Benefit Options
Choice Value Health

STATE OF ARIZONA BENEFIT OPTIONS
2015 RETIREE ENROLLMENT FORM

☐ **NEW RETIREE** ☐ **NEW LTD PARTICIPANT** ☐ **ADDRESS CHANGE**

☐ **QUALIFIED LIFE EVENT** ☐ **TERMINATE INSURANCE**

☐ RETIRED ☐ DISABLED ☐ SURVIVING SPOUSE	**Retirement System** ☐ ASRS (ZA) ☐ PSPRS, CORP, EORP (ZP) ☐ OPTIONAL (ZT)	
EFFECTIVE DATE:	**DECEASED MEMBER'S NAME:**	**DECEASED DATE:**

MEMBER IDENTIFICATION

LAST NAME, FIRST NAME, M.I.	EMPLOYEE EIN or SSN	☐ MALE ☐ FEMALE	☐ MARRIED ☐ SINGLE	DATE OF BIRTH
STREET ADDRESS (NO P.O.BOX)		COUNTY OF RESIDENCE		
CITY, STATE, ZIP CODE	E-MAIL ADDRESS (Mandatory)			

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

DEPENDENTS MUST BE LISTED FOR FAMILY COVERAGE

LAST NAME, FIRST NAME, MIDDLE INITIAL	**DATE OF BIRTH *(Required)***	**RELATIONSHIP CODE S=Spouse C=Child G=Guardian P=Placed for adoption T=Stepchild**	**MEDICARE A=Medicare A B=Medicare B C=Medicare A & B D=Medicare Unknown E=No Medicare**	**SOCIAL SECURITY NUMBER *(Required)***	**MALE OR FEMALE M OR F**	**ADD OR DELETE**	**Indicate Plan Type Medical(M) Dental(D) Vision(V)**
MEMBER:							☐ M ☐ D ☐ V
SPOUSE:							☐ M ☐ D ☐ V
							☐ M ☐ D ☐ V
							☐ M ☐ D ☐ V
							☐ M ☐ D ☐ V
							☐ M ☐ D ☐ V
							☐ M ☐ D ☐ V
							☐ M ☐ D ☐ V

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

VISION PLAN - MONTHLY PREMIUMS AMOUNT

☐ **DECLINE VISION COVERAGE**

Select A Plan	Retiree Only	Retiree + Adult	Retiree + Child	Retiree & Family
Avesis	☐ $3.99	☐ $12.94	☐ $12.76	☐ $16.10

DENTAL PLANS - MONTHLY PREMIUMS AMOUNT

☐ **DECLINE DENTAL COVERAGE**

Select A Plan	Retiree Only	Retiree + Adult	Retiree + Child	Retiree & Family
Delta Dental PPO Plus Premier	☐ $35.94	☐ $75.63	☐ $60.48	☐ $118.26
Total Dental Administrators	☐ $8.99	☐ $17.98	☐ $17.51	☐ $26.97

MEDICAL PLANS - MONTHLY PREMIUMS AMOUNT

☐ **DECLINE MEDICAL COVERAGE**

Select A Plan	Retiree Only	Retiree + One	Retiree & Family
NON MEDICARE EPO PLANS			
AETNA EPO	☐ $593.00	☐ $1,387.00	☐ $1,869.00
BCBS AZ AZ EPO	☐ $593.00	☐ $1,387.00	☐ $1,869.00
CIGNA EPO	☐ $593.00	☐ $1,387.00	☐ $1,869.00
UNITEDHEALTHCARE EPO	☐ $593.00	☐ $1,387.00	☐ $1,869.00
NON MEDICARE PPO PLANS			
AETNA PPO	☐ $943.00	☐ $2219.00	☐ $3,074.00
BCBS AZ PPO	☐ $943.00	☐ $2219.00	☐ $3,074.00
UNITEDHEALTHCARE PPO	☐ $943.00	☐ $2219.00	☐ $3,074.00
NAU Only - Available in ALL regions NON MEDICARE			
BCBS AZ PPO	☐ $730.79	☐ $1,461.57	☐ $2,046.23

BENEFIT SERVICES DIVISION USE ONLY

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

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

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2015 RETIREE ENROLLMENT FORM

FOR MEMBERS WITH MEDICARE - You are required to complete the 2015 Group Part D Prescription Drug Enrollment Form

