

ARIZONA STATE RETIREMENT SYSTEM

RETIREE GROUP HEALTH INSURANCE INITIAL ENROLLMENT GUIDE

2016

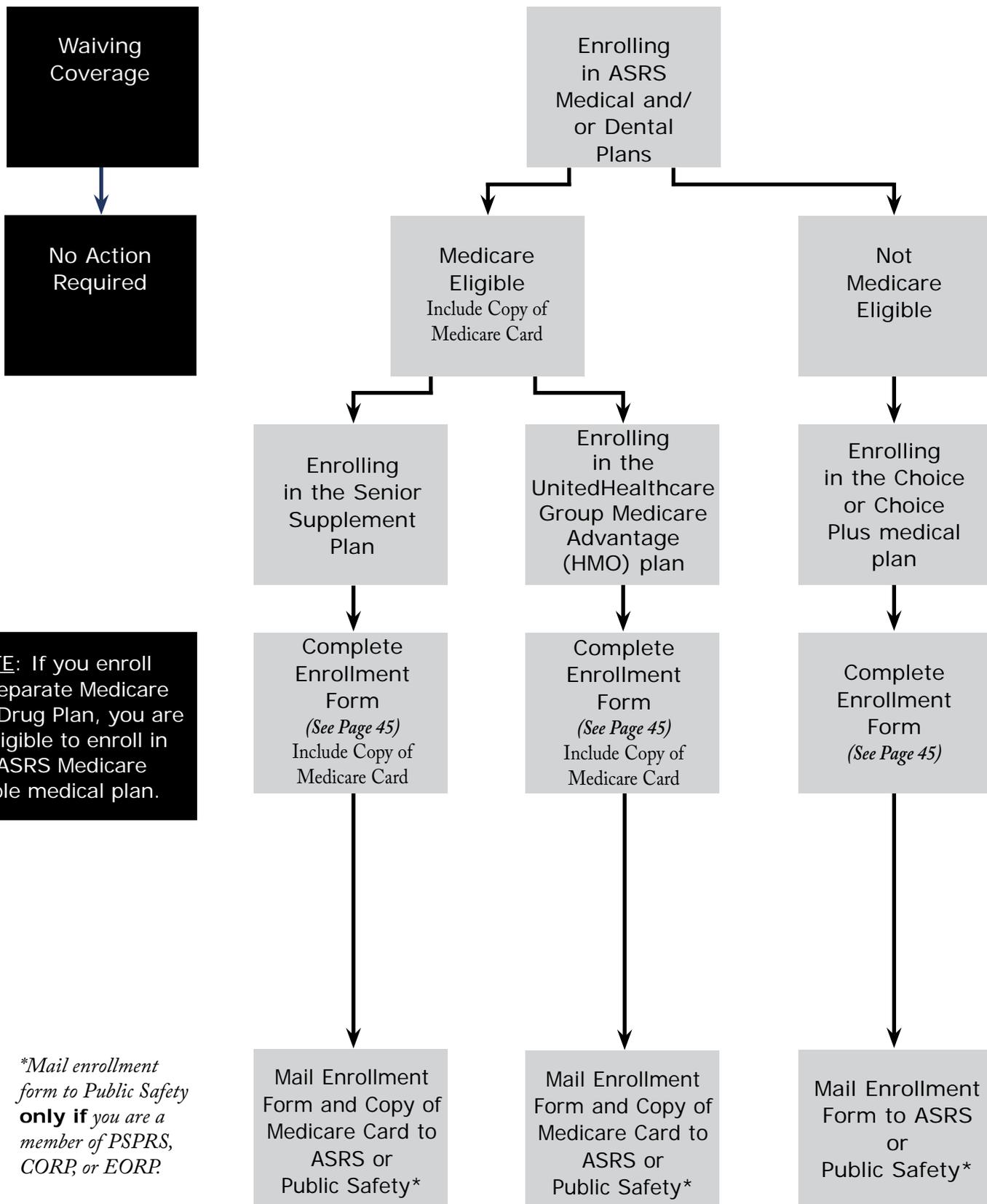


Effective January 1, 2016



2016 ASRS Enrollment

At-a-Glance



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Arizona State Retirement System

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Welcome and Congratulations!

Welcome to your retiree health care program. You may elect to participate in this program whether you retire from the Arizona State Retirement System (ASRS), Public Safety Personnel Retirement System (PSPRS), Elected Officials' Retirement Plan (EORP), Corrections Officer Retirement Plan (CORP) or University Optional Retirement Plans (UORP). We recognize that you may have a choice in retiree health care programs not only from the ASRS but also from your employer or, if applicable, a health care plan sponsored by the Arizona Department of Administration (ADOA).

This guide is intended to help you become better acquainted with the features and options of the ASRS health insurance program. For Medicare eligible retirees the ASRS provides two options: UnitedHealthcare Group Medicare Advantage (HMO) plan and the Senior Supplement plan. For non-Medicare eligible retirees there are two choices: the Choice Plan (in-network and in-state only) and the Choice Plus Plan (out-of-state) health insurance plans.

This summary provides only a general overview of the benefits of enrolling in the ASRS retiree health care program. It does not include details of all covered expenses or exclusions and limitations. Please refer to each plan's Evidence of Coverage (EOC) booklet for exact terms and conditions of coverage. The carrier mails EOCs to enrolled members upon initial enrollment or if requested.

The ASRS program includes choices of medical plans with prescription drug coverage, dental plans, a health discount savings card applicable to all retirees whether or not enrolled in the ASRS program, wellness and disease management programs, a nurse line, housecalls visits to your home and the SilverSneakers fitness program. There are other useful and important topics also covered in this guide, such as premiums for the insurance plans, explanations of the Premium Benefit and Optional Premium Benefit Programs, an overview of your Medicare benefits, frequently asked questions, various worksheets, and instructions on how to complete the enrollment process.

Please don't "go it alone" as ASRS knowledgeable staff are ready to help you understand the features of the ASRS plans outlined in this guide. If you have questions about your ASRS retirement or health benefits, please contact an ASRS Benefits Advisor in our Member Advisory Center. Likewise assistance may be received from the Public Safety Personnel Retirement System staff if you are a retiree of that retirement system, or the Corrections Officer or Elected Officials' retirement plans. Our staff is familiar with the complex topics governing this health care program and can help you navigate through this guide, offering additional information that you may find helpful. Phone numbers and web addresses are listed on the inside back cover of this guide.

To your health,

ARIZONA STATE RETIREMENT SYSTEM

About This Guide

Information provided in this Guide is intended solely to help you make important enrollment decisions.

The benefits described are highlights of the Arizona State Retirement System's (ASRS) retiree health insurance program. The information is effective January 1, 2016 unless otherwise noted.

This Guide constitutes a summary of the ASRS's official plan documents, contracts, Arizona statutes and federal regulations that govern the plans. If there is any discrepancy

between the information in this guide and the official documents, the official documents will always govern.

The ASRS reserves the right to change or terminate any of its plans, in whole or in part, at any time in accordance with state laws.

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Overview of 2016 Retiree Group Health Insurance Program

PLEASE READ THIS GUIDE CAREFULLY.

Who is eligible to participate?

As a retiring employee of a Participating Employer of the Arizona State Retirement System (ASRS), Public Safety Personnel Retirement System (PSPRS), Corrections Officer Retirement Plan (CORP), Elected Officials' Retirement Plans (EORP DB Plan -or- EORP DC Plan), or the University Optional Retirement Plans (UORP), you and your eligible dependents may enroll in a medical and/or dental plan provided by the ASRS. You must enroll no later than thirty-one (31) calendar days after your retirement date in order to preserve your eligibility to be covered by the ASRS upon your retirement. If you enroll no later than thirty-one (31) days after your retirement date, **your coverage will be effective on the first day of the month coincident with or following your retirement date and the timely submission of your properly completed retiree health insurance enrollment form(s).**

Enrollment also applies to any member who begins to receive a long-term disability (LTD) benefit from the ASRS and who may not be enrolled in health insurance benefits through his or her Participating Employer. If you receive health care coverage from your Participating Employer as a retiree, you may elect to become covered by the ASRS at a future date. You may enroll with the ASRS during our annual open enrollment period (usually in October of each year) or if you experience a "qualifying event" (see page 54).

If you are currently enrolled for health insurance with your Participating Employer, please contact them for specific employer-related enrollment information and continued eligibility for their insurance coverage.

ASRS Retiree Medical Plans

For 2016, UnitedHealthcare continues to be the sole provider offering medical benefits to eligible public sector retirees and LTD recipients and all eligible dependents through the Arizona State Retirement System.

Depending upon where you live and whether you are eligible for Medicare, UnitedHealthcare has the following plans from which to choose: Group Medicare Advantage (HMO) plan; a Senior Supplement plan which is a group retiree medical plan that pays secondary to Medicare; a non-Medicare in-network and in-state medical / prescription drug plan (UnitedHealthcare Choice plan); and a non-Medicare out-of-state UnitedHealthcare Choice Plus PPO plan.

Non-Medicare Eligible Plans

UnitedHealthcare Choice Plan (In-Network, In-State Only)

CHOICE is an HMO in-network in-state only plan that gives members the freedom to see any physician, specialist, hospital or other healthcare professional in the network - without a referral.

You must use contracted Choice providers within the State of Arizona except for urgent care and emergency services.

UnitedHealthcare Choice Plus PPO (Out-of-State)

CHOICE PLUS has coverage for in-network providers, as well as, non-network providers. It also gives members the freedom to see any physician, specialist, hospital or other healthcare professional in the network - without a referral. But Choice Plus gives members the added flexibility to seek care from doctors and hospitals outside the network - and still receive coverage. In order to control costs, additional out-of-pocket costs apply for non-network care.



Medicare Eligible Plans

UnitedHealthcare Group Medicare Advantage (HMO) Plan

UnitedHealthcare Group Medicare Advantage (HMO) Plan is a plan for members who are enrolled in Medicare Parts A & B and in which UnitedHealthcare has entered into a contract with The Centers for Medicare and Medicaid Services (CMS), the federal agency that administers Medicare. This contract authorizes UnitedHealthcare to provide comprehensive health services to persons who are entitled to Original (traditional) Medicare benefits and who choose to enroll in the Group Medicare Advantage (HMO) Plan. By enrolling in the Group Medicare Advantage (HMO) Plan, you have made a decision to receive all your routine health care from UnitedHealthcare contracted providers. If you receive services from a non-contracted provider without prior authorization, except for emergency services, out-of-area urgently needed services and renal dialysis, neither UnitedHealthcare nor Medicare will pay for those services.

Physician and network names are required on the enrollment form if you select the Group Medicare Advantage (HMO) Plan. Provider directories are available upon request. The plan is an approved Medicare medical plan with an approved Medicare prescription drug plan.

Senior Supplement Plan

Senior Supplement Plan is for members who are enrolled in both Medicare Parts A & B. With Senior Supplement you have the freedom to obtain medical care from any physician and hospital that accepts Medicare. This plan is a retiree medical plan which includes a separate approved Medicare prescription Part D drug plan.

NOTE: For both plans you must maintain enrollment in Medicare parts A and B to be enrolled in one of the ASRS Retiree plans.

What Medical Plan Am I Eligible For?

Medicare Eligible Retirees/LTD Recipients:

Retirees/LTD Recipients and/or dependents residing in:

- **All Arizona Counties** with Medicare Parts A and B may select either the Group Medicare Advantage (HMO) Plan or Senior Supplement.
- **All other states nationwide** with Medicare Parts A & B will have coverage through the Senior Supplement Plan.

Non-Medicare Eligible Retirees/LTD Recipients:

Retirees/LTD Recipients and/or dependents residing in:

- **All Arizona counties** will have coverage under the UnitedHealthcare Choice plan.
- **All other states, nationwide** will have coverage under the UnitedHealthcare Choice Plus PPO Plan.

NOTE: If you or your dependent(s) are a combination of Medicare eligible and non-Medicare eligible, you fall under the combination plans. See page 46 for combination plan premiums.

Becoming Medicare Eligible

If you or your dependent(s) will become Medicare eligible on your, or their, next birthday, there are changes in your medical coverage, premiums or premium benefit that you need to know about. The address of your primary residence will dictate the Medicare plan for which you are eligible.

Current non-Medicare Choice and/or Choice Plus members are sent a letter 90 days prior to Medicare eligibility. If a member does not respond by switching to a Medicare plan, the member will be terminated as ineligible. It is very important to note that **the premium benefit to which you are entitled will be reduced** to the amount applicable to Medicare-eligible retirees. State law governs how much premium benefit is paid for non-Medicare and Medicare-eligible retirees/LTD recipients. In order to receive the highest premium benefit and pay the lowest health insurance premium, please let the ASRS or PSPRS, if applicable, know that you are eligible for Medicare **prior** to the month in which you become Medicare-eligible.

Please send the enrollment form and a copy of your Medicare card(s) showing Parts A and B, or provide ID with effective date for Part A and B, or a copy of your Medicare Award letter to ASRS or, if applicable, to PSPRS, 30 days **prior** to the effective date of your Medicare coverage. **Medicare becomes effective the first day of the month of your 65th birthday. The effective date of your ASRS medical coverage will be effective the first of the month following receipt of your enrollment form.** Therefore, there is no retroactive coverage for health insurance simultaneous enrollment in Medicare and in an ASRS medical plan is important.

A new ID card(s) and Certificate(s) of Coverage for your new medical plan will be sent by UnitedHealthcare after your forms have been processed.

Enrolling in Medicare is easy! If you have delayed your Medicare enrollment or you are not collecting social security, you will need to notify Medicare when you start.

Visit Medicare.gov or call 800-MEDICARE (633-4227). TTY users should call (877) 486-2048, 24 hours / day, 7 days / week. Make sure you sign up three months before you turn 65, or when you want to start coverage, so that you'll get coverage beginning the month you actually reach your 65th birthday. This will avoid any delays getting your benefits.

NOTE: Failure to enroll in one of the Medicare plans will result in termination of your medical coverage and you will not be able to enroll in an ASRS Medicare medical plan until the next Open Enrollment period.

So, be thorough. If, in fact, you are declining coverage, please check the appropriate box(es). **A properly completed enrollment form must be received by the ASRS or PSPRS, if applicable, before you become Medicare eligible.**

NOTE: If you enroll with a non-ASRS Medicare plan, notify the ASRS or PSPRS in writing of your cancellation of ASRS/PSPRS medical coverage.

Comparison of Benefits



The medical plan comparison charts on the following pages contain a partial listing of the benefits offered to Medicare eligible and non-Medicare eligible retirees, LTD recipients and eligible dependents. Please remember that benefits are subject to plan limitations and exclusions.

After you enroll for coverage, UnitedHealthcare will send you an Identification (ID) Card and an Evidence of Coverage booklet for the Group Medicare Advantage (HMO) plan or a Certificate of Coverage for the Choice, Choice Plus PPO, and Senior

Supplement Plans. Please review these documents before you begin to use services so you understand the terms and conditions of the plan you selected.

A glossary in the back of this guide defines many of the terms used in the charts.

Questions concerning your plan should be directed to the UnitedHealthcare Customer Service number listed on the back of your ID card or inside the back cover of this guide.



2016 Medicare Eligible Retiree/LTD Medical Plans Comparison Chart

The information contained in this chart is a partial summary of the medical benefits offered by UnitedHealthcare for Medicare eligible retirees, disabled members, and eligible dependents. It also serves as a comparison between plans.

Outpatient Benefits	Group Medicare Advantage (HMO)	Senior Supplement		
	Member Pays	Medicare Pays	Supplement Pays	Member Pays
Doctor Office Visit	\$15 Copayment	80% of MAC* After \$166 Deductible	Deductible then 20% of MAC*	\$15 Copayment
Specialist Office Visit	\$30 Copayment			\$15 Copayment
Routine Physical	No Charge	Subject to Medicare Guidelines		
Immunizations	No Charge	80% of MAC* after Deductible	Deductible then 20% of MAC*	Subject to Medicare Guidelines
Outpatient Mental Health	\$30 Copayment	65% of MAC* after Deductible	Deductible then 35% of MAC*	\$0
Outpatient Hospital & Surgical Services	\$100 Copayment	80% of MAC* after Deductible	Deductible then 20% of MAC*	\$50 copayment
X-Rays Outpatient-Standard Outpatient-Specialized Scans	No Charge \$50 Copayment	80% of MAC* after Deductible	Deductible then 20% of MAC*	\$0
Outpatient Lab Tests	No Charge	80% of MAC* after Deductible	Deductible then 20% of MAC*	\$0
Durable Medical Equipment	No Charge	80% of MAC* after Deductible	Deductible then 20% of MAC*	\$0
Skilled Nursing Facility	No Charge Limit of 100 days per Benefit Period	Days 1–20: 100% of MAC* Days 21–100: All but \$161 per day Days over 100: \$0	Days 1–20: \$0 Days 21–100: \$161 per day Days over 100: \$0	Days 1–20: \$0 Days 21–100: \$0 Days over 100: All Costs
Home Health Care	No Charge	100% of MAC*	\$0	\$0
Physical, Speech and Occupational Therapy	\$15 Copayment	80% of MAC*	Deductible then 20% of MAC*	\$0

* Medicare Approved Charges (MAC)

2016 Medicare Eligible Retiree/LTD Medical Plans Comparison Chart

Inpatient Benefits	Group Medicare Advantage (HMO)	Senior Supplement		
	Member Pays	Medicare Pays	Supplement Pays	Member Pays
Inpatient Hospital Expenses	\$100 per admission	Subject to Medicare Guidelines	Subject to Medicare Guidelines	\$150 Copayment with 1st admission only
Inpatient Mental Health	\$100 per admission 190 days Lifetime	Subject to Medicare Guidelines	Subject to Medicare Guidelines	\$150 Copayment with 1st admission only
UnitedHealthcare Prescription Benefits				
Tier 1/Tier 2/Tier 3/Tier 4 Mail Order (90-day Supply)	\$10/\$40/\$40/\$40 Copayment \$20/\$80/\$80/\$80 Copayment	\$0	All But Member Copay to \$3,310 Annual Max	\$10/\$35/\$35/\$35 Copayment** \$20/\$70/\$70/\$70 Copayment**
Other Benefits				
Emergency Room (waived if admitted)	\$50 Copayment	80% of MAC*	20% of MAC*	\$50 Copayment
Urgent Care Facility	\$15 Copayment	80% of MAC*	20% of MAC*	\$25 Copayment
Ambulance	\$25 Copayment	80% of MAC*	20% of MAC*	\$0
Other				
Hearing Exam/Aids (EPIC Hearing)	No Charge / \$500 Allowance Every 36 Mo.	Not Covered	Not Covered	All Costs
Deductible	None	\$0 per Person Outpatient Services	\$166 per Person Outpatient Services	\$0
Annual out-of-pocket maximum	\$6,700	No Maximum	No Maximum	\$6,700
Vision Exam	\$20 Copayment	Not Covered	\$80 Allowance Per Calendar Year	\$20 Deductible Plus All Cost Above Allowance
Lenses and Frames	\$130 Allowance per Calendar Year	Not Covered	\$130 Allowance Per Calendar Year	All Cost Above Allowance
SilverSneakers Fitness Program	Free Membership at Participating Clubs	\$0	Free Membership at Participating Clubs	\$0

* Medicare Approved Charges (MAC). ** Member pays copayment up to \$3,310.00 in Total Drug Expenditures. Member then pays 58% or 45% of prescription costs until \$4,850.00 in True Out-of-Pocket costs has been met. Member then pays \$2.95 generic, \$7.40 brand copay or 5% of drug cost, whichever is greater.

Important Note: This is only a brief summary of benefits. Please refer to the plan's Evidence of Coverage or Certificate of Coverage for a list of benefits and exclusions specific to the ASRS retiree medical plan. UnitedHealthcare will send you an Evidence of Coverage or Certificate of Coverage with complete information on the benefits, limitations and exclusions once your enrollment form is processed.

Your Medicare Benefits

Your Medicare benefits are provided by the Federal Government and integrated through the ASRS Retiree Medical Plans. In order for a Medicare eligible ASRS retiree to be covered by an ASRS medical plan, the retiree and, if family coverage is elected, his/her eligible

dependent(s) who qualify for Medicare, must be enrolled in both Parts A and B of Medicare. Failure to enroll in Medicare when the retiree becomes eligible will cause a delay in ASRS medical plan coverage.

MEDICARE PART A: 2016*			
Services	Benefit	Medicare Pays	You Pay
Hospitalization Semiprivate room and board, nursing and other hospital services and supplies.	First 60 days	All costs less \$1,288	\$1,288
	61st to 90th day	All costs less \$322/day	\$322/day
	91st to 150th day	All costs less \$644/day	\$644/day
	Beyond 150 days	Nothing	All costs
Skilled Nursing Facility (SNF) Care** Semiprivate room and board, skilled nursing and rehabilitative services and other services and supplies.	First 20 days	100% of approved amount	Nothing
	Additional 80 days	All costs less \$161/day	\$161/day
	Beyond 100 days	Nothing	All costs
Home Health** Part-time skilled nursing, physical therapy, speech-language therapy, home health aide services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers) and supplies, and other services.	You pay nothing 100% of approved amount for Home Health Care		20% of approved amount for durable medical equipment
	Have questions: Call your Regional Home Health Intermediary. Consult your Medicare booklet.		
Hospice Care** Medical and support services from a Medicare-approved hospice, drugs for symptom control & pain relief, short-term respite care, care in a hospice facility, hospital, or nursing home when necessary, and other services not otherwise covered by Medicare. Home care is also covered.	Copayment of up to \$5 for outpatient prescription drugs. You pay 5% of the Medicare-approved amount for inpatient respite care (short-term care given to a hospice patient by another caregiver so that the usual caregiver can rest). If you have questions about Hospice care and conditions of coverage, call your Regional Intermediary. Consult your Medicare booklet.		
Blood Given at a hospital or skilled nursing facility during a covered stay.	You pay for the first three pints of blood, then 20% of the Medicare-approved amount for additional pints of blood after the deductible.		

