 321-5557	
MASSACHUSETTS: Medicaid and CHIP	NEW MEXICO: Medicaid and CHIP
Medicaid & CHIP Web site: http://goo.gl/AXk2c Medicaid & CHIP phone: (800) 462-1120	Medicaid Web site: http://www.hsd.state.nm.us/mad/index.html Medicaid phone: (888) 997-2583 CHIP Web site: http://goo.gl/t3nud ; click on Insure New Mexico CHIP phone: (888) 997-2583
MINNESOTA: Medicaid	
Web site: http://goo.gl/DsuoX Phone (outside of Twin City area): (800) 657-3739 Phone (Twin City area): (641) 431-2670	
NEW YORK: Medicaid	TEXAS: Medicaid
Web site: http://www.nyhealth.gov/health_care/medicaid/ Phone: (800) 541-2831	Web site: https://www.gethipptexas.com/ Phone: (800) 440-0493
NORTH CAROLINA: Medicaid	UTAH: Medicaid
Web site: http://www.ncdhhs.gov/dma/medicaid/index.htm Phone: (919) 855-4100	Web site: http://health.utah.gov/medicaid/ Phone: (866) 435-7414

Special Plan Notices (continued)

NORTH DAKOTA: Medicaid	VERMONT: Medicaid
Web site: http://goo.gl/Ob9eI Phone: (800) 755-2604	Web site: http://www.greenmountaincare.org/ Phone: (800) 250-8427
OKLAHOMA: Medicaid	VIRGINIA: Medicaid and CHIP
Web site: http://www.insureoklahoma.org Phone: (888) 365-3742	Medicaid Web site: http://goo.gl/XsbFT Medicaid phone: (800) 432-5924 CHIP Web site: http://www.famis.org/ CHIP phone: (866) 873-2647
OREGON: Medicaid and CHIP	WASHINGTON: Medicaid
Medicaid & CHIP Web site: http://goo.gl/V7uEX Medicaid & CHIP phone: (877) 314-5678	Web site: http://goo.gl/dKFtx Phone: (800) 562-3022, ext. 15473
PENNSYLVANIA: Medicaid	WEST VIRGINIA: Medicaid
Medicaid Web site: http://goo.gl/EUWdP CHIP Web site: http://www.chipcoverspakids.com/ Medicaid phone: (800) 644-7730 CHIP phone: (800) 986-KIDS	Web site: http://goo.gl/k2R11 Phone: (304) 342-1604
RHODE ISLAND: Medicaid	WISCONSIN: Medicaid
Web site: http://goo.gl/m2Wgj Phone: (401) 462-5300	Web site: http://goo.gl/f35Bw Phone: (800) 362-3002
SOUTH CAROLINA: Medicaid	WYOMING: Medicaid and CHIP
Web site: http://www.scdhhs.gov/medicaid.asp Phone: (888) 549-0820	Medicaid and CHIP Web site: http://goo.gl/cc7B8 Phone: (307) 777-7656

To determine whether other states have added a premium assistance program since January 31, 2011, or for more information on special enrollment rights, you may contact:

U.S. Department of Labor
Employee Benefits Security Administration
<http://www.dol.gov/ebsa>
(866) 444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
<http://www.cms.hhs.gov>
(877) 267-2323, ext. 61565

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