* You pay nothing for Part A of Medicare. You paid for Part A while you were employed and making FICA contributions.

** You must meet certain conditions in order for Medicare to cover these services. Consult your Medicare booklet.

NOTE: Actual amounts you must pay are higher if the doctor does not accept Medicare assignment.

Your Medicare Benefits (cont.)

These two pages contain a summary of Medicare coverage and premiums in effect for 2016. If you wish additional information, contact the Centers for Medicare and Medicaid Services (CMS) either

by phone at 800-633-4227 (TTY 877-486-2048), 24 hours a day / 7 days a week or at their website at www.medicare.gov.

MEDICARE PART B: 2016*	
Services	
<p>Medical and Other Services Doctor’s services (except for routine physical exams), outpatient medical and surgical services and supplies, diagnostic tests, ambulatory surgery center facility fees for approved procedures, and durable medical equipment (such as wheelchairs, hospital beds, oxygen and walkers).</p> <p>Also covers outpatient physical and occupational therapy including speech-language therapy and mental health services.</p>	<p>You Pay: \$166 deductible (pay per calendar year).</p> <ul style="list-style-type: none"> <input type="checkbox"/> 20% of approved amount after the deductible, except in the outpatient setting. <input type="checkbox"/> 20% for all outpatient physical, speech therapy and occupational therapy services. <input type="checkbox"/> 35% for most outpatient mental health services.
<p>Clinical Laboratory Service Blood tests, urinalysis and more.</p>	<p>You Pay: Nothing for Medicare-approved services.</p>
<p>Home Health Care** Part-time skilled care, home health aide services, durable medical equipment when supplied by a home health agency while getting Medicare covered home health care and other services.</p>	<p>You Pay: Nothing for services. 20% of approved amount for durable medical equipment.</p>
<p>Outpatient Hospital Services Services for the diagnosis or treatment of an illness or injury.</p>	<p>You Pay: 20% of approved amount after the deductible.</p>
<p>Blood Pints of blood needed as an outpatient or as part of a Part B covered service.</p>	<p>You Pay: For the first 3 pints of blood, then 20% of the Medicare-approved amount for additional pints of blood after the deductible.</p>

*For 2016, the monthly Medicare Part B premium is \$104.90.

**You must meet certain conditions in order for Medicare to cover these services. Consult your Medicare booklet.

NOTE: Actual amounts you must pay are higher if the doctor does not accept Medicare assignment.

2016 Non-Medicare Eligible Retiree/LTD Medical Plans Comparison Chart

The information contained in this chart is a partial summary of the medical benefits offered by UnitedHealthcare for non-Medicare eligible retirees, disabled members and dependents.

Outpatient Benefits	CHOICE (All AZ Counties)	Choice Plus PPO (Outside AZ)	
	Member Pays	In-Network Plan Pays	Out-of-Network Plan Pays
PCP Office Visits	\$20 Copayment	\$20 Copayment	60%*
Specialist Office Visit	\$50 Copayment	\$50 Copayment	
Routine Physical	No Charge	100%	60%*
Examinations/ Immunizations	\$20/\$50 Copayment	\$20 Copayment \$50 Copayment	60%*
Vision Examination	\$50 Copayment	Not Covered	Not Covered
Hearing Examination	No Charge	No Charge	60%*
Outpatient Mental Health	\$20 Copayment	100% after \$35 co-payment	60%*
Outpatient Hospital Services	30%	70%	60%*
X-Rays Outpatient – Standard	\$10 Copayment	100%	60%*
Outpatient – Specialized Scans	\$150 Copayment	80%	60%*
Outpatient Lab Tests	\$10 Copayment	\$10 Copayment	60%*
Durable Medical Equipment	No Charge	80%	60%*
Prosthetic Devices	50%	80%	60%*
Skilled Nursing Facility	No Charge	80%	60%*
Home Health Care	No Charge	80%	60%*
Physical, Speech and Occupational Therapy	\$40 Copayment	100% after \$35 Copayment	60%*

* Subject to Calendar Year Deductible

2016 Non-Medicare Eligible Retiree/LTD Medical Plans Comparison Chart

Inpatient Benefits	CHOICE (All AZ Counties)	Choice Plus PPO (Outside AZ)	
	Member Pays	In-Network Plan Pays	Out-of-Network Plan Pays
Inpatient Hospital Expenses	\$100 copayment per stay plus 30%	\$100 copayment per stay plus 30%	60%*
Inpatient Mental Health	\$100 copayment per stay plus 30%	\$100 copayment per stay plus 30%	60%*
Prescription Benefits	Formulary	Formulary	Formulary
Tier 1 / 2 / 3 (Generic / Brand / Specialty)	\$10/\$50/\$100	\$10/\$50/\$100	\$10/\$50/\$100
Mail Order (90 day supply)	\$25/\$125/\$250	\$25/\$125/\$250	\$25/\$125/\$250
Other Benefits	Member Pays	In-Network Plan Pays	Out-of-Network Plan Pays
Emergency Room (waived if admitted)	\$150 Copayment	\$150 deductible	\$150 deductible
Urgent Care Facility	\$50 Copayment	100% after \$50 Copayment	60%
Ambulance	No Charge	80%*	80%
Lenses and Frames	Not Covered	Not Covered	Not Covered
Hearing Aids (EPIC Hearing - Per hearing impaired ear, per year)	30%	70%	50%

* Subject to Calendar Year Deductible

2016 Non-Medicare Eligible Retiree Medical Plans Comparison Chart

	CHOICE (All AZ counties)	Choice Plus PPO (Outside AZ)	
Other	Member Pays	In-Network Plan Pays	Out-of-Network Plan Pays
Calendar Year Deductible	None	\$500 per Individual \$1,000 per Family	\$500 per Individual \$1,000 per Family
Out of Pocket/ Coinsurance Maximum	\$3,500 per Individual \$7,000 per Family including copays for medical and prescription plus co-insurance you have paid	\$3,500 per Individual \$7,000 per Family including deductibles	\$6,000 per Individual \$12,000 per Family including deductibles
Maximum Lifetime Benefit		No Maximum	
SilverSneakers Fitness Program	No Maximum	Free Membership at Participating Clubs	

Important Note: This is only a brief summary of benefits. Please refer to the plan's Certificate of Coverage for a list of benefits and exclusions specific to the ASRS retiree medical plan. UnitedHealthcare will send you a Certificate of Coverage with complete information on the benefits, limitations and exclusions once your enrollment form is processed.

ASRS Retiree/LTD Medical Plans Sample ID Cards

The sample ID cards below show you which card belongs to which UnitedHealthcare-sponsored ASRS retiree medical, prescription and vision plan. These sample ID cards will help you identify the medical plan in which you are enrolled as well as the number and kinds of different cards you should have or should receive.

For retirees/LTD recipients enrolled in **UnitedHealthcare Group Medicare Advantage (HMO) Plan**, your ID card is a medical, vision and prescription drug plan ID card.

 	
Health Plan (80840): 911-87726-04	
Member ID: 0000000-01	Group Number: 900009
Member: SUBSCRIBER BROWN	PLAN CODE: 5AS ASRS
PCP Name: DOCTOR BROWN	Payer ID: 87726
PCP Phone: (000) 000-0000	
XYZ NETWORK	
Copay: PCP: \$ 15	ER: \$ 50
Spec: \$ 30	RxBin: 610097 RxPCN: 9999 RxGrp: SHAZ
H0303 PBP# 804	
UnitedHealthcare Group Medicare Advantage (HMO)	

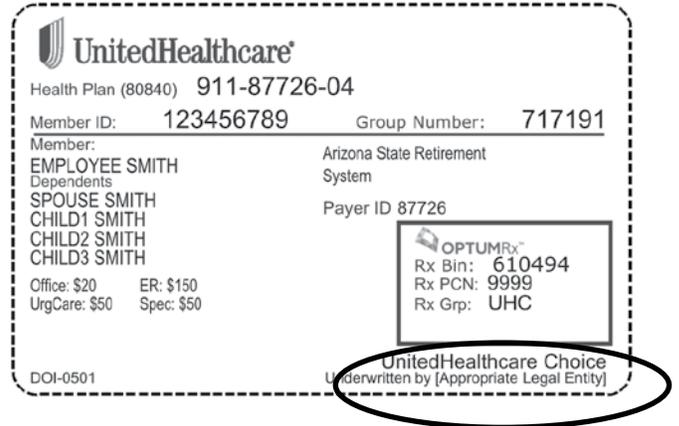
For retirees/LTD recipient enrolled in **UnitedHealthcare Senior Supplement Plan**, you have separate ID cards for your medical/vision plan and for your prescription drug plan. Your prescription drug card bears the name "UnitedHealthcare Medicare Rx for Groups (PDP)". Your cards look like these:

	
Health Plan (80840) 911-87726-04	
Member ID: 999999999-99	Group Number: 99999
Member: SUBSCRIBER BROWN	ASRS Payer ID 87726
Copay: Office/ Spec/ ER \$ 15/ \$ 15/ \$ 50	
UnitedHealthcare Senior Supplement SRSUP PBP# 904	

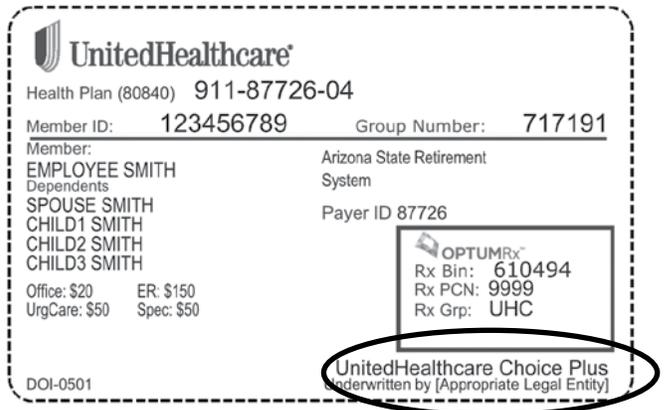
	
Issuer (80840): 9151014609	
Member ID: 0000000000	
Member: SUSAN SAMPLE	ASRS
RxBin: 610097 RxPCN: 9999 RxGrp: PDPIND	
S5921 PBP# 802	
UnitedHealthcare MedicareRx for Groups (PDP)	

ASRS Retiree Medical Plans Sample ID Cards

For UnitedHealthcare's **Choice Plan**,
your ID card is a medical and prescription
drug ID card.



For UnitedHealthcare's **Choice Plus PPO Plan**, your ID card is a medical and prescription
drug ID card.



Understanding the Medicare Prescription Drug Plans

PLEASE NOTE: If you enroll in any Medicare prescription drug plan, in addition to one of the ASRS plan options, you will become ineligible for both medical and prescription drug coverage under the ASRS plan, and will be automatically disenrolled. **Medicare allows you to be enrolled in only one prescription drug plan at a time.**

Enrollment in a Medicare prescription drug plan is an option, not a requirement. You do not have to enroll in a separate Medicare Part D prescription drug plan.

However, both Medicare prescription drug plans offered by ASRS are equal to, or offers more than, the standard Medicare Part D coverage.

When an eligible ASRS Medicare beneficiary is enrolled in either of the ASRS-sponsored prescription drug plans, when first eligible for Medicare prescription drug coverage, there is no enrollment penalty if you should enroll in an individual Medicare Part D prescription drug plan at a future date.

UnitedHealthcare "tier" concept to prescription drugs for Medicare eligible retirees

UnitedHealthcare classifies its prescription drugs as Tier 1, 2, 3 or 4. Much of Medicare's communication about its Part D program refers to prescription drugs in "tiers" or in various classifications as noted below. UnitedHealthcare will use the prescription drug classification system shown below.

- **TIER 1** are *preferred generic* medications
- **TIER 2** are *preferred brand-name* medications
- **TIER 3** are *non-preferred* medications (these require prior authorization on the Group Medicare Advantage HMO plan)
- **TIER 4** are *specialty medications* (these require prior authorization on both ASRS Medicare eligible plans)

Understanding the Medicare Prescription Drug Plans

The ASRS offers two different medical plan options; each with prescription drug coverage for Medicare eligible retirees/LTD recipients and dependents.

UnitedHealthcare Group Medicare Advantage® (HMO) Plan Prescription Drug Coverage

Prescription drug plan features:

- No prescription drug plan deductible
- \$10 Tier 1 and \$40 Tier 2, 3 and 4 drugs for up to a 30 day supply at contracted retail pharmacies.
- \$20 Tier 1 and \$80 Tier 2, 3 and 4 drugs for up to a 90 day supply through the prescription by mail program
- Copay while in the coverage gap and no annual benefit limit in coverage
- Catastrophic Coverage: After your true out-of-pocket expenses reach \$4,850 you begin catastrophic coverage and pay whichever is higher: a \$2.95 co-payment for generic drugs; a \$7.40 copayment for brand name drugs, or 5% of the drug costs until the end of the calendar year.
- Standard UnitedHealthcare Group Medicare Advantage (HMO) plan formulary applies.
- To view the national network of contracted retail pharmacy locations (national chains and local pharmacies) near you, visit: UHCretiree.com/ASRS.
- Convenient prescription by mail program.

Senior Supplement Plan Prescription Drug Coverage

The name / brand of the prescription drug coverage that is available with the Senior Supplement Plan is UnitedHealthcare MedicareRx for Groups.

Prescription drug plan features include:

- No prescription drug plan deductible
- Low copayments:
 - \$10 Tier 1 and \$35 Tier 2, 3 and 4 drugs for up to a 30 day supply at contracted retail pharmacies.
 - \$20 Tier 1 and \$70 Tier 2, 3 and 4 drugs for up to a 90 day supply through the prescription by mail program
- Coverage gap begins after \$3,310 in total drug costs in 2016.
- In the coverage gap the member pays 58% of generic and about 45% of brand name prescriptions.
- Catastrophic Coverage: After your true out-of-pocket expenses reach \$4,850 you begin catastrophic coverage and pay whichever is higher: a \$2.95 co-payment for generic drugs; a \$7.40 co-payment for brand name drugs; or 5% of the drug costs until the end of the calendar year.
- “Medicare formulary” plan design (some prior authorization requirements may apply)
- To view the national network of contracted retail pharmacy locations (national chains and local pharmacies) near you, visit: UHCretiree.com/ASRS.
- Convenient prescription by mail program.

Note: While in the coverage gap stage, the pharmaceutical manufacturer applies a 50% discount on brand name drugs which goes towards the members true-out-of-pocket expense amount.

Understanding the Prescription Drug Plan Available with the Senior Supplement Plan

I am enrolled in the Senior Supplement Plan. How does the UnitedHealthcare MedicareRx for Groups prescription drug plan work for me?

Each time you purchase a covered prescription medication, two payments are actually being made: the copayment you pay out of your pocket for the drug, called true out-of-pocket (TrOOP) costs, and the payment your plan pays for the drug. Together these payments make up the "total drug expenditure".

What is my initial prescription drug coverage (Stages 1 and 2)?

Under the UnitedHealthcare MedicareRx for Groups prescription drug plan, there is no prescription plan deductible. For all covered prescription drugs you simply pay your copayments for the first \$3,310 of "total drug expenditure" during 2016.

When does the coverage gap (Stage 3) begin?

The coverage gap begins after you and the plan together have spent \$3,310 in "total drug expenditure" during the year. During the coverage gap, you pay 58% of generic and about 45% of brand name prescriptions.

When does the coverage gap end (Stage 4)?

The coverage gap ends when your true out-of-pocket costs reach \$4,850 and you begin catastrophic coverage. When you reach Stage 4, you will pay whichever is higher: a \$2.95 co-payment for generic drugs; a \$7.40 co-payment for brand-name drugs; or, 5% of the drug costs until the end of the calendar year.

Your Medicare Part D Prescription Benefit

STAGE 1: Annual Deductible

Your plan has no annual deductible.

STAGE 2: Initial Coverage

You pay copays for each prescription filled; the plan pays remainder until together you have paid \$3,310 in total drug costs.

STAGE 3: Coverage Gap

You pay 58% of generic and about 45% of brand name prescription drug costs until your yearly true out-of-pocket drug costs equal \$4,850.

STAGE 4: Catastrophic Coverage

After \$4,850 in out-of-pocket drug costs, the plan pays the majority of the drug expenses until the end of the year.

Please note: the coverage gap referenced above applies **ONLY** to the UnitedHealthcare MedicareRx for Groups prescription drug plan offered with the Senior Supplement plan. There is no coverage gap with the UnitedHealthcare Group Medicare Advantage (HMO) prescription drug plan.

Rx Explanation of Benefits (EOB) Provided

The Medicare prescription drug plans provide a monthly prescription benefit summary tailored specifically to individual Medicare members.

The summary helps you:

- Understand how much you and your drug plan spent year-to-date on prescription drugs
- Details your prescription history to help lower monthly spending
- Review prescriptions, including fill dates, prescribing doctor and pharmacy information

Prescription drug payment stages Medicare Advantage HMO

1. ANNUAL DEDUCTIBLE

Your plan does not have an annual deductible

2. INITIAL COVERAGE STAGE

During this stage you pay a flat fee (copay) for each prescription you fill. **The plan pays the rest until your total drug costs (paid by you and the plan) reach \$3,310.**

3. COVERAGE GAP STAGE

During this stage you continue to pay your flat fee (copay). However, the manufacturers discount on brand name drugs (about 50%) gets applied towards the out-of-pocket cost. Once your out-of-pocket costs reach \$4,850, you move to catastrophic coverage.

4. CATASTROPHIC COVERAGE

In this stage you pay only a small copay or coinsurance amount for each filled prescription. (\$2.95 generic copay, \$7.40 brand name copay or 5% of the drug cost – whichever is higher.) **The plan pays the rest until the end of the calendar year.**



Initial Coverage
Up to \$3,310

Gap
Up to \$4,850

Catastrophic
Through the end of benefit year

Prescription drug payment stages Senior Supplement Prescription Drug Plan

1. ANNUAL DEDUCTIBLE

Your plan does not have an annual deductible

2. INITIAL COVERAGE STAGE

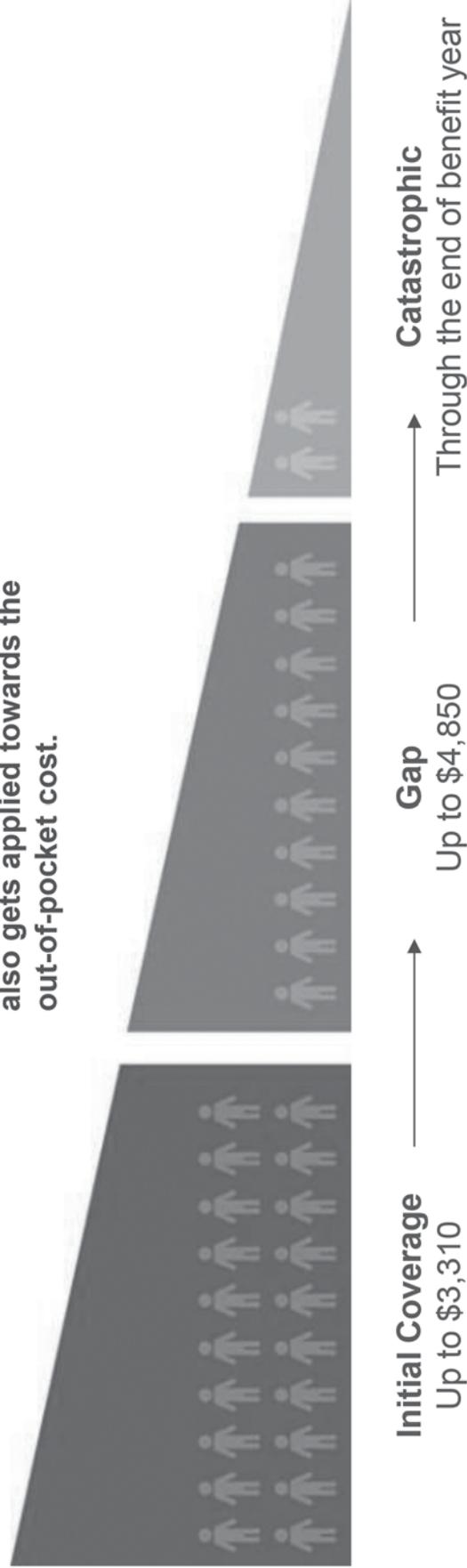
During this stage you pay a flat fee (copay) for each prescription you fill. **The plan pays the rest until your total drug costs (paid by you and the plan) reach \$3,310.**

3. COVERAGE GAP STAGE

During this stage you pay **45% of the total cost for brand-name drugs and 58% of the total cost for generic drugs.** Once your out-of-pocket costs reach \$4,850, you move to catastrophic coverage. The manufacturers discount on brand name drugs (about 50%) also gets applied towards the out-of-pocket cost.

4. CATASTROPHIC COVERAGE

In this stage you pay only a small copay or coinsurance amount for each filled prescription. (\$2.95 generic copay, \$7.40 brand name copay or 5% of the drug cost – whichever is higher.) **The plan pays the rest until the end of the calendar year.**



General Information About UnitedHealthcare's Prescription Drug Benefits

What is a Formulary and why is it important?

UnitedHealthcare keeps your medication costs down through a Formulary (also known as a Prescription Drug List (PDL)). The Formulary is a list of UnitedHealthcare-approved outpatient prescription drugs that are covered under the Choice, Choice Plus PPO, and Group Medicare Advantage (HMO) plans. A pharmacy and therapeutics committee that consists of practicing physicians and pharmacists determines and maintains the Formulary. The committee decides which prescription drugs provide quality treatment for the best value. It includes a broad range of generic and brand name drugs, although it does not include all prescription drugs.

What medical plans utilize the Formulary?

The Choice, Choice Plus PPO, and Group Medicare Advantage (HMO) plans utilize the Formulary. For you to receive prescription drug benefits, your physician must prescribe medication for you from the Formulary and the prescription must be filled at a participating pharmacy.

Do I have a Prescription Drug Formulary in the Plan?

The Prescription Drug Plan utilizes the Medicare Part D formulary. Medicare, not UnitedHealthcare, determines what drugs are covered under the Medicare Part D plan. Check with your doctor as some drugs may not be covered.

What is covered?

All medications listed in the Formulary are covered. In order to receive your prescription benefits, your physician must prescribe medication for you from the Formulary and the prescription must be filled at a participating pharmacy.

What if my prescription is not listed in the Formulary?

Your physician can contact OptumRx, UnitedHealthcare's prescription manager, for an exception explaining why you must have that drug

rather than the one on the Formulary, or your physician must change your prescription to an equivalent Formulary drug.

What is the difference between brand name and generic drugs?

A generic drug is a medication which has met the standards set by the Food and Drug Administration (FDA) to assure its equivalence to the original patented brand name medication. Generic drugs are chemically identical to their brand name equivalents. Many brand name drugs do not have generic equivalents. In these cases, your physician may prescribe a "therapeutic" drug instead. Unlike generic drugs which have the identical active ingredients as a brand name version, a therapeutic drug substitute has a chemical composition close to its brand name counterpart and has been determined to provide the same clinical or therapeutic results.

How can I obtain a copy of the Formulary?

The Formulary is available upon request from UnitedHealthcare and can also be found on their website at www.uhcretiree.com/asrs or www.uhc.com. The name of the Group Medicare Advantage (HMO) formulary is Formulary MAPDG.

How can I save money by using the Prescription Mail Order Program?

OptumRx, UnitedHealthcare's prescription manager, offers a mail order program for maintenance medications. Through the mail order program, you can order a three (3) month supply of medications and save money on your prescriptions. Medicare members pay two (2) copayments for a three (3) month supply and non-Medicare members pay two and a half (2-1/2) copayments for a (3) months supply. Prescriptions are mailed to your home in discreetly labeled packages. Refills can be ordered by mail, over the phone or through the Internet. Mail order claim forms may be ordered through UnitedHealthcare's Customer Service or their website at www.optumrx.com. PLEASE NOTE: not all prescriptions are eligible for a 90-day supply through mail order.

UnitedHealthcare's Vision Care Benefits

UnitedHealthcare Group Medicare Advantage (HMO) Plan

Your medical plan covers one eye exam per year and medically necessary glasses or lenses following cataract surgery. Your Routine Prescription Eyewear benefit provides a routine exam, eyeglasses or contact lenses for routine vision correction.

For a routine eye exam you must go to a OptumHealth Vision provider. In both instances, the vision eyewear is only available through the OptumHealth Vision network. Locate a vision provider near you by either going to www.optumhealthvision.com or calling OptumHealth Vision Customer Service at 800-638-3120, (or for the hearing impaired 800-524-3157).

At a OptumHealth Vision network vision center, you can receive routine eye exams (also called refractive eye exams) for a \$20 copayment, eyeglass lenses (single, bifocal and trifocal) are covered in full, and you have a \$130 retail allowance toward frames. In lieu of eyeglasses, there is a \$105 allowance toward contacts. Exams, lenses and frames are covered once every 12 months. You will be responsible for any charges in excess of the \$130 frame allowance or the \$105 contact lens allowance.

This vision care plan is designed to cover your vision needs rather than cosmetic materials. However, most lens options are available at a discount.

If you need the services of an eye specialist for a medical eye condition (i.e. you have diabetes, cataracts, glaucoma, etc.), you should call Group Medicare Advantage (HMO) Plan Customer Service at 866-208-3248 for the nearest Participating Provider. There is also a listing in each network of the Provider Directory under Specialist - Optometry. The Optometrist listed in the Provider Directory will provide your medical eye care and will also be the provider to give you a referral to the Ophthalmologist.

For a complete listing of providers, go to **OptumHealthVision.com**. The vision network is provided by OptumHealth.

If you have questions about this plan you may call OptumHealth Vision Customer Service at 800-638-3120, (or for the hearing impaired 800-524-3157), Monday through Friday, 8 AM to 11:00 PM (EST) and Saturday, 9:00 AM to 6:30 PM (EST).

UnitedHealthcare's Vision Care Benefits

*UnitedHealthcare
Senior Supplement Plan*

Your Routine Prescription Eyewear benefit provides eye refraction, eye-glasses or contact lenses for routine vision correction.

You have the choice of any vision provider, but you receive the greatest savings by using a OptumHealth Vision network provider. To locate a vision provider near you, go to www.optumhealthvision.com or call OptumHealth Vision Customer Service at 800-638-3120, (or for the hearing impaired 800-524-3157). You may then schedule an appointment for your vision exam. For a complete listing of providers, go to www.optumhealthvision.com. The vision network is provided by OptumHealth. Please confirm your provider is participating in the network before making an appointment.

At a OptumHealth Vision network provider, after a \$20 deductible, you have coverage for routine eye exams (also called refractive eye exams). Standard eyeglass lenses (single, bifocal and trifocal) are covered in full, and you have a \$130 retail allowance toward frames. In lieu of eyeglasses, there is a \$105 allowance toward contacts. Exams, lenses and frames are covered once every

12 months. If you chose not to use an OptumHealth Vision network provider, there is an \$80 allowance toward the routine examination after satisfying a \$20 deductible. Your eyewear benefit is \$100 toward the purchase of eyeglasses, frames or contact lenses in place of eyeglasses. You will be responsible for charges in excess of the \$100 allowance. You are eligible to receive this benefit once every 12 months.

This vision care plan is designed to cover your vision needs rather than cosmetic materials.

If you have questions about this plan you may call OptumHealth Vision Customer Service at 800-638-3120, (or for the hearing impaired 800-524-3157), Monday through Friday, 8 AM-11 PM (EST) and Saturday, 9 AM-6:30 PM (EST).

If you need the services of an eye specialist for a medical eye condition (i.e. you have diabetes, cataracts, glaucoma, etc.), Medicare is primary and the Senior Supplement Plan is secondary so you may see any physician that accepts Medicare.

Benefit limited to 1 time every 12 months	In-Network You Pay	Out-of Network You Pay
Deductible	\$20	\$20
Routine Eye Refraction (examination)	\$0 after deductible satisfied	Charges in excess of \$80
Eyeglass Lenses (single, bifocal and trifocal)	\$0 covered in full	Charges in excess of \$100 for Lenses, Frames, or contacts combined
Eyeglass Frames	Charges in excess of \$130 retail allowance	
Contact Lenses (in place of eyeglasses)	Charges in excess of \$105 allowance	



Solutions for Caregivers

Access your caregiver service for support that can make it easier to care for a family member, friend or neighbor.



On-site assessments

Have a registered nurse perform an on-site health and well-being overview.



Caregiver case manager

Let a case manager counsel you by offering advice along with decision-making support.



Personalized care plans

Get a customized care plan that may address your needs and the needs of your family member, friend or neighbor.



Coordination of services

Allow us to help you plan and arrange community-based programs and services for your specific needs.

Note: We provide caregiver resources and coordination, but we do not pay for supportive services or perform medical treatments.

Do you need extra help?

Seeing a decline in your loved one's health can feel overwhelming. If you find yourself asking the questions below, accessing your service of Solutions for Caregivers could help you get the answers.

- What help do I really need?
- What services will Medicare pay for?
- What community resources could I take advantage of that are available to me?
- Is my loved one's home still clean and safe?

If you're a caregiver or anticipate taking on a caregiver role in the future, call us at:



1-866-896-1895, TTY 711

24 hours a day, 7 days a week



Solutions for Caregivers assists in coordinating community and in-home resources. The final decision about your care arrangements must be made by you. In addition, the quality of a particular provider must be solely determined and monitored by you. Information provided to you about a particular provider does not imply and is in no way an endorsement of that particular provider by Solutions for Caregivers. The information on and the selection of a particular provider has been supplied by the provider and is subject to change without written consent of Solutions for Caregivers.

The products and services described above are neither offered nor guaranteed under our contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services may be subject to the UnitedHealthcare grievance process.

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UnitedHealthcare Wellness & Disease Management

Personal Health Management

A comprehensive program of care management services providing guidance and support for retirees diagnosed with complex and/or co-morbid health conditions, and for those who are not engaged in the disease and condition-specific management programs. The program components serve retirees with moderate and high risk factors, including those transitioning from hospital care to home.

- **Focus & High Risk Care Management.** Both phone-based and field-based (in-person) care managers conduct evaluations and interventions with retirees/LTD Recipients with targeted and impactable healthcare needs.
- **Transition Coach.** A key focus of the program is to assist individuals returning home from a hospital stay, to assist with this transition of care, and to enhance stability upon return-to-home (primary emphasis on reconciliation of medication discrepancies and facilitation of follow-up services by treating physicians).



UnitedHealthcare Wellness & Disease Management

UnitedHealthcare has designed preventive health services to help maintain the well being of members who are basically healthy. These include education and screening guidelines and programs available through members' primary care physicians and health-related information and programs accessible on their websites at www.uhcretiree.com/ASRS.

- **Solutions for Caregivers.** A comprehensive eldercare management program designed to support retirees and family caregivers in remaining healthy, function as independently as possible and to live with dignity. Simultaneously, the program helps caregivers maintain their own health, to mitigate stress and caregiver burnout, and to maximize available community resources and support.
- **Access Support.** Through the Nurseline service, retirees are connected with Access Support Advocates. This dedicated team identifies network providers who meet certain quality standards, and facilitates member contact/appointments with those physicians.
- **"Know Your Numbers".** Providing onsite health screenings at UnitedHealthcare Town Hall meetings (e.g., blood glucose, cholesterol, blood pressure).

Disease & Specialty Case Management

UnitedHealthcare is committed to improving the quality of care received by our retirees with chronic diseases. The disease management program targets chronic conditions of key concern to retirees, provides interventions to assist retirees in effectively managing these chronic conditions, and bridges gaps between retirees and their care teams.

- **Integrated Coronary Artery Disease & Diabetes.** A program aimed primarily at those with these common co-morbidities, and who are at highest risk.
- **End Stage Renal Disease.** A specialized condition management program focused on those in the early phase of ESRD and dialysis, mitigating complications and acute care admissions.
- **Transplant Care Management.** Specialized transplant nurses providing guidance and interventions throughout the stages of transplant (from pre-transplant through post-transplant stages).

Advanced Illness Care Management

Providing services for retirees/LTD Recipients with advanced illnesses and who are facing end-of-life issues (generally those in the last 12 months of life). Services focus on facilitating palliative care, reducing pain and suffering, assisting individuals and families in understanding their goals and preferences for end-of-life care, and providing bereavement services for family members following the individual's death.



Introducing HouseCalls from UnitedHealthcare.®

A health and wellness program that comes to you.

As part of your UnitedHealthcare plan membership, we are now offering our HouseCalls program to qualified members. HouseCalls is designed to support and complement your regular doctor's care through a visit with a licensed health care practitioner in your home.

With HouseCalls, UnitedHealthcare will send a knowledgeable health care practitioner to you. They will work with you to help you understand your current health status and provide you with information that may help you maintain or improve your health. You can ask questions and go at your own pace. Best of all, there is **no copay for a HouseCalls visit.**

HouseCalls health care practitioners have conducted more than 260,000 visits, and our members are overwhelmingly satisfied with the HouseCalls experience. In fact, 99% of surveyed members indicate that they were satisfied with their visit, and 96% found their in-home visit to be helpful.*

What you can expect from a HouseCalls visit.

- ✔ One of our knowledgeable health care practitioners will review your health history and medication(s), perform a physical exam, identify health risks and provide education on your health.
- ✔ You can discuss your health concerns one-on-one with the practitioner and ask questions.
- ✔ You will get an Ask Your Doctor worksheet, which you can bring to the next visit with your doctor.

A HouseCalls visit doesn't replace your regular doctor visits or annual wellness exams. This visit is meant to add to your health care experience and it may help you stay ahead of your health care concerns.

How a HouseCalls visit can help you and your doctor.

Through our advanced technology, we are able to use your HouseCalls results to help coordinate care with your doctors. This may include:

- Identifying any treatment needs.
- Addressing health education needs.
- Recommending preventive services you may need.

At the end of your visit, you will receive a checklist of topics you can discuss with your doctor. We will also provide your physician a follow-up letter with the HouseCalls results.

Who receives a HouseCalls visit?

HouseCalls is for all health types, whether you are healthy or have chronic conditions. Everyone can benefit from a HouseCalls visit. We may contact you when we have an available health care practitioner in your area.

How does it work?

You will receive a letter and phone call from HouseCalls to schedule your visit. If you're not comfortable having the HouseCalls visit in your home, we recommend you ask a friend or family member to be there with you. Or, we can visit you at another location.

Once your HouseCalls visit is scheduled, you may receive a reminder call and/or postcard prior to the appointment. All of the licensed health care practitioners are contracted with UnitedHealthcare and have received specialized training regarding the health care needs of qualified members.

Do you have questions or want to set up an appointment for a HouseCalls visit?



Give us a call. **1-866-686-2504**, TTY **711**, Monday – Friday
8 a.m. – 7:30 p.m. EST; Saturday 8 a.m. – 6:30 p.m. EST



Or visit us online at **www.UHCHouseCalls.com**

*August, 2012 UnitedHealthcare HouseCalls Member Survey Data. Sample size: 17,879

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract. Enrollment in UnitedHealthcare plans depends on contract renewal.

myNurseLine

Your Health Advocate

When you have a health concern, it can be difficult and time-consuming to find the information you need. **myNurseLine** can help you make smart health care decisions with immediate telephone access to experienced registered nurses.

Your Health Advocate

One toll-free number connects you with a registered nurse who will take the time to understand what is going on with your health and provide personalized information that is right for you. And this is all available 24 hours a day, seven days a week, at no additional cost to you. It is included with your benefits.

Experience You Can Rely On

myNurseLine nurses have an average of 15 years clinical nursing experience. They are an excellent resource when you need help choosing care, managing a chronic condition, understanding treatment options and more.

Your One-Stop Source

Whether you have a temperature of 102 at midnight or need help managing your diabetes, **myNurseLine** is the one source to give you the answers you need. Not sure if you need a doctor, urgent care clinic or just some good health advice? One call to **myNurseLine** can help you get information about the care and services you need. So, think of **myNurseLine** as your one-stop resource to help you make smart health care decisions everyday.

To Talk To myNurseLine:

Group Medicare Advantage HMO and Senior Supplement members call:

800-365-7949

Choice and Choice Plus members call:

888-877-4114

myNurseLine Can Help You:

- Chat with a nurse
- Understand treatment option
- Ask medication questions
- Choose appropriate medical care
- Locate available local resources
- Find a doctor, hospital or specialist and check if a doctor is in your network and is accepting new patients.

For Group Medicare Advantage (HMO) Members Only**Introducing the UnitedHealth Passport® program.**

The UnitedHealth Passport® program offers coverage for members who travel or live away from home up to nine consecutive months during the year. Whether you plan a scenic road trip or extended stay, when you travel within the UnitedHealth Passport service area, you will have health care coverage in the event you need it.

This program is included with your plan. You pay no additional charge for health care coverage when you travel within the UnitedHealth Passport service area. You simply pay the same copayment (copay) or coinsurance as you would at home.

How the UnitedHealth Passport program works.

Activate the UnitedHealth Passport program before you travel. This will make certain your health care coverage travels with you.

Step 1: Activate your coverage before your trip.

Call UnitedHealthcare Customer Service from 8 a.m. – 8 p.m. local time, 7 days a week. The number is located on the back of your member ID card.

Make sure you have your travel dates and destination, including ZIP Code, available when you call. UnitedHealthcare will confirm if you're traveling to a UnitedHealth Passport service area. You can also get names and telephone numbers of contracted physicians in your travel destination area.

Step 2: Get ready for your trip.

It's a good idea to schedule any routine services with your local doctor before you leave. It is also recommended that you take a copy of your medical records with you when you travel.

Step 3: Once you are back home again.

Call UnitedHealthcare to have the UnitedHealth Passport program deactivated. This is an important step. Plan disenrollment may occur if you do not return to your home service area within nine months of activating the UnitedHealth Passport program or if you do not notify us of your return and the nine-month Passport period expires.

Call Customer Service on the back of your I.D. card to get participating counties.



MyAdvocate®

2016 Update from Social Service Coordinators (SSC)

Who is SSC/ My Advocate?

As the leading provider of outreach and advocacy in the United States, SSC/My Advocate is contracted with UnitedHealthcare (UHC) to help **MA/MAPD** members apply and submit applications for Medicare Savings Programs (MSPs), Extra Help (Low Income Subsidy) and other community assistance programs.

What exactly does SSC/My Advocate do?

SSC/My Advocate reaches out to (UHC) Medicare beneficiaries who may be eligible for – but not enrolled in – a broad range of government and other community assistance programs. SSC/My Advocate uses a proprietary scoring algorithm to identify UHC MA/MAPD members with a higher probability of program qualification, and engages them by mail and outbound phone calls from Miami Lakes, FL. UHC realizes there are thousands of eligible members who are unaware of and not enrolled in assistance programs that can positively impact their circumstances. Participation impacts some of the financial challenges of Medicare eligibles which in part can close gaps in care and promote living a healthier life. **UHC ASRS members may also call 1-877-218-4967 for education and enrollment assistance.**

Medicare Savings Complete® is our service that assists eligible members with applying for Medicare Savings Programs (MSPs). Enrollment in a MSP results in reimbursement of a member's Part-B Medicare Premium - \$104.90 per month in 2016. These programs include Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualified Individual (QI-1) and Qualified Disabled and Working Individual (QDWI).

Part D Complete®: SSC will screen members for the Medicare Part D – LIS/Extra Help Program and electronically submit the application to Social Security for members who qualify.

Individuals who are eligible have an income up to **150%** of Federal Poverty Level:

Income Limits:	\$1456.25/Single & \$1958.75/Couple
Asset Limits:	\$13,300/Single & \$26,580/Couple

Golden Touch®, a social advocacy program designed to assist Medicare beneficiaries gain a greater understanding of what public or private benefits and services are available to them. SSC can help members find financial relief and assistance through thousands of programs including:

- Energy Assistance
- Transportation Assistance
- Telephone Assistance
- Rx Discount
- Nutrition Resources

SSC/My Advocate helps UHC MA/MAPD members (at no cost to them) apply for Medicare Savings Programs, Extra Help/LIS and community based programs

SSC/My Advocate is a division of Altegra Health



Don't let hearing loss make you lose out on life.

Hearing aids at a discount through hi HealthInnovations.



Hearing and your health.

If you've started to notice a change in your hearing, you're not alone. Hearing loss is the third most common chronic condition, affecting 1 in 5 Americans age 12 and older.¹ It can impact how you connect with your family, friends and the world around you. Left untreated, it can contribute to social isolation, lower general health and safety concerns. In contrast, people who treat hearing loss often report significant improvements in relationships, self-esteem, overall quality of life, mental health and safety.²



Pay a fraction of retail.

As a member of this plan, you're able to purchase digital hearing aids at a discount through hi HealthInnovations,TM potentially saving you thousands of dollars.³



¹http://www.hopkinsmedicine.org/news/media/releases/one_in_five_americans_has_hearing_loss; 2011

²National Council on Aging, "The Consequences of Untreated Hearing Loss in Older Persons," NCOA, 1999.

³www.HealthyHearing.com, 5/2010

Two simple steps to help better hearing:

1 Get your hearing tested.

Call hi HealthInnovations toll-free at 1-855-523-9355 to schedule an appointment with a hearing professional, search for a provider online at hihealthinnovations.com, or ask your doctor for a hearing test.

2 Place your order.

Choose the convenient option that best suits your needs.



In Person

Call us toll-free at 1-855-523-9355, TTY 711, 9 a.m. to 5 p.m. CT, Monday through Friday, to schedule an appointment with a hearing professional for a consultation and/or hearing test.

Your professional will submit your hearing test results to us and we will send your custom programmed hearing aids directly to you.



By phone

Mail or fax hi HealthInnovations your hearing test results taken within the past year. Our address is P.O. Box 356, Minneapolis, MN 55440. We'll call you within three days of receiving your results with your recommended hearing aid options. You may call us toll-free at 1-855-523-9355, TTY 711, 9 a.m. to 5 p.m. CT, Monday through Friday to order. Your custom-programmed hearing aids will be sent directly to you.



Online

Mail or fax hi HealthInnovations your hearing test results taken within the past year. We'll call you within 3 days of receiving your results with your recommended hearing aid options. Go online at hihealthinnovations.com/medicare to order your recommended hearing aids. Your custom-programmed hearing aids will be sent directly to you.

hi ITC™ (In-The-Canal)

Nearly invisible. Fits comfortably in your ear canal.

\$799* each



hi BTE™ (Behind-The-Ear)

Thin and lightweight. Fits comfortably behind the ear.

\$599* each



Each hearing aid comes with:

- Free batteries that last most users six months.
- 70-day money-back guarantee.
- One-year manufacturer's warranty.

*Shipping and sales tax may be applicable. Some models require an ear mold at approximately \$100 each. Additional models are available.

The products and services described above are neither offered nor guaranteed under our contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services may be subject to the UnitedHealthcare grievance process.



High quality hearing aids at more than 60% off the industry price

hi HealthInnovations digital hearing aids are of equal or superior quality to hearing aids that cost thousands of dollars more

- A subsidiary of UnitedHealth Group, a leading healthcare company that serves more than 85 million people. We buy in bulk, eliminate enormous mark-ups and transfer the savings directly to you.
- Included state-of-the-art digital technology that has been proven to enhance sound quality and removed unnecessary bells and whistles that drive up cost.
- Confident in the quality of our product that we offer a 70-day money-back guarantee.

"I purchased another brand of hearing aids costing over \$7000 for the pair. I ordered hearing aids from hi HealthInnovations for less than \$1000."
- Fred S. (Palo Alto, CA)



"Even though the hearing aids you have provided for me cost about 1/5 of those I had previously used, they are much more effective. The new devices are more powerful, more adaptable and certainly provide a much improved level of performance."
- Dwayne T. (Las Vegas, NV)

Learn how hearing aids may improve your well-being and how to best use them

hi HealthInnovations provides robust, nationwide support, especially helpful when you travel or relocate

In addition to this professional, you have access to:

- Free daily new user seminar hosted by hearing professionals.
- Toll-free support from product support specialists and hearing professionals. (Monday-Friday, 9 am - 5 pm CT)
- In-person support from hearing professionals in many US cities.
- Helpful videos and user guides.
- Free programming adjustments, if needed.

Join our FREE telephonic hearing health seminar

Monday – Thursday
6 p.m. CT (7 p.m. ET, 4 p.m. PT)

Friday
10 a.m. CT (11 a.m. ET, 8 a.m. PT)

Call 1-888-844-7278
Access code: 9428061#

For more information call **1-855-523-9355** or visit hiHealthInnovations.com

Hearing Aid Models and Advantages

Includes nationwide support, a 70-day money-back guarantee, batteries and accessories, along with:

Directional Processing*	Enhances the sounds in front of you while reducing distracting background noise
Tri-Mode Noise Reduction System	Helps you to better understand speech by reducing distracting environmental noise such as fans or motors
Automatic Gain Control	Helps you hear soft sounds while keeping loud noises at a comfortable level
Advanced Feedback Manager	Enables greater amplification without creating feedback or whistling
12 Gain Adjustment Bands	Allows for more custom programming to your specific hearing needs

		Advantages	Color	
Hearing Loss Severity Mild - Moderate  Severe - Profound	hi ITC™ (In-the-Canal) \$999 each	<ul style="list-style-type: none"> ✓ Nearly invisible ✓ Fits comfortably in your ear canal ✓ Open-fit design provides more natural sound quality (i.e., not plugged up) 	 Beige	 Black
	hi BTE™ (Behind-the-Ear) \$799 each hi BTE™ w telecoil (Behind-the-Ear) \$829 each	<ul style="list-style-type: none"> ✓ Compact, thin and lightweight ✓ Fits comfortably behind the ear ✓ More durable because less contact with earwax ✓ Easier battery replacement and volume control ✓ Open-fit design provides more natural sound quality ✓ A telecoil helps you hear better while on the telephone and it can connect to FM or audio loops 	 Champagne	 Graphite
	hi BTE™ power plus (Behind-the-Ear) \$879 each	<ul style="list-style-type: none"> ✓ Same advantages as hi BTE with telecoil ✓ For more severe hearing loss ✓ Requires ear mold for additional charge 	 Champagne	 Graphite
	hi BTE™ power max (Behind-the-Ear) \$929 each	<ul style="list-style-type: none"> ✓ Same advantages as hi BTE with telecoil ✓ For profound hearing loss ✓ Requires ear mold for additional charge 	 Tan	

* hi BTE power plus and hi BTE power max use an omni directional microphone for increased amplification of sounds



The SilverSneakers® Fitness program gives you options.

SilverSneakers is available at no additional cost for all Arizona State Retirement System (ASRS) retired members and dependents enrolled in the ASRS medical plan.

Work out indoors

- More than 13,000 fitness locations*
- All fitness equipment and SilverSneakers classes
- Easy to use with your SilverSneakers ID number



Take SilverSneakers FLEX™ classes

- Tai chi, yoga, walking groups and more
- At places you may already go (in many states)
- Online sign-up



Connect online

- Fitness location lookup tool
- Downloadable meal plans and healthy recipes
- Support from other SilverSneakers members

Go to the SilverSneakers website or call SilverSneakers to:

- Find fitness locations
- Request your SilverSneakers ID number
- Enroll in FLEX classes

silversneakers.com

1-888-423-4632 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. EST

Find a SilverSneakers location and get started today.



*If you are in need of an at-home kit, please visit us online or call our Customer Service phone number.

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my pharmacist shows me the savings!”

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- Doctor Visits
- Dental Care
- Vision Care
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- 24/7 Doctor
- Hearing Care
- Medical Bill Help
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Start saving today...

1. Find a pharmacy or provider by visiting www.WellCardHealth.com or calling 800-562-9625.
2. Keep this card in your wallet and present it at your pharmacy or provider's office to save.

Show the pharmacy your WellCard, and they'll show you the savings on your prescriptions.

A PRESCRIPTION SAVINGS PROGRAM
Present this card to your pharmacy and provider.

Group ID: ASRSH
Member ID: Enter member's 10-digit phone #, then add 2-digit person code. 01=Member, 02=Spouse, 03=Dependent, etc.
Processor: NetCard Systems
Bin #: 008878

WellCard Health
Smart. Simple. Savings.

OUTLOOK FIRST ACCESS DENTEMAX

MEMBER:
To find a provider: visit www.WellCardHealth.com or call 800-562-9625.
To speak to a physician 24/7 by phone, call 855-717-6200.
You must mention WellCard Health.

PHARMACY:
Add 2-digit person code to Member ID
01 = Member
02 = Spouse
03 = Dependent, etc.
Pharmacist Help Desk:
888-886-5822

PROVIDER:
Physician & Dental Provider:
To verify eligibility & for patient responsibility call 888-203-6711.
The patient is responsible for the entire discounted cost at the time of service.
Vision Provider:
To verify eligibility call 888-203-6662.

This is Not Insurance. It is a discount medical program. It does not replace COBRA or any other medical insurance program nor is it a Medicare Part D prescription drug plan. Cardholders are responsible for paying the discounted cost at the time of service from participating providers. The DPMO does make available a list of all program providers which includes their name, city and state, and medical specialty prior to purchase, upon request. WellCard Health is FREE. WellCard Health will not share or sell your personal information. The discount plan organization is AccessOne Consumer Health, Inc., 84 Villa Road, Greenville, SC, 29615, www.accessonedmpo.com. This program is not available to residents of Montana, but may be used at participating Montana providers. Other state residents: visit www.WellCardHealth.com for full disclosure.

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This is Not Insurance. It is a discount medical program. It does not replace COBRA or any other medical insurance program nor is it a Medicare Part D prescription drug plan. Cardholders are responsible for paying the discounted cost at the time of service from participating providers. The DPMO does make available a list of all program providers which includes their name, city and state, and medical specialty prior to purchase, upon request. WellCard Health is FREE. WellCard Health will not share or sell your personal information. The discount plan organization is AccessOne Consumer Health, Inc., 84 Villa Road, Greenville, SC, 29615, www.accessonedmpo.com. This program is not available to residents of Montana, but may be used at participating Montana providers. Other state residents: visit www.WellCardHealth.com for full disclosure.

Assurant Employee Benefits Retiree Dental Plans

For 2016, Assurant Employee Benefits continues to be the sole provider offering dental benefits to eligible public sector retirees, LTD recipients and eligible dependents through the Arizona State Retirement System. Assurant Employee Benefits offers different dental plan options depending on where you live.

There are two Indemnity Dental Plan options that are available in all states. Retirees/LTD recipients in many states can also choose a Prepaid Dental Plan. In Arizona only, retirees/LTD recipients have two different Prepaid Dental Plan options from which to choose. You have the freedom to choose the dental plan that best fits your individual needs. Compare the cost and benefits of each to determine which plan will meet your family's dental health needs.

NOTE: There are significant differences between the Indemnity and Prepaid Dental Plans. Below is a brief overview of the features of the Indemnity vs. the Prepaid Dental Plans.

INDEMNITY DENTAL PLANS

There are two Indemnity Dental Plan options: Freedom Basic (the “Low” option) and Freedom Advance (the “High” option). These plans pay the indicated percentages of Allowable Charges for covered services. Benefits are paid after any applicable deductible has been met, up to the Annual Maximum Benefit which is \$2,500 for the Freedom Advance plan and \$1,000 for the Freedom Basic plan. You are responsible for any applicable coinsurance percentages not covered by the plan. Allowable charges are based on charges being made by providers in the area where dental services are performed. You also have access to the Assurant® Dental Network, for additional savings on your dental care. The Indemnity Plan features include:

- Freedom to choose any dentist, including specialists
- Access to over 100,000 individual dentists participating in the Assurant Dental Network nationwide who have agreed to negotiated fee arrangements of up to 30% off their usual & customary fees.
- Coinsurance plan
- Fast and accurate claims processing

The Indemnity Dental Plans are available to retirees/LTD recipients in all states.

A vision discount benefit is included with all dental plans. See page 44 for details about the Vision Service Plan (“VSP”).

** Assurant Employee Benefits is the brand name for insurance products underwritten by Union Security Insurance Company and for prepaid dental products provided by affiliated prepaid dental companies. Please refer to issued plan documents for complete details, including all limitations, exclusions, and restrictions. Assurant Dental Network benefits include dentists contracted with Dental Health Alliance, LLC® (DHA®) and dentists under access arrangements with other PPO dental networks.*

PREPAID DENTAL PLANS

The Prepaid Dental Plans provide a variety of benefits through a network of participating dentists. You may change your dentist throughout the plan year. All services must be performed by a participating provider (note the exception to this requirement for the DHMO Dental Plan 220 with Ortho copayments offered in Arizona, as detailed on page 41). You pay a fixed copayment directly to the network dentist for covered dental procedures. The Prepaid Dental plan features include:

- Fixed copayment schedule for Plan Dentist Services
- No deductibles or claim forms
- No annual maximums or waiting periods
- Pre-existing dental conditions are covered
- Each family member may choose their own network dentist
- Orthodontia for both children and adults

The Prepaid Dental Plans vary by state and are available to retirees/LTD recipients in AZ, CA, CO, FL, GA, KS, MO, NE, NV, NM, OH, OK, OR, TX, and UT. Retirees in Arizona choose between two Prepaid Dental Plans – the Heritage Secure with Specialty Benefit Amendment (“SBA”) or the DHMO Dental Plan 220 with Ortho copayments.

Important Information Regarding On-Going Dental Care If Newly Enrolled with ASRS: If you are actively undergoing major dental procedures with your current dental provider and the service(s) is not completed prior to the effective date of your dental coverage with an ASRS-sponsored dental plan, your current provider may allow that on-going procedure to be a covered expense under your current dental plan even after your termination from your employer's dental plan. Check with your current dental provider to learn if your procedure qualifies for continued coverage. Dental procedures you are receiving under coverage from your current non-ASRS dental plan **will not be eligible** for benefits through Assurant Employee Benefits.

Important Things to Consider When Making Your Dental Plan Elections

Depending on where you live, your dental plan options vary. The Indemnity Dental Plans are available to retirees/LTD recipients in all states. The Prepaid Dental Plans vary by state and are available to retirees/LTD recipients in AZ, CA, CO, FL, GA, KS, MO, NE, NV, NM, OH, OK, OR, TX and UT. If you live in Arizona, you can choose from two different prepaid dental plans: the Heritage Secure with Specialty Benefit Amendment (“SBA”) or the DHMO Dental Plan 220 with Ortho copayments. You should carefully review the differences in the dental plans. See pages 41-42 for a comparison and summary of the dental plan options available to you.

- If you enroll in one of the Prepaid Dental Plans, you must choose a General Dentist as your Primary Care Dentist. The Directory of Dentists available to you will vary according to the Prepaid Plan you choose and where you live. Once you have selected a Primary Care Dentist, you must enter the Facility ID number from the directory on your enrollment form. This is very important! It allows Assurant Employee Benefits to notify your selected General Dentist that you will be a new patient and include your dental plan information on the dentist’s eligibility list called a “roster”.
- If you enroll in the Heritage Secure with Specialty Benefit Amendment (“SBA”) Prepaid Dental Plan available to Arizona residents, you will want to pay special attention to your options for receiving dental care from specialty dentists. All Plan Specialists who contract with the Heritage Secure plan will discount their services between 15%-25%. The 15% reduction applies if the Plan Specialist is an endodontist. The 25% reduction applies if the Plan Specialist is any other type of specialist, including but not limited to an orthodontist. Some plan Specialists have agreed to perform certain common specialty procedures for a fixed copayment rather than a discounted fee. These Assurant SBA Plan Specialists – Endodontists, Periodontists, and Oral Surgeons – are identified with an SBA indicator in the Directory of Dentists. All other services performed by an SBA Plan Specialist and not listed on the SBA copayment list will be provided at the discounted fee.
- If you enroll in the DHMO Dental Plan 220 with Ortho copayments (available to Arizona residents), many of the common specialty procedures can be performed by a participating network General Dentist or Specialist for the same fixed copayment. In addition, there are certain common specialty procedures that can also be performed by a Non-Plan Specialty Dentist. For the specific procedures that can be performed by a Non-Plan Specialty Dentist, you will submit a claim to Assurant Employee Benefits and receive reimbursement up to a maximum amount based on the procedure performed.
- The Indemnity Dental Plans offer freedom of choice to use any eligible licensed dentist or specialist in the United States.
- If you enroll in either of the Indemnity Dental Plans and you want to save dollars on your dental care, use a dentist who participates in the Assurant Dental Network. All of the dentists who participate in the Assurant Dental Network have agreed to negotiated fee arrangements of up to 30% off their usual and customary fees and they will not balance bill you for services that are covered by the plan.

To find a network dentist who participates in the nationwide Assurant Dental Network, the Heritage Secure or DHMO Dental Plan 220 networks in Arizona, or the networks for the Prepaid Plans offered in the other states, please visit Assurant’s Employee Benefit’s dedicated web site for ASRS members at www.assurantemployeebenefits.com/ASRS, call their representative **on-site** at ASRS, or call their toll-free Customer Service Center (see the contact information listed on the inside back cover of this guide).

Please review the information on pages 41-42 for a comparison of the dental plan options available to you. There are *significant* differences between all the dental plan options. If you are considering one of the Prepaid Dental Plans in Arizona, you should compare the copayments you will pay for certain common procedures on page 41-42 of this guide, along with the total annual premium you will pay, in order to accurately assess which Prepaid Dental Plan option is the best choice for you.

Assurant Employee Benefits Retiree Dental Plans

Freedom Advance (High Option)	Freedom Basic (Low Option)	DHMO Dental Plan 220 with Ortho	Heritage Secure with SBA
AVAILABLE NATIONWIDE		AVAILABLE IN ARIZONA ONLY	
You have freedom to use any licensed dentist in the United States. Or use an Assurant Dental Network dentist for savings on your dental care. The Assurant Dental Network has more than 100,000 dentists in their nationwide network of dentists		You must select a General Dentist as your Plan Dentist. Except for certain specialty dental procedures listed in the plan copayment schedule, all services must be performed by your Plan Dentist. Certain specialty dental procedures can also be provided by non-Plan Specialists	
Provider fees are based on Usual & Customary. Assurant Dental Network dentists discount their fees up to 30% for all covered procedures. Benefits are paid at the negotiated fee level for Assurant Dental Network (in-network) dentists. Benefits for services from out-of-network dentists will be paid at the 80th percentile of the amount charged by the majority of dentists in the area		Provider fees are based on fixed copayment schedule. Certain procedures can be performed by your Plan Dentist or by a Plan Specialist for the same copayment as identified in the Plan copayment list	
Type I Preventive services are covered at 80% and the deductible is waived. The \$50 deductible is paid once per year, up to a maximum of three times per family	Type I Preventive services are covered at 100% and the deductible is waived. The \$50 deductible is paid once per year, up to a maximum of three times per family	No copayment for most Preventive services	There are copayments for some Preventive services
Type II Basic services are covered at 80% after the \$50 deductible has been paid. Includes new and replacement fillings, root canals, periodontics (treatment of gum disease), minor oral surgery	Type II Basic services are covered at 80% after the \$50 deductible has been paid. Includes new and replacement fillings, some minor oral surgery, minor periodontics, scaling & root planing, periodontic maintenance	Fixed copayments and certain identified procedures can be performed by your Plan Dentist or by a Plan Specialist for the same copayment. When compared to the AZ Heritage Secure plan, there are more than 130 additional copayments and most copayments are lower	Fixed copayments or discounts on services performed by network specialty dentists
Type III Major Services are covered after the \$50 deductible has been paid. New enrollees will start at a 25% coinsurance level for Type III Major Services for the 1st year of continuous dental coverage and then graduate to 50% coinsurance for the 2nd year of continuous dental coverage and each year thereafter	Type III Major services are not covered	For certain specialty procedures performed by a non-Plan dentist, you will submit a claim to Assurant and receive reimbursement up to a specified amount	Specialty dentists who have agreed to the SBA (indicated by an "SBA" in the directory) provide certain specialty procedures for a fixed copayment. Many other services by specialty dentists are provided at a discount
If you are currently enrolled in the Prepaid dental plan and you enroll in the Freedom Advance plan, your benefits for Type III Major Services will be paid at the 50% coinsurance level (assuming you have been enrolled in the Prepaid plan for at least 12 months)	If you are currently enrolled in the Freedom Basic dental plan and you enroll in the Freedom Advance plan, your benefits for Type III Major Services will be paid at the 25% coinsurance level for the 1st year of coverage and then 50% for the 2nd year of continuous dental coverage and each year thereafter	Implant benefit. Receive \$300 discount off specified implant procedures from Plan dentists	Copayment for teeth bleaching
Annual benefit maximum per person per calendar year is \$2,500	Annual benefit maximum per person per calendar year is \$1,000	No annual maximum for Plan Dentist and Plan Specialty Dentist services. Plan benefit payments for services by non-Plan Specialty Dentists limited to \$2,000 per person per calendar year	No annual maximums
Orthodontia is not covered	Orthodontia is not covered	Orthodontia copayments for children and adults when provided by a Plan Orthodontist	Plan orthodontists provide discounts of 25% off their usual fees for child and adult ortho treatment; no maximum
The Freedom Basic and Freedom Advance Plans are subject to the Alternative Treatment provision. If the cost of a proposed Dental Treatment Plan exceeds \$300, it should be submitted for an estimate of benefits payable.		Prepaid dental plans are also available in CA, CO, FL, GA, KS, MO, NE, NV, NM, OH, OK, OR, TX, and UT. For a copy of the Schedule of Benefits and Provider Directory in one of these states, please call the Assurant ASRS on-site representative at the number listed on the inside back cover of this guide in the Dental Provider section	

This provides only a brief summary of some unique features and benefits of the dental plans for your ease of comparison. For complete details, please refer to the dental plan documents that are available to the ASRS retirees during open enrollment, as well as throughout the year. For additional information or questions, you should contact Assurant Employee Benefits. Plans contain limitations, exclusions, and restrictions.

Assurant Employee Benefits Retiree Dental Plans

DENTAL PLAN COMPARISON

		INDEMNITY DENTAL PLAN OPTIONS		ARIZONA PREPAID PLAN OPTIONS	
		Freedom Advance (High Option)	Freedom Basic (Low Option)	DHMO Dental Plan 220 with Ortho	Heritage Secure with SBA
Calendar Year Deductible (Per Person; maximum of three deductibles per family)		\$50/\$150 - Waived for Type I services	\$50/\$150 - Waived for Type I services	NA	NA
Annual Maximum (Per Person)		\$2,500	\$1,000	NA ⁶	NA
ADA CODE	Description				
	EXAMS AND XRAY¹	Plan Pays² (Subject to Frequency Limitations)		You Pay (Fixed Copay)	You Pay (Fixed Copay)
D0120	Periodic Exam (checkup)	80%	100%	\$0	\$0
D0140	Limited Exam (problem focused)	80%	100%	\$0	\$25
D0150	Comprehensive Exam (initial)	80%	100%	\$0	\$0
D0220	Intraoral - periapical first film (xray)	80%	80%	\$0	\$0
D0230	Intraoral - periapical each addition film (xray)	80%	80%	\$0	\$0
D0272	Bitewings - Two films (xrays)	80%	100%	\$0	\$0
D0274	Bitewings - Four films (xrays)	80%	100%	\$0	\$0
D0330	Panoramic film (xray)	80%	80%	\$0	\$10
	PREVENTIVE SERVICES¹				
D1110	Routine dental cleaning (adult)	80%	100%	\$0	\$10
D1120	Routine dental cleaning (child)	80%	100%	\$0	\$10
D1203	Fluoride, child ³	80%	100%	\$0	\$0
D1351	Sealant ⁴	80%	100%	\$0	\$20
	FILLINGS				
D2140	Amalgam - 1 surface	80%	80%	\$10	\$25
D2150	Amalgam - 2 surfaces	80%	80%	\$15	\$30
D2160	Amalgam - 3 surfaces	80%	80%	\$20	\$45
	CROWNS				
D2751	Crown - porcelain fused to predominately base metal	25%/50% ⁵	Not Covered	\$220 + Lab Fee	\$295 + Lab Fee
D2950	Core Build Up	25%/50% ⁵	Not Covered	\$75	\$55
	ROOT CANALS				
D3310	Endodontics - Anterior	80%	Not Covered	\$95	\$145
D3320	Endodontics - Bicuspid	80%	Not Covered	\$220	\$225-\$280 ⁷
D3330	Endodontics - Molar	80%	Not Covered	\$275	\$295-\$395 ⁷
	PERIODONTAL CARE (FOR GUMS)				
D4341	Periodontal Therapy, 4+ teeth/quadrant	80%	80%	\$75	\$90-\$100 ⁷
D4910	Periodontal Maintenance	80%	80%	\$45	\$55
	BRIDGES AND DENTURES				
D5110	Complete denture - maxillary (upper)	25%/50% ⁵	Not Covered	\$295 + Lab Fee	\$385 + Lab Fee
D5120	Complete denture - mandibular (lower)	25%/50% ⁵	Not Covered	\$295 + Lab Fee	\$385 + Lab Fee
D5213	Removable partial denture - maxillary (upper)	25%/50% ⁵	Not Covered	\$365 + Lab Fee	\$495 + Lab Fee
D5214	Removable partial denture - mandibular (lower)	25%/50% ⁵	Not Covered	\$365 + Lab Fee	\$495 + Lab Fee
	EXTRACTIONS				
D7140	Extraction, Erupted Tooth or Exposed Root	80%	80%	\$30	\$25
D7210	Extraction, Surgical	25%/50% ⁵	Not Covered	\$60	\$85
	ORTHODONTIA CARE				
None	Bracketing	Not Covered	Not Covered	\$300	25% Discount from Plan Orthodontist
D8080	Comprehensive Ortho (under age 19)	Not Covered	Not Covered	\$2,000	
D8090	Comprehensive Ortho (19 or older)	Not Covered	Not Covered	\$2,200	

¹ Services are subject to frequency limitations and allowable charges.

² All services may be subject to frequency limitations, allowable charges, limitations and exclusions.

³ Only for children under age 14.

⁴ Only for children under age 16 on the Freedom Basic and Advance plans.

⁵ 25% during first year; 50% for 2nd and subsequent years of continuous coverage.

⁶ Plan Benefit payments for services by non-Plan Specialty Dentists limited to \$2,000 per calendar year.

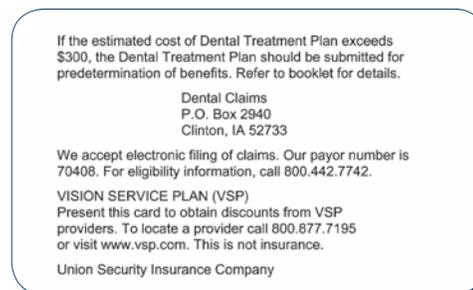
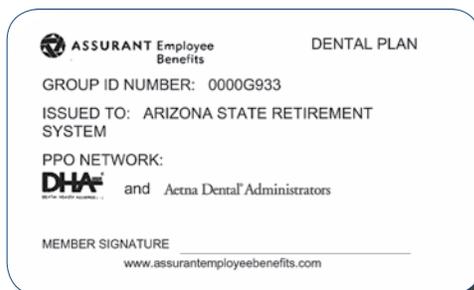
⁷ Copayment will vary depending on whether procedure is performed by your Plan Dentist or by a Specialist who participates with the SBA.

The Freedom Basic and Advance plans are subject to the Alternative Treatment provision. If the cost of a proposed Dental Treatment Plan exceeds \$300, it should be submitted for an estimate of benefits payable.

ASRS Retiree Dental Plans Sample ID Cards

The sample ID cards below show you which ID card corresponds to each Assurant Employee Benefits ASRS retiree dental plan. The card also provides information on Assurant Employee Benefits vision discount plan offered through Vision Service Plan (VSP).

For retirees/LTD recipients enrolled in Assurant Employee Benefits Freedom Advance (High Option) or Freedom Basic (Low Option) indemnity dental plan PRIOR TO September 1, 2013, your ID card will look like this:



For retirees/LTD recipients enrolled in Assurant Employee Benefits Freedom Advance (High Option) or Freedom Basic (Low Option) Indemnity dental plan ON OR AFTER September 1, 2013 (or if you request a new ID card on or after this date) your ID Card will look like this:



For retirees/LTD recipients enrolled in Assurant Employee Benefits Heritage Secure with SBA Prepaid Plan or DHMO 220 with Ortho Plan offered in Arizona, or other states where Assurant Employee Benefits offers Prepaid dental plans, your ID card looks like this:



Note: Vision Service Plan (VSP) information is located on the back side of each ID card.

VISION DISCOUNT SERVICES



ACCESS PLAN

Your Assurant Employee Benefits dental plan includes a vision discount plan through Vision Service Plan (VSP). The vision plan includes discounts on exams (including contact lens exams) and the purchase of eyeglasses, sunglasses and other prescription eyewear when provided by VSP doctors. VSP is available for you and everyone covered on your dental plan!

Services Available from a VSP Doctor

- **Eye Exams** – 20% discount applied to VSP doctor’s usual and customary fees for eye exams¹
- **Glasses** – 20% discount applied to VSP doctor’s usual and customary fees for complete pairs of prescription glasses and spectacle lens options²
- **Contact Lenses** – 15% discount on VSP network doctor’s professional services when purchasing all prescription contact lenses² (materials at doctor’s usual and customary fees)³.
- **Laser VisionCareSM** – VSP has contracted with many of the nation’s laser surgery facilities and doctors, offering you a discount off PRK and LASIK surgeries, available through contracted laser centers

Other Valuable Features for You

- Immediate savings when using a VSP doctor
- You may use the discounts as often as you wish
- No waiting periods
- No deductibles
- No claim forms to fill out



How to Use VSP

Locate a VSP doctor near you. You may either use the web-based doctor locator at www.vsp.com, or call VSP at 800.877.7195 to request a doctor listing.

Identify yourself as a VSP member and be prepared to provide the *enrolled member’s* social security number when you make your appointment. (The VSP doctor will verify your eligibility and vision plan coverage, and will obtain authorization for services and materials. If you are not currently eligible for services, the VSP doctor is responsible for communicating this to you.)

Your fees are automatically reduced at the time of service – with no claim forms to fill out!

THIS VISION DISCOUNT PLAN IS NOT INSURANCE.

¹Note: Does not apply to contact lens services. See contact lens section for applicable discount.

²Discounts only offered through the VSP doctor who provided an eye exam within the last 12 months.

³VSP offers valuable savings on annual supplies of selected brands of contact lenses.

VSP Member Services Support: 800.877.7195
Visit the Web site at www.vsp.com

How to Complete Your 2016 Enrollment Form

Complete an ASRS 2016 Enrollment Form if you are enrolling for the first time, electing new coverage, or changing existing coverage. Submission of a properly completed enrollment form is required to enroll in an ASRS medical and/or dental plan. Please complete the enclosed enrollment form as outlined below:

Step 1

- Effective Date: Fill in the month that you need the insurance coverage to begin. Effective date of your coverage will be the first of the month following receipt of the Enrollment Form unless a future date is provided.
- Check boxes that apply to you:
Reason for Enrollment Form
Status

Step 2

- Provide your social security number, name, address, etc. If you want your mail sent to a different mailing address than your primary residence, complete the mailing address line.

Step 3

- If you are enrolling in a medical plan, check the box of the medical plan you are electing. You can only select one option. If you are not enrolling in medical, check the box that states: "I'M DECLINING MEDICAL COVERAGE".
- If you are enrolling in a dental plan, check the box of the dental plan you are electing. You can only select one option. If you are not enrolling in dental, check the box that states: "I'M DECLINING DENTAL COVERAGE".

Step 4

- List yourself and all other eligible dependents that you are enrolling in the medical and/or dental plans.
- If you are electing the dental Prepaid DHMO, Heritage Secure or Out of State Prepaid plan, you must provide a Dentist ID number or a dentist will be automatically assigned to you. If you are unsure what to include, you can find the dentist directory at www.assurantemployeebenefits.com/ASRS or by calling (800) 443-2995.
- Group Medicare Advantage HMO only: List the names of the persons enrolling in this plan in the Covered Person Name box; indicate the names of the Primary Care Physicians and Networks you are choosing. If you are unsure what to include, you can find the Group Medicare Advantage HMO directory at www.uhcretiree.com/ASRS or you can call (866) 208-3248.

Step 5

- Sign and date the Enrollment Form. Signature must be from either the retiree, disabled member or a surviving dependent. **The enrollment form cannot be dated more than 90 days prior to the requested effective date.**
- If you are enrolling in a Medicare plan, please provide a copy of your Medicare card or an award letter showing you are eligible for Medicare.
- If you are enrolling mid-year (a time other than Open Enrollment period) in a medical and/or dental insurance plan, please provide proof of the qualifying event that you are experiencing. If you are unsure on what to provide, you may contact ASRS Member Services at (602) 240-2000 in Phoenix, (520) 239-3100 in Tucson or outside of Phoenix and Tucson, at (800) 621-3778.
- **KEEP THE GOLDENROD COPY OF THE ENROLLMENT FORM FOR YOUR OWN RECORDS.**
- Mail your Enrollment Form to:

Arizona State Retirement System
Attn: Health Insurance
PO Box 33910
Phoenix, AZ 85067

If you are terminating your current ASRS medical and/or dental coverage, please send a letter in writing to ASRS, with the retiree, disabled member or surviving spouse's social security number and your signature. If you and/or your dependents are terminating an ASRS Medicare plan, please include all covered members' signatures.

Cost for Coverage *Medical Plan Premiums*

(January 1 through December 31, 2016)

Use this chart to determine how your medical plan election will affect your pension check.

MONTHLY PREMIUMS – MEDICAL PLANS PROVIDED BY UNITEDHEALTHCARE

WITHOUT MEDICARE		
You and your dependents do not have Medicare Part A and B		
ALL ARIZONA COUNTIES		
	Single Coverage	Family Coverage
UnitedHealthcare Choice (#0717191-0013)	<input type="checkbox"/> \$793.00 per month	<input type="checkbox"/> \$1586.00 per month
OUT OF STATE		
	Single Coverage	Family Coverage
UnitedHealthcare Choice Plus PPO (#0717191-0003)	<input type="checkbox"/> \$1112.00 per month	<input type="checkbox"/> \$2224.00 per month
WITH MEDICARE A & B		
You and your dependent(s) have Medicare Part A and B		
ALL ARIZONA COUNTIES		
	Single Coverage	Family Coverage (1)
UnitedHealthcare Group Medicare Advantage HMO	<input type="checkbox"/> \$194.00 per month	<input type="checkbox"/> \$388.00 per month
UnitedHealthcare Senior Supplement & PDP (2)	<input type="checkbox"/> \$337.00 per month	<input type="checkbox"/> \$674.00 per month
OUT OF STATE		
	Single Coverage	Family Coverage (1)
UnitedHealthcare Senior Supplement & PDP (2)	<input type="checkbox"/> \$337.00 per month	<input type="checkbox"/> \$674.00 per month
COMBINATION PLANS		
	One person on Medicare, the other(s) without Medicare	Two people on Medicare, the other(s) without Medicare
ALL ARIZONA COUNTIES		
UnitedHealthcare Group Medicare Advantage HMO with Choice (#0717191-0014)	<input type="checkbox"/> \$987.00 per month	<input type="checkbox"/> \$1181.00 per month
UnitedHealthcare Senior Supplement & PDP(2) with Choice (#0717191-0014)	<input type="checkbox"/> \$1130.00 per month	<input type="checkbox"/> \$1467.00 per month
OUT OF STATE		
UnitedHealthcare Senior Supplement & PDP(2) with Choice Plus PPO (#0717191-0009)	<input type="checkbox"/> \$1449.00 per month	<input type="checkbox"/> \$1786.00 per month

(1) Retiree and dependents monthly premium is a multiple of the number of lives covered and the single coverage premium.

(2) The Senior Supplement medical plan can only be selected in conjunction with the Prescription Drug Plan (PDP). If you are currently enrolled in the Senior Supplement medical plan and you elect to cancel your medical plan coverage, your Medicare Part D Prescription drug coverage will be cancelled as well.

Cost for Coverage *Dental Plan Premiums*

(January 1 through December 31, 2016)

Use this chart to determine how your dental plan election will affect your pension check.

MONTHLY PREMIUMS – DENTAL PLANS PROVIDED BY ASSURANT EMPLOYEE BENEFITS

Assurant Employee Benefits	Single Coverage	Member + 1 Dependent	Member + 2 dependents or more	Dentist ID Number (Facility ID number can be found in Assurant Directory)
Freedom Advance (High Option) (Nationwide coverage)	\$34.44 per month	\$68.74 per month	\$97.28 per month	NOT APPLICABLE
Freedom Basic (Low Option) (Nationwide coverage)	\$16.17 per month	\$34.19 per month	\$62.60 per month	NOT APPLICABLE
DHMO 220 Prepaid Plan with Ortho Copays (Available in Arizona only)	\$13.96 per month	\$23.34 per month	\$39.23 per month	
Heritage Secure Prepaid Plan w/SBA (Available in Arizona only)	\$10.61 per month	\$17.41 per month	\$26.90 per month	
Prepaid (Available in CA, CO, FL, GA, KS, MO, NE, NV, NM, OH, OK, OR, TX and UT)	\$10.21 per month	\$17.27 per month	\$27.24 per month	

Calculating Your Monthly Health Insurance Cost

Each retiree’s circumstances are different. The ASRS offers retiree/LTD recipient health insurance plans as does the Arizona Department of Administration and more than 600 participating employers to allow retirees to remain on their active employee coverage. Premium benefits vary depending on a retiree’s years of service. They also vary among the four state retirement systems and plans. Premiums also differ depending on the plan in which the retiree is enrolled and whether single or family coverage is elected.

Use the worksheet on the next page to determine the monthly cost of health insurance based on the plans you have selected and any applicable

premium benefit amount. Amounts for insurance premiums will be deducted from your monthly pension check or you will be required to pay to the insurance carrier(s) or your employer directly.

If you log into your personal homepage on the ASRS website, you can see your monthly pension payment history. It displays any basic premium benefit (HI SUPPLEMENT) and the full amount of your health insurance premium (HI PREMIUM). However, only your **net health insurance cost (NET PREMIUM)** is being deducted from **your pension check**.

Net Monthly Health Insurance Cost Worksheet

Your monthly medical plan premium from page 46.

A

Your monthly dental plan premium from page 47.

+

B**Total Premium**

(A plus B)

C

Your Basic Premium Benefit (See chart on page 49).

-

D**Your Net Premium**

(C minus D)

=

E

Retiree Health Insurance Premium Benefit Program

Basic Premium Benefit Amounts

The monthly premiums shown in the charts on pages 46-47 are the full cost for the medical and dental coverages. The Arizona State Retirement System, Public Safety Personnel Retirement System, Elected Officials' Retirement Plan, and/or Corrections Officer Retirement Plan will provide payment toward insurance premiums for eligible members and their dependents. The chart below reflects the maximum monthly basic premium benefit available for eligible members and their dependents.

No basic premium benefit is provided to retiree/LTD recipients in the University Optional Retirement Plans.

To determine your basic premium benefit, you need to know your years of credited service in your retirement system or plan; your coverage type, i.e., single or family coverage; and, whether you and covered family members are eligible for Medicare.

Years of Service	WITHOUT MEDICARE		WITH MEDICARE A & B		COMBINATIONS	
	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) Members						
not applicable	\$150.00	\$260.00	\$100.00	\$170.00	\$215.00	\$215.00

Optional Health Insurance Premium Benefit Program

Effective January 1, 2004, a new ASRS retiree may elect to receive a reduced premium benefit that, upon his or her death, may be continued to the retiree's contingent annuitant. There are certain restrictions applicable to this benefit:

- election of a joint and survivor or period certain pension option is required;
- the contingent annuitant must receive, upon the death of the retiree, a continuing monthly pension benefit;
- the contingent annuitant must either be participating or eligible to participate in the retiree's health care program at the time of the retiree's death;
- the reduced premium benefit will remain in effect as long as the contingent annuitant receives a monthly pension benefit and remains enrolled in an eligible health care plan; and
- the retiree may cancel in writing the election at anytime and be eligible for the unreduced premium benefit payable for the retiree's lifetime and as provided by law.

The law also provides that members have a "one-time" opportunity to elect this benefit when they retire. Therefore, the election to participate in this program is made at the time the retiree completes his or her ASRS retirement application.

This benefit is applied in the following manner depending on your election of either a joint and survivor or period certain pension option:

Joint and Survivor Pension Option

If the retiree elects a Joint and Survivor option, the retiree would receive a reduced premium benefit based on a factor determined by the ages of the retiree and the contingent annuitant. Upon the death of the retiree, the contingent annuitant would receive either 100%, 66 2/3%, or 50% of the reduced premium benefit. This benefit would be further reduced if a change from family coverage to single coverage occurs.

Period Certain and Life Pension Option

If the retiree elects a period certain option, the retiree would receive a reduced premium benefit based on a factor determined by the ages of the retiree and the contingent annuitant. Upon the death of the retiree, the contingent annuitant would receive the reduced premium benefit the retiree was receiving only for the remainder of the period certain. This benefit would be further reduced if a change from family coverage to single coverage occurs.

Please use the worksheet on page 52 to calculate an estimate of your optional premium benefit and what continuing amount may be applicable to your contingent annuitant.

It is very important to remember that the ASRS will not know **exactly** how much the premium benefit will be for the contingent annuitant at the time of the retired member's death. Adding or deleting dependents, changes to the statute which provides premium benefits and going from non-Medicare to Medicare eligible status affect the amount of premium benefit to which the retiree or contingent annuitant is entitled.

Calculating Your Optional Premium Benefit

Completing the worksheet on the next page will assist you in understanding the reduction(s) to your premium benefit if you elect to participate in this program. Please remember that participation is voluntary. If you elect to participate, you may rescind your election at a later date and your unreduced premium benefit will be reinstated and will continue to be applied for the remainder of your lifetime and as provided by law.

In order to complete this worksheet, you need to know the dollar amount of the unreduced premium benefit to which you are entitled, the pension option you will elect, and the age of your contingent annuitant. The unreduced amount of your premium benefit is a function of your years of credited service, where you live, whether you are Medicare eligible and your election of family or single coverage.

Calculating Your Optional Premium Benefit Worksheet

<p>Total unreduced Premium Benefit to which you are entitled:</p> <p>Pension option chosen: _____</p> <p>Your age at retirement: _____</p> <p>Your contingent annuitant's age at your retirement: _____</p> <p>Factor from appropriate Table: (Factor Tables begin on page 66-71).</p>	<p>Family Coverage</p>	<p>A</p>	<p>Single Coverage</p>	
	\$ <input style="width: 100px;" type="text"/>	A	A	\$ <input style="width: 100px;" type="text"/>
	A times B	B	B	
	A times B	C	C	
<p>Effective on the first day of the month following your date of death, your contingent annuitant is entitled to a reduced premium benefit, based on your chosen pension option, equal to:</p>				
<p>For Joint and Survivor Options:</p>				
Option Chosen: (100%, 66 2/3% or 50%)	<input style="width: 100px;" type="text"/>	D	D	<input style="width: 100px;" type="text"/>
If family coverage remains in effect, the contingent annuitant is entitled to:	C times D	E		
If single coverage becomes effective, the contingent annuitant is entitled to a recalculation based on a single unreduced premium benefit X the factor X the J&S pension option.		C times D	E	\$ <input style="width: 100px;" type="text"/>
<p>For Period Certain and Life Options:</p>				
If family coverage remains in effect, the contingent annuitant is entitled to:	Box C Amount	F		
If single coverage becomes effective, the contingent annuitant is entitled to a recalculation based on the single unreduced premium benefit X the factor.		Box C Amount	F	\$ <input style="width: 100px;" type="text"/>

2016 Program Overview

My current coverage will continue to be provided by my Participating Employer. What do I need to do?

Many employers allow retirees to continue coverage indefinitely or for a specific period of time. Review with your Participating Employer your continuing eligibility. If you continue health insurance with your employer, complete a health insurance application with them. It is important you understand how long you may continue coverage with your Participating Employer. Once you drop your Participating Employer health insurance coverage, you may not be eligible to return to their plan. NOTE: You are eligible to enroll in ASRS health insurance at the time of retirement, during any open enrollment, or if you have a qualifying event.

When I retire should I enroll in my employer's COBRA coverage?

COBRA is a federal law that allows former employees, who terminate their employment for reasons other than gross misconduct, to continue their employer's coverage up to 18 months.

To determine which health care plan may be right for you, please compare your employer's coverage and cost with the ASRS retiree health care plan for which you are eligible. Identify which physicians may be accessed in each program because you may find that your current physician accepts patients from both programs. If that is the case, the amount of your premium payment may become a determining factor in your enrollment decision.

Whether you elect to participate in your employer's coverage or that of the ASRS, you will be entitled to the Premium

Benefit Program discussed on page 49 of this guide.

What do I need to do when my COBRA coverage ends?

If you wish to be enrolled in the ASRS retiree health insurance program when your employer's COBRA coverage terminates, you must complete an ASRS enrollment form(s) **and provide a letter from your former employer or COBRA administrator indicating the date your COBRA coverage ends. This letter is very important as it establishes your "qualifying event" that allows you to enroll with the ASRS.** Failure to provide this letter may cause a delay in your ASRS health insurance enrollment. **Though you have 31 days following the termination of your COBRA coverage to enroll with the ASRS, your ASRS coverage will always be effective on the first day of the month following receipt of your completed ASRS enrollment application.** Therefore, there is no retroactive coverage for health insurance. Please remember to begin your enrollment process with the ASRS **before** your employer's COBRA coverage ends.

What will happen if I don't submit my enrollment form when I retire?

If you wish to enroll for health care coverage with the ASRS and you fail to submit your completed enrollment form within the thirty-one (31) day grace period, you will not have health care coverage with the ASRS.

Consequently, you will not be eligible to enroll in the retiree health insurance program until the next open enrollment which will take place in the autumn of

2016 Program Overview continued...

2016. However, should you experience a “qualifying event,” as defined by law, during the course of the year, you may enroll in an ASRS retiree medical and/or dental plan at that time.

What is a 'qualifying event'?

A “qualifying event” permits members to make a specific mid-year change to their benefits coverage that is **consistent** with the qualifying event. If you have a qualifying event and want to enroll or are required to make a change in your coverage (i.e., add or delete dependents or are required to change your benefit plan), you must notify the ASRS or, if applicable, the Public Safety Personnel Retirement System (PSPRS) Member Services, in writing, within 31 days of the event to request a change. Following is a list of eligible qualifying events:

- **Change in member’s marital status** – marriage, divorce, legal separation, annulment, death of spouse (e.g., enroll yourself and/or add or delete a spouse),
- **Change in dependent status** – birth, adoption, placement for adoption, death, or dependent eligibility due to age (e.g., enroll yourself and/or add or delete eligible dependents),
- **Change in member’s primary residence causing a change in benefit plan availability** (e.g., change medical and/or dental plans),
- **Eligibility for Medicare** – member, spouse, dependent child (e.g., enroll yourself and add your eligible dependents in a medical and/or dental plan or, if enrolled, change medical plan of affected person),
- **Significant change in spouse’s group**

benefits plan cost or coverage (e.g., enroll yourself if you are enrolled in your spouse’s group benefit plan, and add eligible dependents),

- **Significant change in Participating Employer’s group benefits plan cost or coverage** (e.g., enroll yourself if you are enrolled in your employer’s group benefit plan, and add eligible dependents), and
- **Termination of COBRA coverage** – member, spouse, dependent child (e.g., enroll yourself and/or add eligible dependents).

Note: If you enroll in the Arizona Health Insurance Marketplace, then terminate your private individual medical insurance and want to return to ASRS for your medical insurance, this is not a qualifying event. You will not be eligible to enroll in the ASRS retiree health insurance program until the next open enrollment which will take place in the autumn of 2016.

Who is an 'eligible dependent'?

Your legal spouse,

A natural child, legally adopted or placed for adoption children; or stepchildren up to age 26,

A child for whom legal guardianship has been awarded to the retiree or retiree's spouse up to the age of 26,

Foster children up to the age of 26,

A child for whom insurance is required through a Qualified Medical Child Support Order or other court or administrative order.

If you enroll your eligible dependent(s), addi-

2016 Program Overview continued...

tional documentation will be requested:

If you have a dependent child age 26 or older who is disabled or under legal guardianship, you will be requested to provide:

- a certified copy of a court order granting legal guardianship, or
- verification that your dependent child has a qualifying permanent disability that occurred prior to his or her 26th birthday and is in accordance with Social Security Administration guidelines. This continuation of coverage is also subject to approval by the Medical Director of the Medical and/or Dental Health Insurance providers for ASRS.

Both my spouse and I are ASRS retirees. How may the Premium Benefit Program help us?

The ASRS Premium Benefit Program provides the greater of 2 single premium benefits or 1 family premium benefit to each eligible retiree. Such retirees generally can receive the greatest application of the premium benefit program with each retiree enrolling in a medical plan choosing single coverage and one retiree enrolling in a dental plan choosing family coverage.

What should I do if my spouse has benefits through another employer?

Coordinate your coverages. Study what your spouse has, then decide which ASRS retiree health insurance options provide you with the most appropriate overall coverage. It is usually best to pick coverage that complements, not duplicates, the other coverage.

What should I tell my dependent beneficiary to do about

my pension benefits and health insurance coverage in the event of my death?

There is no quick or simple answer. Your dependent beneficiary is encouraged to contact ASRS Member Services or PSPRS Benefits Office staff, if applicable, at the time of your death. Decisions will have to be made regarding continuation of pension benefits if you elected a pension option other than straight life annuity. Likewise, continuation of or enrollment in an ASRS retiree health care plan by your beneficiary must be decided within six (6) months of your death. Also, if you elected a reduced premium benefit, your beneficiary may be entitled to a continuation of that benefit. Your beneficiary will need to provide certified copies of your death certificate to affect any change in your pension or health insurance benefits.

What happens if my monthly health insurance premium exceeds the amount of my pension check?

If your monthly pension check has insufficient funds to cover your health insurance premiums, then premiums will not be deducted. The insurance carrier(s) would be notified that you did not make a premium payment for that month and they will mail a bill to you. It will be your responsibility to pay any outstanding premiums directly to the insurance carrier(s). Direct bills are mailed at the end of the month and due by the 25th of the following month. You will be paying your premium in arrears instead of in advance as you would if you had a pension deduction.

What do I need to do if I decide to change my retirement date or go back to work?

2016 Program Overview continued...

If a member changes their retirement date or goes back to work after UnitedHealthcare has already processed the enrollment form, UnitedHealthcare can't retroactively disenroll a member (Medicare in particular), so the member is responsible for the premium.

What happens if I fail to pay my direct bill?

Your health insurance coverage will be terminated. You will not be allowed to come back onto an ASRS-sponsored plan until the next Open Enrollment period, and only if your previous balance is paid in full.

What do I need to do to cancel my ASRS health care coverage?

If you wish to terminate your enrollment in an ASRS retiree health insurance plan, you must do so in writing either in a letter or using the ASRS enrollment form by checking the appropriate "decline" box(es) or you may email your cancellation to ASRS if you are a non-Medicare member. Your cancellation must be received by the ASRS prior to the first day of the month your cancellation is to become effective. Please note that if your notice of cancellation arrives after the first day of the month, your coverage will not be cancelled until the first day of the following month unless a future date is requested. If you do not notify ASRS you will be responsible for your monthly premium until ASRS receives your written cancellation or for non-Medicare members you may email your cancellation to ASRS.

If you are enrolled in the UnitedHealthcare Group Medicare Advantage (HMO) or Senior Supplement Plans, you must submit a Disenrollment Letter to "unlock" your

Medicare so you may return to original Medicare. The letter must be signed and dated by all Medicare enrolled members

After I enroll in an ASRS retiree health care plan, when will I receive my ID cards?

UnitedHealthcare will mail your medical plan ID card(s) approximately 10 days prior to the first day of the month in which your medical plan becomes effective. Assurant Employee Benefits also will mail your dental plan ID card(s) approximately 10 days prior to the first day of the month in which your dental plan becomes effective.

After I submit my retirement paperwork and the health care enrollment form, when will the deductions start for the health care coverage?

It takes a couple of months before the pension check deduction starts. Members will be on direct bill status for the first few months before the pension deduction is set up. Members receive a bill for their premium until the deduction is set up on the pension check.

Must I notify the ASRS or PSPRS of an address change?

Yes, all mailings, including pension and LTD benefit plan checks, newsletters, open enrollment and additional insurance information are delivered to the address of record on file with the ASRS or PSPRS, if applicable. **It is always in your best interest to ensure a correct mailing address.** While many retirees and LTD recipients have seasonal or even secondary addresses (such as a PO Box), **the address of the primary residence is key to the availability of medical plan options and their costs as well as the forwarding of important periodic information that**

2016 Program Overview continued...

may be time sensitive. In short, it is your responsibility to let the ASRS or PSPRS if applicable, know in writing or via the secure ASRS website when you have an address change.

What is the Health Insurance Marketplace and How Does it Affect my Enrollment in an ASRS Insurance Plan?

The federal Affordable Care Act (ACA) health insurance marketplace, created in 2014, continues to provide an option for non-Medicare eligible individuals shopping for health insurance.

The ACA health insurance marketplace, also known as an exchange, provides a new option for individuals to purchase private coverage. Individuals may be eligible for tax credits that can lower the monthly premium and may also qualify for additional subsidies. Savings depend upon household income.

If you are eligible for Medicare and participate in a Medicare plan, either through the ASRS or some other option, the new Health Insurance Marketplace does not apply to you.

If you are not eligible for Medicare and have health insurance through the ASRS retiree health insurance, the ACA may provide a new option for you.

The ASRS has prepared a Guide to the Affordable Care Act, available on our website under the Retiree > Health Care section. It contains information on the ACA and plan comparisons for the original insurer participants in the Arizona health insurance exchange.

Visit AzASRS.gov or HealthCare.gov for more information.

How do I access my behavioral health benefit?

(UNITEDHEALTHCARE GROUP MEDICARE ADVANTAGE (HMO) and NON-MEDICARE MEMBERS)

To access your behavioral health benefits, call the behavioral health number on the back of your member ID card, 24 hours a day, 7 days a week. You may also access the providers by logging into **LiveAndWorkWell.com**. When you call, a representative will check your eligibility and get basic information about you and your situation. Depending on the help you need, a clinician may talk with you to figure out the provider and treatment plan that would work well for you. You may also ask your PCP to call the number on the back of your ID card and arrange a referral for you. Or, you can call to get information about network practitioners, subspecialty care and how to get care after normal office hours. Any personal information you discuss with the staff will be kept strictly confidential.

Frequently Asked Questions

1.) What is the best way to determine which medical plan is right for me?

There's a lot to consider. The key is to look at your own situation, study what the plans offer, and their corresponding premiums, where the plans offer coverage (i.e., in which Arizona county or out-of-state), and decide what is best for you.

2.) What is coordination of benefits?

When a retiree or LTD recipient has more than one health plan, or is considered a covered dependent under another plan, benefits are coordinated so that no more than 100% of the claim is paid to a medical provider. One plan will be considered the primary and the other will be considered secondary. If you are enrolled in Medicare, Medicare will be your primary plan and ASRS will be your secondary plan.

3.) I'm enrolling in the Group Medicare Advantage (HMO) plan. What kind of doctors are available from which to choose when selecting a PCP? Must I choose a Primary Care Physician (PCP) for myself and for my whole family?

Your medical plan PCP is responsible for coordinating all of your medical care, including referrals to specialists and obtaining necessary prior authorizations. PCPs are Family Practice, General Practice or Internal Medicine. Women may self-refer to an in-network OB/GYN.

While you may select one PCP for your whole family, you may want to choose different PCPs for each family member. Each covered family member may have his or her own PCP. You will need to record a PCP for each covered family member, even if you all use the same one, on the Enrollment Form in the "listing of eligible individuals to be enrolled" section near the bottom of the form.

4.) How can I get a directory of medical providers?

For Group Medicare Advantage (HMO) call 866-208-3428 or visit **UHCretiree.com/ASRS**. For Choice or Choice Plus call 800-357-0971 or visit **UHC.com**. Please remember that a copy of a provider directory is only accurate as of the date it is printed. Updated provider information is available online. You may call the physician you wish to select to verify their participation and availability.

5.) Is there a pre-existing condition clause under the health insurance plans ASRS offers?

A pre-existing condition is generally considered an illness a person has prior to applying for health insurance. Currently ASRS does not deny health insurance for any reason relating to a pre-existing condition.

6.) What is the best way to determine which dental plan is right for me?

You should consider your own situation and type of dental care you typically need during the year (and, if you are covering any dependents, you will want to factor in their dental care needs, too). In particular, if you are considering enrolling in one of the indemnity plans, be sure that you compare the differences in the two plans and the type of coverage each plan offers. If you are thinking about choosing one of the Prepaid dental plans offered in Arizona only, be sure you compare the copayment schedules of the two plans and factor in those costs along with the annual premium amounts when making your decision.

7.) How Medicare works with employer group health plan coverage with End Stage Renal Disease (ESRD)

Frequently Asked Questions continued...

If you're eligible for Medicare only because of permanent kidney failure, your Medicare eligibility usually can't start until the fourth month of dialysis. This means if you have coverage under an employer group health plan, that plan will be the only payer for the first 3 months of dialysis.

Once you become eligible for Medicare because of permanent kidney failure (usually the fourth month of dialysis), there will still be a period of time, called a "coordination period," when your employer group health plan will continue to pay your health care bills.

If your plan doesn't pay 100% of your health care bills, Medicare may pay some of the remaining costs. This is called "coordination of benefits," under which your plan "pays first" and Medicare "pays second." During this time, Medicare is called the secondary payer. This coordination period lasts for 30 months.

The 30-month coordination period The waiting period for eligibility will start even if you haven't signed up for Medicare. The same is true of the 30-month coordination period, which starts the first month you would be eligible to get Medicare because of permanent kidney failure (usually the fourth month of dialysis), even if you haven't signed up for Medicare yet.

Example: If you start dialysis and are eligible for Medicare in June, the 30-month coordination period will start September 1, the fourth month of dialysis even if you don't have Medicare.

Important: If you have employer group health plan coverage, tell your health care provider that you have this coverage. This is very important to make sure that your services are billed correctly.

If you are under the 30-month coordination period, in order to have medical

coverage with the ASRS, you must enroll with the Non-Medicare plan. Once you have satisfied your 30-month coordination period, you must submit a new enrollment application electing one of the ASRS Medicare options.

8.) What kind of dentist may I choose when selecting a General Dentist?

Prepaid Dental: With your Assurant prepaid dental plan, you must select a General Dentist from the list of contracted providers. Simply choose a provider from the provider directory and list the dentist ID# on your Enrollment Form. To get a directory, please call the Assurant ASRS onsite representative at the number listed on the inside back cover of this guide or visit the Assurant website dedicated to ASRS at AssurantEmployeeBenefits.com/ASRS. When you are selecting your dentist, be sure you select the correct Prepaid dental network for the plan you are choosing. In Arizona, you will choose either the network from "Heritage Series" (for the Heritage Secure w/ SBA) or "DHMO Dental Series" (for the DHMO Dental Plan 220 w/ Ortho copayments).

Indemnity Dental: With your Assurant indemnity dental plan, you have complete freedom-of-choice in dental providers. You may visit any licensed general dentist or specialist in the United States. However, you also have the option to use a dentist who participates in the Assurant Dental Network. All of the dentists who participate in the Assurant Dental Network have agreed to negotiated fee arrangements of up to 30% off their usual and customary fees and they will not balance bill you for services that are covered by the plan. To get a directory, please call the Assurant ASRS on-site representative at the number listed on the inside back cover of this guide or visit the Assurants website dedicated to

Frequently Asked Questions continued...

ASRS at AssurantEmployeeBenefits.com/ASRS.

9.) *I'm enrolling for family coverage in one of the Assurant prepaid dental plans. May I select a General Dentist for my whole family?*

Prepaid Dental: While you may select one General Dentist for everyone, you may want to choose a different General Dentist for each family member. Each covered family member can have his or her own General Dentist. Just be sure to include the dentist ID# for each covered family member on your Enrollment Form.

10.) *How do I change my General Dentist?*

Prepaid Dental: Call Assurant at 800.443.2995 to change your General Dentist. Requests must be received by the 20th of the month to be effective the 1st day of the following month. Requests received after the 20th of the month will be effective on the 1st day of the following month. Remember, if you would like to change your General Dentist, you must contact Assurant before making an appointment with your new General Dentist. You should also confirm that you are on your General Dentist's monthly roster when you make your dental appointment.

Indemnity Dental: The plan provides complete freedom-of-choice in providers. No selection is necessary.

11.) *How do I use my General Dentist?*

Prepaid Dental: Your General Dentist is responsible for maintaining your dental health. Should you need to see a specialist (periodontist, endodontist, oral surgeon, orthodontist), you may self-refer for dental care. You are encouraged to discuss all your dental health needs with your General Dentist. He or she will be happy to work with you to assure you understand your

dental health needs. Assurant's provider directory lists all dental providers who participate with the plan. The contracted providers are credentialed to assure they meet Assurant's corporate standards.

Indemnity Dental: You may receive dental care from any licensed dentist or specialist in the United States. However, you also have the option to use a dentist who participates in the Assurant Dental Network. All of the dentists who participate in the Assurant Dental Network have agreed to negotiated fee arrangements of up to 30% off their usual and customary fees and they will not balance bill you for services that are covered by the plan. Assurant strongly recommends that whenever the cost of any proposed dental treatment exceeds \$300, a pre-treatment estimate be submitted for review before treatment begins. This pre-estimate of benefits will inform you of your expected out-of-pocket costs.

12.) *What is the procedure if I need to see a specialist?*

Prepaid Dental: You do not need a referral from your General Dentist to see a participating Plan Specialty Dentist. Plan Specialty Dentists are listed in the Assurant provider directory with their specialty type. If you enroll in the Heritage Secure w/ SBA plan in Arizona, there are specific procedures identified in the Schedule of Benefits that have a set copayment when performed by a Plan Specialty Dentist who accepts the SBA plan. The SBA Plan Specialty Dentists are indicated with an "S" in the directory listing. For services that are not listed on the SBA copayment list, the Plan Specialty Dentists will offer a 25% discount (15% for endodontic care) off their usual and customary charge (UCR). Benefits for specialty care are not available from non-Plan dentists. Orthodontic care is offered to adults and children at a 25%

Frequently Asked Questions continued...

discount from the participating orthodontist's UCR fee.

If you enroll in the DHMO Dental Plan 220 with Ortho copayments in Arizona, many common specialty procedures can be performed by a participating network General Dentist or Plan Specialty Dentist for the same fixed copayment and are identified as such in the copayment listing with the symbol "(S)" after the applicable Service Description. In addition, many of these same common specialty procedures can also be performed by a Non-Plan Specialty Dentist. The specific procedures are listed in the copayment schedule. For these specific procedures, you will submit a claim to Assurant and receive reimbursement up to a maximum amount based on the procedure code performed. For dental services obtained from a Plan Specialty Dentist that are not listed in the copayment schedule, the Plan Specialty Dentist will offer a 25% discount (15% for endodontic care). Orthodontic care is provided for a set copayment for certain orthodontic procedures as listed in the copayment schedule for adults and children. Other orthodontic care is offered to adults and children at a 25% discount from the participating orthodontist's UCR fee.

Indemnity Dental: You can receive your dental care from any licensed dentist or specialist in the United States. However, you also have the option to use a dentist who participates in the Assurant Dental Network. All of the dentists who participate in the Assurant Dental Network have agreed to negotiated fee arrangements of up to 30% off their usual and customary fees and they will not balance bill you for services that are covered by the plan. Assurant strongly recommends that whenever the cost of any proposed dental treatment exceeds \$300, a pre-treatment esti-

mate plan be submitted for review before treatment begins. This pre-estimate of benefits will inform you of your expected out-of-pocket costs.

13.) How much and when do I have to pay for my dental visit?

Prepaid Dental: You will be charged according to your Schedule of Benefits on the Prepaid Dental Plan, depending on which plan you choose. You should carefully review your Evidence of Coverage and copayment listing and discuss all charges with your Plan dentist before the services are performed. Payment for dental services is due at the time treatment is rendered or in accordance with the Plan dentist's billing procedures. Except for certain specialty procedures as listed in the DHMO Dental Plan 220 copayment schedule, any services performed by a Non-Plan Dentist are NOT covered.

Indemnity Dental: Most dentists will file your dental claims for you and charge you your coinsurance and any deductible that may apply. You will receive an Explanation of Benefits after Assurant pays the claim which will show you what benefits have been covered and the amount for which you are responsible. Assurant strongly recommends that whenever the cost of any proposed pre-treatment estimate exceeds \$300, a dental treatment plan be submitted for review before treatment begins. This pre-estimate of benefits will inform you of your expected out-of-pocket costs. You should review your Certificate of Coverage and discuss your proposed dental treatment options with your dentist before the services are performed.

14.) What should I do if I have a dental emergency?

Prepaid Dental: First, contact your Plan General Dentist to make an appointment.

Frequently Asked Questions continued...

If your Plan General Dentist is unable to see you, you may seek treatment from any licensed dentist in the United States. Please be informed that the emergency benefit in your plan is limited to the temporary relief of pain and has limited benefits.

Indemnity Dental: You can receive your dental care from any licensed dentist or specialist in the United States. If your regular dentist cannot see you in an emergency, the dentist who treats you may require that you pay for your emergency dental care at the time treatment is rendered and then you will submit a claim directly to Assurant.

15.) How can I get a directory of participating dentists?

Prepaid Dental: Call Assurant's ASRS on-site representative OR Assurant's customer service department at the numbers listed in the back of this guide or visit Assurant's dedicated web site at **AssurantEmployeeBenefits.com/ASRS** and select the directory listing for the Prepaid Dental plan you have selected.

Indemnity Dental: You can receive your dental care from any licensed dentist or specialist in the United States. However, you also have the option to use a dentist who participates in the Assurant Dental Network to receive additional savings on all your covered dental treatments and services. Call Assurant's ASRS on-site representative OR Assurant's customer service department at the numbers listed in the back of this guide or visit Assurant's dedicated web site at **AssurantEmployeeBenefits.com/ASRS** and select the directory listing for the Assurant Dental Network of dentists.

16.) Can I enroll in one of the ASRS-sponsored dental plans if I do not enroll in one of the ASRS-sponsored medical plans?

Yes, all eligible public sector retirees, LTD recipients and eligible dependents are

eligible to enroll in one of the dental plans offered by Assurant Employee Benefits even if they do not enroll in an ASRS medical plan. The ASRS does not require enrollment in an ASRS medical plan in order for you to be eligible to enroll in a dental plan through the ASRS. Although some retirees maintain their employer's medical plan and others may be enrolled on their spouse's medical coverage, they are still eligible to enroll in a dental plan through the ASRS. When you are enrolled in one of the ASRS-sponsored dental plans, the Premium Benefit to which you are entitled will be applied to your dental plan premium first. If you are also enrolled in an eligible medical plan, the remainder of the Premium Benefit will then be applied to the medical plan's premium.

Glossary

Allowable Amount Term used by some health care plans (both medical and dental plans) to determine the amount of the Billed Charge which would be considered Usual, Customary, and Reasonable (see definition below). Term may also be known as the allowable charge.

Balance Billing Billing a patient for the difference between the dentist's actual charge and the amount allowed or paid by the patient's dental benefits plan. Balance billing for an amount other than the discounted fee for the covered service(s) performed is not allowed by dentists participating in the Assurant Dental Network.

Billed Charge The amount the provider bills for services rendered.

Coinsurance The percent of the allowable amount to be paid by the insurance company and the patient; i.e., 60/40 or 80/20. The first percentage is paid by the company; 60% or 80% and the second percentage paid by the patient: 40% or 20%.

Copayment The fixed fee that must be paid to the provider at the time services are provided, such as the pharmacy for a prescription or the network dentist for a prepaid dental plan.

Deductible The initial amount the patient must pay out of their pocket for covered services before benefits are payable by the insurance carrier.

Emergency Defined by each plan in accordance with their standard definitions.

Health Maintenance Organization (HMO) A medical plan providing comprehensive medical benefits, including preventive care, when you agree to use a select group of network providers. Generally, all care is directed by your chosen Primary Care Physician (PCP). Your PCP will refer

you to a specialist if medically appropriate.

Indemnity Dental Plan A dental plan that allows you to choose any eligible licensed provider in the United States to receive care. Members and dentists are reimbursed for eligible dental expenses according to the benefit schedule in effect, allowing for deductibles and coinsurance.

In-Network Services provided by a contracted provider in accordance with all plan requirements.

Medicaid A state-run health insurance program designed primarily to help those with low income and little or no resources. The federal government helps pay for Medicaid, but each state has its own rules about who is eligible and what is covered under Medicaid. Some people qualify for both Medicare and Medicaid.

Medicare Our country's health insurance program for people age 65 or older, certain people with disabilities who are under age 65 and people of any age who have permanent kidney failure. It provides basic protection against the cost of health care, but it doesn't cover all medical expenses or the cost of most long-term care.

Medicare is financed by a portion of Federal Insurance Contributions Act (FICA) taxes, or payroll taxes, paid by workers and their employers. It also is financed in part by monthly premiums paid by beneficiaries.

The Centers for Medicare and Medicaid Services (CMS) is the federal agency responsible for managing both Medicare and Medicaid.

There are three parts of Medicare. They are:

- **Hospital Insurance** (also called Medicare "Part A"), helps pay for care in a hospital and skilled nursing facility, home health care and hospice care.

Glossary (continued)

- **Medical Insurance** (also called Medicare “Part B”), helps pay for doctors, out-patient hospital care and other medical services. Medicare requires that you pay a monthly premium for Part B coverage.
- **Prescription Drug Insurance** (also called Medicare “Part D”), helps pay for a portion of the prescription drug expense after satisfying a calendar year deductible. Medicare requires that you pay a monthly premium for the "Part D" coverage. ASRS enrolled members do not have to purchase separate "Part D" coverage as each ASRS Medicare eligible medical plan provides a similar prescription drug program.

Group Medicare Advantage (HMO) Plan is a plan for members who are enrolled in Medicare Parts A & B and in which UnitedHealthcare has entered into a contract with The Centers for Medicare and Medicaid Services (CMS), the federal agency that administers Medicare. This contract authorizes UnitedHealthcare to provide comprehensive health services to persons who are entitled to Original Medicare benefits and who choose to enroll in the Group Medicare Advantage (HMO) Plan. By enrolling in the Group Medicare Advantage (HMO) Plan, you have made a decision to receive all your routine health care from UnitedHealthcare contracted providers.

Non-Participating Provider A provider with no contractual limitation on what he or she may bill and thus may practice balance-billing, as well as require payment at the time services are rendered.

Participating Specialty Dentist A specialized provider, such as an endodontist, oral surgeon, orthodontist, pedodontist, periodontist or prosthodontist, with a contractual limitation on what he or she may bill the patient for services covered by the prepaid dental plan or that offers discounts on covered services for members enrolled in one of the indemnity dental plans.

Pre-Estimate of Benefits (Indemnity Dental plan only) Whenever the estimated cost of a recommended Dental Treatment Plan exceeds \$300, the treatment plan should be submitted to the insurance carrier for review. This permits the carrier to review the treatment plan for alternative treatment procedures, which may be less costly, provided they do not affect the quality of care. The member knows in advance what his or her financial responsibility for the treatment will be prior to the actual services being performed.

Preferred Provider A provider who has signed an agreement with the insurance carrier not to charge that carrier's members more than the insurer's Allowable Amount.

Prepaid Dental Plan A dental plan that offers fixed copayments or discounts for dental services for members who agree to use dentists in the plan's provider network. Members select a general dentist from the network of participating dentists as their primary dentist and are listed as a member on the dentists' roster (the roster is a list of eligible members that is provided to the dentist on the 1st of every month). The member will receive a list of covered services and the amount he / she will pay to their selected Plan dentist (or Plan specialist) at the time services are rendered (referred to as the copayment).

Glossary (continued)

Primary Care Physician (PCP) The physician responsible in an Group Medicare Advantage (HMO) plan for directing all patient care including referrals to specialists and obtaining necessary pre-certifications. This physician is a General Practice, Family Practice, Pediatric or Internal Medicine specialist. Women can self-refer to an in-network OB/GYN.

Prophylaxis A routine cleaning procedure that includes light scraping (scaling) of the teeth to remove plaque and calculus/tartar. This procedure should be performed at least every six months.

Rehabilitation Usually physical therapy, speech therapy and/or occupational therapy.

Senior Supplement Plan is for members who are enrolled in both Medicare Parts A and B. With this plan you have the freedom to obtain medical care from any physician or hospital that accepts Medicare.

Specialty Benefit Amendment An amendment added to the Arizona Heritage Secure Prepaid Dental Plans Schedule of Benefits that allows members to receive select major dental services from Assurant contracted specialty dentists for a specific copayment; available to Arizona residents only.

Precertification Review A process that verifies the medical necessity and appropriateness of proposed services or supplies.

Preferred Provider Organization (PPO) Plan A plan that provides benefits in an indemnity fashion, but pays a higher percentage of the cost of services if patients use a PPO network provider than if they use a non-PPO provider. **If you go to a provider who is a member of the PPO network**, after you first satisfy a deductible, the plan generally pays 80 percent of the cost for care and you pay 20 percent. **If you go to a provider who is not a member of the PPO network**, after you first satisfy a deductible, the plan generally pays 60 percent of the cost for care and you pay 40 percent.

Usual, Customary and Reasonable (UCR) A charge which is based on the general level of charges made by other providers in the area for like treatment, procedures, services, and/or supplies, also known as the Allowable Amount or allowable charge. The insurance carrier's determination of the UCR is final for the purpose of determining benefits payable under the insurance carrier's policy.

Optional Premium Benefit Program Factor Table 100% Joint & Survivor Factors

Age of Retiree*

Age of Contingent Annuitant*	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70
51	0.9640	0.9606	0.9569	0.9527	0.9482	0.9432	0.9376	0.9315	0.9247	0.9171	0.9087	0.8994	0.8891	0.8776	0.8647	0.8537	0.8420	0.8296	0.8166	0.8030
52	0.9654	0.9620	0.9584	0.9544	0.9500	0.9451	0.9397	0.9337	0.9271	0.9197	0.9115	0.9024	0.8923	0.8810	0.8684	0.8576	0.8461	0.8340	0.8212	0.8078
53	0.9667	0.9635	0.9599	0.9560	0.9518	0.9470	0.9418	0.9359	0.9295	0.9223	0.9143	0.9054	0.8955	0.8844	0.8721	0.8614	0.8502	0.8383	0.8258	0.8125
54	0.9680	0.9648	0.9614	0.9577	0.9535	0.9489	0.9438	0.9381	0.9318	0.9248	0.9170	0.9083	0.8986	0.8878	0.8757	0.8653	0.8542	0.8426	0.8303	0.8173
55	0.9692	0.9662	0.9629	0.9592	0.9552	0.9507	0.9458	0.9403	0.9341	0.9273	0.9197	0.9112	0.9017	0.8911	0.8792	0.8690	0.8582	0.8468	0.8347	0.8220
56	0.9704	0.9675	0.9643	0.9608	0.9569	0.9526	0.9477	0.9424	0.9364	0.9297	0.9223	0.9140	0.9047	0.8943	0.8827	0.8727	0.8621	0.8509	0.8391	0.8266
57	0.9716	0.9688	0.9657	0.9623	0.9585	0.9543	0.9496	0.9444	0.9386	0.9321	0.9249	0.9167	0.9077	0.8975	0.8860	0.8762	0.8659	0.8549	0.8433	0.8310
58	0.9728	0.9700	0.9671	0.9637	0.9601	0.9560	0.9515	0.9464	0.9407	0.9344	0.9273	0.9194	0.9105	0.9005	0.8892	0.8797	0.8695	0.8587	0.8473	0.8353
59	0.9739	0.9712	0.9683	0.9651	0.9616	0.9576	0.9532	0.9483	0.9428	0.9366	0.9297	0.9219	0.9132	0.9034	0.8923	0.8829	0.8729	0.8623	0.8511	0.8393
60	0.9749	0.9724	0.9696	0.9665	0.9630	0.9592	0.9549	0.9501	0.9447	0.9387	0.9319	0.9243	0.9157	0.9061	0.8951	0.8859	0.8761	0.8656	0.8546	0.8429
61	0.9758	0.9734	0.9707	0.9677	0.9644	0.9606	0.9564	0.9518	0.9465	0.9406	0.9340	0.9265	0.9181	0.9085	0.8977	0.8886	0.8789	0.8686	0.8577	0.8462
62	0.9767	0.9744	0.9718	0.9688	0.9656	0.9620	0.9579	0.9533	0.9482	0.9424	0.9359	0.9285	0.9202	0.9108	0.9001	0.8911	0.8815	0.8713	0.8605	0.8490
63	0.9775	0.9752	0.9727	0.9699	0.9667	0.9632	0.9592	0.9547	0.9497	0.9440	0.9375	0.9303	0.9220	0.9127	0.9020	0.8931	0.8835	0.8734	0.8626	0.8513
64	0.9782	0.9760	0.9735	0.9708	0.9677	0.9642	0.9603	0.9559	0.9509	0.9453	0.9389	0.9317	0.9235	0.9142	0.9035	0.8946	0.8851	0.8749	0.8641	0.8527
65	0.9788	0.9766	0.9742	0.9715	0.9685	0.9651	0.9612	0.9569	0.9520	0.9464	0.9400	0.9328	0.9246	0.9152	0.9044	0.8955	0.8859	0.8757	0.8648	0.8533
66	0.9798	0.9777	0.9754	0.9728	0.9699	0.9667	0.9630	0.9588	0.9541	0.9487	0.9426	0.9356	0.9276	0.9185	0.9080	0.8992	0.8899	0.8799	0.8693	0.8580
67	0.9807	0.9788	0.9766	0.9741	0.9714	0.9683	0.9647	0.9607	0.9562	0.9510	0.9451	0.9384	0.9306	0.9217	0.9115	0.9030	0.8939	0.8841	0.8737	0.8627
68	0.9817	0.9798	0.9777	0.9754	0.9728	0.9698	0.9664	0.9626	0.9582	0.9533	0.9476	0.9411	0.9336	0.9250	0.9150	0.9068	0.8979	0.8884	0.8782	0.8674
69	0.9826	0.9808	0.9788	0.9766	0.9741	0.9713	0.9681	0.9644	0.9602	0.9555	0.9500	0.9437	0.9365	0.9282	0.9185	0.9105	0.9018	0.8926	0.8827	0.8722
70	0.9834	0.9818	0.9799	0.9778	0.9754	0.9727	0.9697	0.9662	0.9622	0.9576	0.9524	0.9463	0.9394	0.9313	0.9219	0.9141	0.9058	0.8968	0.8872	0.8769

*For factors outside these age ranges, please contact the ASRS Member Services Division. Date: January 1, 2007

Optional Premium Benefit Program Factor Table 66-2/3% Joint & Survivor Factors

Age of Retiree*

Age of Contingent Annuitant*	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70
51	0.9757	0.9734	0.9708	0.9680	0.9648	0.9614	0.9575	0.9532	0.9485	0.9432	0.9372	0.9306	0.9232	0.9149	0.9055	0.8974	0.8888	0.8796	0.8698	0.8594
52	0.9766	0.9744	0.9719	0.9691	0.9661	0.9627	0.9590	0.9548	0.9502	0.9450	0.9392	0.9328	0.9255	0.9174	0.9082	0.9003	0.8919	0.8828	0.8732	0.8631
53	0.9775	0.9753	0.9729	0.9703	0.9673	0.9640	0.9604	0.9564	0.9518	0.9468	0.9412	0.9349	0.9278	0.9199	0.9109	0.9032	0.8949	0.8861	0.8767	0.8667
54	0.9784	0.9763	0.9739	0.9714	0.9685	0.9653	0.9618	0.9579	0.9535	0.9486	0.9431	0.9370	0.9300	0.9223	0.9135	0.9060	0.8979	0.8892	0.8801	0.8703
55	0.9793	0.9772	0.9750	0.9725	0.9697	0.9666	0.9632	0.9594	0.9551	0.9503	0.9450	0.9390	0.9323	0.9247	0.9161	0.9087	0.9008	0.8924	0.8834	0.8738
56	0.9801	0.9781	0.9759	0.9735	0.9708	0.9679	0.9645	0.9608	0.9567	0.9520	0.9468	0.9410	0.9344	0.9270	0.9186	0.9114	0.9036	0.8954	0.8866	0.8773
57	0.9809	0.9790	0.9769	0.9745	0.9720	0.9691	0.9658	0.9622	0.9582	0.9537	0.9486	0.9429	0.9365	0.9292	0.9210	0.9139	0.9064	0.8983	0.8897	0.8806
58	0.9817	0.9798	0.9778	0.9755	0.9730	0.9702	0.9671	0.9636	0.9597	0.9553	0.9503	0.9448	0.9385	0.9314	0.9233	0.9164	0.9090	0.9011	0.8927	0.8838
59	0.9824	0.9806	0.9787	0.9765	0.9741	0.9713	0.9683	0.9649	0.9611	0.9568	0.9520	0.9465	0.9404	0.9334	0.9255	0.9187	0.9115	0.9038	0.8955	0.8868
60	0.9831	0.9814	0.9795	0.9774	0.9750	0.9724	0.9695	0.9662	0.9624	0.9583	0.9535	0.9482	0.9422	0.9353	0.9276	0.9209	0.9138	0.9062	0.8981	0.8895
61	0.9838	0.9821	0.9803	0.9782	0.9760	0.9734	0.9705	0.9673	0.9637	0.9596	0.9550	0.9498	0.9438	0.9371	0.9294	0.9229	0.9159	0.9084	0.9004	0.8919
62	0.9844	0.9828	0.9810	0.9790	0.9768	0.9743	0.9715	0.9684	0.9648	0.9608	0.9563	0.9512	0.9453	0.9387	0.9311	0.9246	0.9177	0.9103	0.9024	0.8940
63	0.9849	0.9834	0.9816	0.9797	0.9776	0.9751	0.9724	0.9693	0.9659	0.9619	0.9575	0.9524	0.9466	0.9400	0.9325	0.9261	0.9192	0.9119	0.9040	0.8957
64	0.9854	0.9839	0.9822	0.9803	0.9782	0.9759	0.9732	0.9702	0.9667	0.9629	0.9585	0.9534	0.9477	0.9411	0.9335	0.9272	0.9203	0.9130	0.9051	0.8968
65	0.9858	0.9843	0.9827	0.9808	0.9788	0.9764	0.9738	0.9708	0.9675	0.9636	0.9592	0.9542	0.9484	0.9418	0.9342	0.9278	0.9209	0.9135	0.9056	0.8971
66	0.9864	0.9850	0.9835	0.9817	0.9798	0.9775	0.9750	0.9722	0.9689	0.9652	0.9610	0.9561	0.9506	0.9441	0.9367	0.9305	0.9238	0.9166	0.9089	0.9006
67	0.9871	0.9858	0.9843	0.9826	0.9807	0.9786	0.9762	0.9735	0.9704	0.9668	0.9627	0.9580	0.9527	0.9464	0.9392	0.9332	0.9267	0.9197	0.9121	0.9041
68	0.9877	0.9864	0.9850	0.9835	0.9817	0.9797	0.9774	0.9748	0.9718	0.9683	0.9644	0.9599	0.9547	0.9487	0.9417	0.9358	0.9295	0.9227	0.9154	0.9075
69	0.9883	0.9871	0.9858	0.9843	0.9826	0.9807	0.9785	0.9760	0.9731	0.9699	0.9661	0.9618	0.9567	0.9509	0.9441	0.9385	0.9324	0.9257	0.9186	0.9110
70	0.9889	0.9878	0.9865	0.9851	0.9835	0.9816	0.9796	0.9772	0.9745	0.9713	0.9677	0.9636	0.9587	0.9531	0.9465	0.9411	0.9351	0.9287	0.9218	0.9144

*For factors outside these age ranges, please contact the ASRS Member Services Division. Date: January 1, 2007

Optional Premium Benefit Program Factor Table 50% Joint & Survivor Factors

Age of Retiree *

Age of Contingent Annuitant*	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70
51	0.9817	0.9799	0.9779	0.9758	0.9734	0.9707	0.9678	0.9645	0.9609	0.9568	0.9522	0.9470	0.9413	0.9348	0.9274	0.9211	0.9142	0.9069	0.8991	0.8907
52	0.9824	0.9807	0.9788	0.9767	0.9743	0.9718	0.9689	0.9657	0.9622	0.9582	0.9537	0.9487	0.9431	0.9367	0.9296	0.9233	0.9166	0.9095	0.9018	0.8937
53	0.9831	0.9814	0.9796	0.9775	0.9753	0.9728	0.9700	0.9669	0.9634	0.9596	0.9552	0.9503	0.9449	0.9387	0.9317	0.9256	0.9190	0.9120	0.9046	0.8966
54	0.9837	0.9821	0.9803	0.9784	0.9762	0.9738	0.9711	0.9681	0.9647	0.9609	0.9567	0.9520	0.9466	0.9406	0.9337	0.9278	0.9214	0.9146	0.9073	0.8995
55	0.9844	0.9828	0.9811	0.9792	0.9771	0.9748	0.9721	0.9692	0.9660	0.9623	0.9582	0.9535	0.9483	0.9424	0.9357	0.9299	0.9237	0.9170	0.9099	0.9023
56	0.9850	0.9835	0.9818	0.9800	0.9780	0.9757	0.9732	0.9703	0.9672	0.9636	0.9596	0.9551	0.9500	0.9442	0.9377	0.9320	0.9259	0.9194	0.9125	0.9051
57	0.9856	0.9842	0.9826	0.9808	0.9788	0.9766	0.9742	0.9714	0.9683	0.9649	0.9610	0.9566	0.9516	0.9460	0.9396	0.9340	0.9281	0.9218	0.9150	0.9077
58	0.9862	0.9848	0.9833	0.9815	0.9796	0.9775	0.9751	0.9725	0.9695	0.9661	0.9623	0.9580	0.9531	0.9476	0.9414	0.9360	0.9302	0.9240	0.9173	0.9102
59	0.9868	0.9854	0.9839	0.9823	0.9804	0.9784	0.9760	0.9735	0.9705	0.9673	0.9635	0.9594	0.9546	0.9492	0.9431	0.9378	0.9321	0.9260	0.9195	0.9126
60	0.9873	0.9860	0.9845	0.9829	0.9812	0.9792	0.9769	0.9744	0.9716	0.9684	0.9647	0.9606	0.9560	0.9507	0.9447	0.9395	0.9339	0.9280	0.9216	0.9148
61	0.9878	0.9865	0.9851	0.9836	0.9819	0.9799	0.9777	0.9753	0.9725	0.9694	0.9659	0.9618	0.9573	0.9521	0.9461	0.9410	0.9356	0.9297	0.9234	0.9167
62	0.9882	0.9870	0.9857	0.9842	0.9825	0.9806	0.9785	0.9761	0.9734	0.9703	0.9669	0.9629	0.9584	0.9533	0.9474	0.9424	0.9370	0.9312	0.9250	0.9184
63	0.9886	0.9875	0.9862	0.9847	0.9831	0.9812	0.9792	0.9768	0.9742	0.9712	0.9678	0.9639	0.9594	0.9543	0.9485	0.9435	0.9382	0.9324	0.9263	0.9197
64	0.9890	0.9879	0.9866	0.9852	0.9836	0.9818	0.9798	0.9775	0.9749	0.9719	0.9685	0.9647	0.9602	0.9552	0.9493	0.9444	0.9390	0.9333	0.9271	0.9205
65	0.9893	0.9882	0.9869	0.9855	0.9840	0.9822	0.9802	0.9780	0.9754	0.9725	0.9691	0.9652	0.9608	0.9557	0.9498	0.9448	0.9395	0.9337	0.9275	0.9208
66	0.9898	0.9887	0.9876	0.9862	0.9847	0.9831	0.9812	0.9790	0.9765	0.9737	0.9704	0.9667	0.9625	0.9575	0.9518	0.9469	0.9417	0.9361	0.9301	0.9236
67	0.9903	0.9893	0.9882	0.9869	0.9855	0.9839	0.9821	0.9800	0.9776	0.9749	0.9718	0.9682	0.9641	0.9593	0.9537	0.9490	0.9440	0.9385	0.9326	0.9263
68	0.9908	0.9898	0.9887	0.9875	0.9862	0.9847	0.9829	0.9809	0.9787	0.9761	0.9731	0.9696	0.9657	0.9610	0.9556	0.9511	0.9462	0.9409	0.9352	0.9290
69	0.9912	0.9903	0.9893	0.9882	0.9869	0.9854	0.9838	0.9819	0.9797	0.9772	0.9744	0.9710	0.9672	0.9627	0.9575	0.9531	0.9484	0.9433	0.9377	0.9317
70	0.9916	0.9908	0.9898	0.9888	0.9876	0.9862	0.9846	0.9828	0.9807	0.9783	0.9756	0.9724	0.9687	0.9644	0.9594	0.9551	0.9506	0.9456	0.9402	0.9344

*For factors outside these age ranges, please contact the ASRS Member Services Division. Date: January 1, 2007

Optional Premium Benefit Program Factor Table 15 Years Period Certain & Life Factors

Age of Retiree*

Age of Contingent Annuitant*	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70
51	0.9850	0.9835	0.9819	0.9800	0.9778	0.9754	0.9726	0.9694	0.9657	0.9614	0.9565	0.9508	0.9443	0.9368	0.9281	0.9202	0.9116	0.9021	0.8919	0.8808
52	0.9855	0.9841	0.9824	0.9806	0.9786	0.9762	0.9735	0.9704	0.9668	0.9627	0.9579	0.9524	0.9461	0.9387	0.9303	0.9226	0.9142	0.9050	0.8950	0.8842
53	0.9860	0.9846	0.9830	0.9812	0.9792	0.9770	0.9743	0.9713	0.9679	0.9639	0.9592	0.9539	0.9477	0.9406	0.9323	0.9248	0.9166	0.9077	0.8979	0.8874
54	0.9864	0.9850	0.9835	0.9818	0.9799	0.9777	0.9751	0.9722	0.9688	0.9650	0.9605	0.9553	0.9493	0.9423	0.9343	0.9270	0.9190	0.9103	0.9008	0.8905
55	0.9868	0.9855	0.9840	0.9823	0.9805	0.9783	0.9759	0.9730	0.9698	0.9660	0.9616	0.9565	0.9507	0.9439	0.9361	0.9290	0.9212	0.9127	0.9034	0.8934
56	0.9871	0.9859	0.9844	0.9828	0.9810	0.9789	0.9765	0.9738	0.9706	0.9669	0.9626	0.9577	0.9520	0.9454	0.9377	0.9308	0.9232	0.9149	0.9059	0.8961
57	0.9875	0.9862	0.9848	0.9833	0.9815	0.9794	0.9771	0.9744	0.9713	0.9677	0.9636	0.9588	0.9532	0.9467	0.9392	0.9324	0.9250	0.9169	0.9081	0.8985
58	0.9878	0.9865	0.9852	0.9836	0.9819	0.9799	0.9776	0.9750	0.9720	0.9685	0.9644	0.9597	0.9542	0.9479	0.9405	0.9339	0.9266	0.9187	0.9100	0.9007
59	0.9880	0.9868	0.9855	0.9840	0.9823	0.9803	0.9781	0.9755	0.9725	0.9691	0.9651	0.9605	0.9551	0.9488	0.9416	0.9351	0.9279	0.9202	0.9117	0.9025
60	0.9882	0.9871	0.9858	0.9843	0.9826	0.9807	0.9785	0.9759	0.9730	0.9696	0.9657	0.9611	0.9558	0.9496	0.9424	0.9360	0.9290	0.9213	0.9130	0.9039
61	0.9884	0.9873	0.9860	0.9845	0.9828	0.9809	0.9788	0.9762	0.9733	0.9700	0.9661	0.9615	0.9563	0.9501	0.9430	0.9366	0.9297	0.9221	0.9139	0.9049
62	0.9885	0.9874	0.9861	0.9846	0.9830	0.9811	0.9789	0.9764	0.9735	0.9702	0.9663	0.9618	0.9565	0.9504	0.9432	0.9369	0.9300	0.9225	0.9143	0.9054
63	0.9886	0.9874	0.9861	0.9847	0.9830	0.9812	0.9790	0.9765	0.9736	0.9702	0.9663	0.9618	0.9565	0.9503	0.9431	0.9368	0.9299	0.9223	0.9141	0.9052
64	0.9885	0.9874	0.9861	0.9846	0.9830	0.9811	0.9789	0.9764	0.9735	0.9701	0.9661	0.9615	0.9562	0.9499	0.9425	0.9362	0.9292	0.9215	0.9132	0.9042
65	0.9884	0.9872	0.9859	0.9845	0.9828	0.9809	0.9786	0.9761	0.9731	0.9696	0.9656	0.9609	0.9554	0.9490	0.9414	0.9349	0.9278	0.9200	0.9115	0.9023
66	0.9885	0.9874	0.9861	0.9846	0.9830	0.9811	0.9789	0.9764	0.9734	0.9700	0.9660	0.9614	0.9560	0.9496	0.9421	0.9356	0.9286	0.9209	0.9125	0.9033
67	0.9887	0.9875	0.9863	0.9848	0.9832	0.9813	0.9792	0.9767	0.9738	0.9704	0.9665	0.9619	0.9565	0.9502	0.9428	0.9364	0.9295	0.9218	0.9135	0.9045
68	0.9888	0.9877	0.9864	0.9850	0.9834	0.9816	0.9795	0.9770	0.9742	0.9709	0.9670	0.9625	0.9572	0.9509	0.9436	0.9373	0.9304	0.9229	0.9147	0.9058
69	0.9890	0.9879	0.9867	0.9853	0.9837	0.9819	0.9798	0.9774	0.9746	0.9714	0.9675	0.9631	0.9579	0.9517	0.9444	0.9382	0.9314	0.9240	0.9159	0.9071
70	0.9891	0.9881	0.9869	0.9855	0.9840	0.9822	0.9802	0.9778	0.9751	0.9719	0.9681	0.9637	0.9586	0.9525	0.9453	0.9392	0.9326	0.9252	0.9173	0.9086

*For factors outside these age ranges, please contact the ASRS Member Services Division. Date: January 1, 2007

Optional Premium Benefit Program Factor Table 10 Years Period Certain & Life Factors

Age of Retiree*

Age of Contingent Annuitant*	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70
51	0.9904	0.9895	0.9886	0.9875	0.9864	0.9849	0.9833	0.9813	0.9790	0.9764	0.9732	0.9696	0.9653	0.9603	0.9544	0.9491	0.9433	0.9370	0.9300	0.9223
52	0.9904	0.9895	0.9886	0.9876	0.9864	0.9850	0.9833	0.9813	0.9791	0.9764	0.9733	0.9696	0.9653	0.9603	0.9544	0.9492	0.9434	0.9370	0.9301	0.9224
53	0.9904	0.9895	0.9886	0.9876	0.9864	0.9850	0.9833	0.9814	0.9791	0.9764	0.9733	0.9696	0.9654	0.9603	0.9544	0.9492	0.9434	0.9371	0.9301	0.9225
54	0.9904	0.9895	0.9886	0.9876	0.9864	0.9850	0.9833	0.9814	0.9791	0.9764	0.9733	0.9697	0.9654	0.9604	0.9545	0.9493	0.9435	0.9372	0.9302	0.9226
55	0.9904	0.9896	0.9886	0.9876	0.9865	0.9850	0.9833	0.9814	0.9791	0.9765	0.9734	0.9697	0.9655	0.9604	0.9546	0.9493	0.9436	0.9373	0.9303	0.9227
56	0.9909	0.9901	0.9892	0.9882	0.9871	0.9857	0.9841	0.9823	0.9801	0.9776	0.9746	0.9712	0.9671	0.9623	0.9566	0.9516	0.9461	0.9400	0.9333	0.9260
57	0.9913	0.9905	0.9896	0.9887	0.9877	0.9864	0.9849	0.9831	0.9810	0.9786	0.9758	0.9725	0.9685	0.9639	0.9585	0.9537	0.9484	0.9425	0.9361	0.9291
58	0.9917	0.9909	0.9901	0.9892	0.9882	0.9869	0.9855	0.9838	0.9818	0.9795	0.9768	0.9736	0.9698	0.9654	0.9601	0.9555	0.9504	0.9448	0.9386	0.9318
59	0.9920	0.9912	0.9905	0.9896	0.9886	0.9874	0.9860	0.9844	0.9825	0.9803	0.9777	0.9746	0.9709	0.9666	0.9615	0.9571	0.9521	0.9467	0.9407	0.9342
60	0.9922	0.9915	0.9908	0.9899	0.9890	0.9879	0.9865	0.9849	0.9831	0.9809	0.9784	0.9754	0.9718	0.9676	0.9627	0.9583	0.9536	0.9483	0.9425	0.9361
61	0.9925	0.9918	0.9910	0.9902	0.9893	0.9882	0.9869	0.9853	0.9835	0.9814	0.9789	0.9760	0.9725	0.9684	0.9635	0.9593	0.9546	0.9494	0.9438	0.9375
62	0.9926	0.9919	0.9912	0.9904	0.9895	0.9884	0.9871	0.9856	0.9838	0.9817	0.9792	0.9763	0.9729	0.9688	0.9640	0.9598	0.9552	0.9501	0.9445	0.9384
63	0.9927	0.9920	0.9913	0.9905	0.9896	0.9885	0.9872	0.9857	0.9839	0.9818	0.9794	0.9764	0.9730	0.9689	0.9640	0.9599	0.9553	0.9502	0.9446	0.9385
64	0.9926	0.9920	0.9912	0.9904	0.9896	0.9884	0.9871	0.9856	0.9838	0.9817	0.9792	0.9762	0.9727	0.9686	0.9636	0.9594	0.9547	0.9496	0.9439	0.9377
65	0.9925	0.9918	0.9911	0.9903	0.9894	0.9882	0.9869	0.9853	0.9835	0.9813	0.9787	0.9757	0.9720	0.9677	0.9625	0.9582	0.9534	0.9481	0.9423	0.9359
66	0.9925	0.9918	0.9911	0.9903	0.9894	0.9883	0.9869	0.9854	0.9836	0.9814	0.9788	0.9758	0.9722	0.9679	0.9627	0.9584	0.9536	0.9484	0.9426	0.9362
67	0.9926	0.9919	0.9912	0.9904	0.9895	0.9883	0.9870	0.9855	0.9837	0.9815	0.9790	0.9760	0.9724	0.9681	0.9629	0.9586	0.9539	0.9487	0.9429	0.9366
68	0.9926	0.9919	0.9912	0.9904	0.9895	0.9884	0.9871	0.9856	0.9838	0.9816	0.9791	0.9761	0.9726	0.9683	0.9632	0.9589	0.9542	0.9490	0.9433	0.9370
69	0.9927	0.9920	0.9913	0.9905	0.9896	0.9885	0.9872	0.9857	0.9839	0.9818	0.9793	0.9763	0.9728	0.9685	0.9634	0.9592	0.9545	0.9494	0.9437	0.9374
70	0.9927	0.9921	0.9913	0.9906	0.9897	0.9886	0.9873	0.9858	0.9840	0.9820	0.9795	0.9765	0.9730	0.9688	0.9637	0.9595	0.9549	0.9498	0.9441	0.9379

* For factors outside these age ranges, please contact the ASRS Member Services Division Date: January 1, 2007

Optional Premium Benefit Program Factor Table 5 Years Period Certain & Life Factors

Age of Retiree*

Age of Contingent Annuitant*	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70
51	0.9955	0.9951	0.9947	0.9942	0.9937	0.9932	0.9925	0.9918	0.9910	0.9901	0.9887	0.9870	0.9850	0.9825	0.9795	0.9770	0.9743	0.9713	0.9680	0.9643
52	0.9955	0.9951	0.9947	0.9942	0.9937	0.9932	0.9925	0.9918	0.9910	0.9901	0.9887	0.9870	0.9850	0.9825	0.9795	0.9770	0.9743	0.9713	0.9680	0.9643
53	0.9955	0.9951	0.9947	0.9942	0.9937	0.9932	0.9925	0.9918	0.9910	0.9901	0.9887	0.9871	0.9850	0.9825	0.9795	0.9770	0.9743	0.9713	0.9680	0.9644
54	0.9955	0.9951	0.9947	0.9942	0.9937	0.9932	0.9925	0.9918	0.9910	0.9901	0.9887	0.9871	0.9850	0.9826	0.9795	0.9771	0.9743	0.9713	0.9680	0.9644
55	0.9955	0.9951	0.9947	0.9942	0.9937	0.9932	0.9925	0.9918	0.9910	0.9901	0.9887	0.9871	0.9850	0.9826	0.9795	0.9771	0.9743	0.9713	0.9680	0.9644
56	0.9955	0.9951	0.9947	0.9942	0.9937	0.9932	0.9926	0.9918	0.9910	0.9901	0.9887	0.9871	0.9850	0.9826	0.9795	0.9771	0.9743	0.9713	0.9680	0.9644
57	0.9955	0.9951	0.9947	0.9942	0.9937	0.9932	0.9926	0.9919	0.9910	0.9901	0.9887	0.9871	0.9851	0.9826	0.9795	0.9771	0.9744	0.9714	0.9681	0.9644
58	0.9955	0.9951	0.9947	0.9942	0.9937	0.9932	0.9926	0.9919	0.9911	0.9901	0.9888	0.9871	0.9851	0.9826	0.9796	0.9771	0.9744	0.9714	0.9681	0.9644
59	0.9956	0.9951	0.9947	0.9942	0.9937	0.9932	0.9926	0.9919	0.9911	0.9901	0.9888	0.9871	0.9851	0.9826	0.9796	0.9771	0.9744	0.9714	0.9681	0.9645
60	0.9956	0.9951	0.9947	0.9942	0.9937	0.9932	0.9926	0.9919	0.9911	0.9901	0.9888	0.9871	0.9851	0.9826	0.9796	0.9771	0.9744	0.9714	0.9681	0.9645
61	0.9960	0.9956	0.9952	0.9948	0.9943	0.9938	0.9932	0.9926	0.9919	0.9910	0.9898	0.9883	0.9864	0.9841	0.9813	0.9791	0.9766	0.9738	0.9708	0.9674
62	0.9963	0.9959	0.9955	0.9952	0.9947	0.9943	0.9937	0.9932	0.9925	0.9917	0.9905	0.9891	0.9874	0.9853	0.9826	0.9805	0.9782	0.9756	0.9728	0.9697
63	0.9965	0.9961	0.9958	0.9954	0.9950	0.9946	0.9941	0.9935	0.9929	0.9922	0.9910	0.9897	0.9880	0.9859	0.9834	0.9814	0.9792	0.9767	0.9740	0.9710
64	0.9965	0.9962	0.9959	0.9955	0.9951	0.9947	0.9942	0.9936	0.9930	0.9923	0.9912	0.9898	0.9882	0.9861	0.9835	0.9815	0.9793	0.9769	0.9742	0.9713
65	0.9964	0.9961	0.9958	0.9954	0.9950	0.9945	0.9940	0.9935	0.9928	0.9921	0.9909	0.9895	0.9878	0.9856	0.9828	0.9808	0.9785	0.9760	0.9732	0.9701
66	0.9964	0.9961	0.9958	0.9954	0.9950	0.9945	0.9941	0.9935	0.9928	0.9921	0.9910	0.9895	0.9878	0.9856	0.9829	0.9808	0.9785	0.9760	0.9732	0.9702
67	0.9965	0.9961	0.9958	0.9954	0.9950	0.9946	0.9941	0.9935	0.9929	0.9921	0.9910	0.9896	0.9878	0.9857	0.9829	0.9809	0.9786	0.9760	0.9733	0.9702
68	0.9965	0.9961	0.9958	0.9954	0.9950	0.9946	0.9941	0.9935	0.9929	0.9921	0.9910	0.9896	0.9879	0.9857	0.9830	0.9809	0.9786	0.9761	0.9733	0.9703
69	0.9965	0.9961	0.9958	0.9954	0.9950	0.9946	0.9941	0.9935	0.9929	0.9922	0.9910	0.9896	0.9879	0.9857	0.9830	0.9810	0.9787	0.9762	0.9734	0.9704
70	0.9965	0.9962	0.9958	0.9954	0.9950	0.9946	0.9941	0.9936	0.9929	0.9922	0.9910	0.9897	0.9879	0.9858	0.9830	0.9810	0.9787	0.9762	0.9735	0.9704

*For factors outside these age ranges, please contact the ASRS Member Services Division. Date: January 1, 2007

Telephone Numbers & Websites

FOR RETIREES, LTD RECIPIENTS & ELIGIBLE DEPENDENTS

REMEMBER WHEN CALLING THE INSURANCE CARRIERS, TELL THEM YOU ARE AN ASRS MEMBER.

CARRIER	MEMBER SERVICES	INTERNET ADDRESS
MEDICAL PROVIDER		
UnitedHealthcare of Arizona (M-F 7 AM-8 PM, MST)		Behaviorial Health: LiveAndWorkWell.com
OptumHealth Vision	800-638-3120	OptumHealthVision.com (Vision Provider)
Choice Plan (in-state)	800-357-0971	UHCretiree.com/ASRS (Medicare Plans)
Choice Plus PPO Plan (out-of-state)	800-509-6729	MyUHC.com (Non-medicare Plans)
Senior Supplement Plan (M-F, 8 AM-8 PM, MST)	866-480-1087	
Group Medicare Advantage (HMO) Plan (M-F, 8 AM-8 PM, MST)	866-208-3248	
OptumRx (Avail 24/7)	800-377-5154	UnitedHealthcare MedicareRX for Groups
Group Medicare Advantage (HMO) Prescription Drug Plan (M-F 8 AM-8 PM, MST)	866-208-3248	Medicare Prescription Drug Plan (Offered with UnitedHealthcare Senior Supplement)
TTY: 711, when prompted:	866-208-3248	888-556-6648 (Available 24/7)
		TTY: 711, when prompted: 888-556-6648
		UnitedHealthRxForGroups.com
DENTAL PROVIDER		
Assurant Employee Benefits (Group #0000G933) (Monday-Thursday 7 AM-7 PM, CST; Friday 7 AM-6 PM, CST)		AssurantEmployeeBenefits.com/ASRS
Indemnity Dental Claims	800-442-7742	
PPO Dental Providers	800-985-9895	
Prepaid Dental	800-443-2995	
Vision Discount Services	800-877-7195	VSP.com
ASRS retirees may also call the ASRS On-Site Representatives (Weekdays 8 AM-5 PM, MST)		
Phoenix Area	602-240-2000, ext. 2032	
Tucson Area	520-239-3100, ext. 2032	
Out-of-Area	800-621-3778, ext. 2032	
PRESCRIPTION DISCOUNT CARD		
WellCard (Available 24/7)	800-479-2000	WellCard.com
HEARING BENEFITS		
EPIC Hearing UnitedHealthCare (Contracted UHC Hearing Provider)		866-956-5400
HEARING DISCOUNT PROGRAM		
Arizona HearCare Network (Weekdays 8 AM-4:30 PM, MST)	800-532-3331	ArizonaHearCare.com
ASRS MEMBER SERVICES		
(Weekdays 8 AM-5 PM, MST)		
Phoenix Area	602-240-2000	AzASRS.gov
Tucson Area	520-239-3100	
Out-of-Area	800-621-3778	
PSPRS, CORP & EORP BENEFITS OFFICE		
(Weekdays 8 AM-5 PM, MST)	602-255-5575	PSPRS.com
ADOA BENEFITS OFFICE		
(Weekdays 8 AM-5 PM, MST)	602-542-5008 800-304-3687	BenefitOptions.az.gov
OTHER HELPFUL NUMBERS & WEBSITES		
Social Security	800-772-1213	SSA.gov
Medicare	800-633-4227	Medicare.gov
SilverSneakers (M-F 8 AM-8 PM, EST)	888-423-4632	SilverSneakers.com

ARIZONA STATE RETIREMENT SYSTEM
3300 North Central Avenue
Phoenix, AZ 85012

Effective January 1, 2016