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

MEDICAL PLANS - MONTHLY PREMIUMS AMOUNT - MEDICARE OPTIONS

☐ **ACCEPT MEDICAL AND PHARMACY COVERAGE - Medicare becomes primary for medical coverage and includes Medicare Part D prescription drug coverage. I understand that if I lose my prescription drug coverage, I will also lose my medical coverage.**

☐ **DECLINE MEDICAL AND PHARMACY COVERAGE**

Select A Plan	Retiree Only with Medicare	Retiree + ONE: Both with Medicare	Retiree + ONE: One with Medicare, the other without	Retiree & Family With Medicare
EPO PLANS				
AETNA EPO	☐ $442.00	☐ $878.00	☐ $,1024.00	☐ $1,166.00
BCBS AZ EPO	☐ $442.00	☐ $878.00	☐ $,1024.00	☐ $1,166.00
CIGNA EPO	☐ $442.00	☐ $878.00	☐ $,1024.00	☐ $1,166.00
UNITEDHEALTHCARE EPO	☐ $442.00	☐ $878.00	☐ $,1024.00	☐ $1,166.00
PPO PLANS				
AETNA PPO	☐ $789.00	☐ $1,576.00	☐ $1,740.00	☐ $1,980.00
BCBS AZ PPO	☐ $789.00	☐ $1,576.00	☐ $1,740.00	☐ $1,980.00
UNITEDHEALTHCARE PPO	☐ $789.00	☐ $1,576.00	☐ $1,740.00	☐ $1,980.00
NAU Only - Available in ALL Regions				
BCBS AZ of Arizona PPO	☐ $594.94	☐ $1,190.02	☐ $1,325.73	☐ $1,635.58

1. If you decline or cancel both medical and dental coverages you will NOT be able to re-enroll with ADOA in the future.
2. If you choose to keep medical or dental coverage through ADOA, you may elect medical and/or dental coverages during future Open Enrollment periods.
3. If you are eligible for Medicare, your medical coverage will include prescription drug coverage in a Medicare Part D plan with additional coverage provided by the State of Arizona.
4. If you are enrolled in another Medicare prescription drug plan or individual Medicare Advantage plan – with or without prescription drug coverage – you will be disenrolled from that coverage. If you enroll in these plans after you are enrolled in the State of Arizona's plan, you will be disenrolled from the State of Arizona plan.
5. If you are disenrolled or otherwise leave the State of Arizona medical or prescription drug plan, you will lose both your medical and prescription drug coverage.

STATE OF ARIZONA BENEFIT OPTIONS
2015 RETIREE ENROLLMENT FORM

I hereby certify, under penalty of perjury, that the information provided in this application for health benefits is correct and true. I am aware that providing false information - including that which is related to my address, spouse, or dependent(s) - may subject me to denial of health benefits, disciplinary action, and prosecution pursuant to ARS 13-2310, 13-2311, 13-2407, 13-2702 and other applicable laws. I hereby acknowledge, I have received the Summary of Benefits and Coverage Documents as part of The Affordable Care Act (ACT).

Member Signature: _____ **Date:** _____

Dependent/Spouse Signature: _____ **Date:** _____

Return form to: ADOA, Benefit Services Division, 100 N. 15th Ave., Suite 103
Phoenix, AZ 85007 or fax: 602-542-4744 or email to: benefitsissues@azdoa.gov.

*** BENEFIT SERVICES DIVISION USE ONLY ***

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

Medicare Generation Rx EMPLOYER PDP

Benefit Options Choice Value Health

Office Use Only	
Main Subscriber ID	Effective Date

2015 Group Participant Part D Prescription Drug Enrollment Form

for Medicare Eligible State of Arizona Benefit Options Program Retirees & Dependents

1. PERSONAL INFORMATION - PLEASE PRINT CLEARLY

Former Employer or Union Name:			Group #:	
LAST Name	FIRST Name	Middle Initial	☐Mr. ☐Mrs. ☐Ms.	
Birth Date __ __/__ __/__ __ __ __ (M M / D D / Y Y Y Y)	Sex ☐M ☐F		Home Phone Number ( )	
Permanent Residence Street Address (No PO Box)	Apt #	City	State	ZIP Code
Mailing address (only if different from above)	Apt #	City	State	ZIP Code

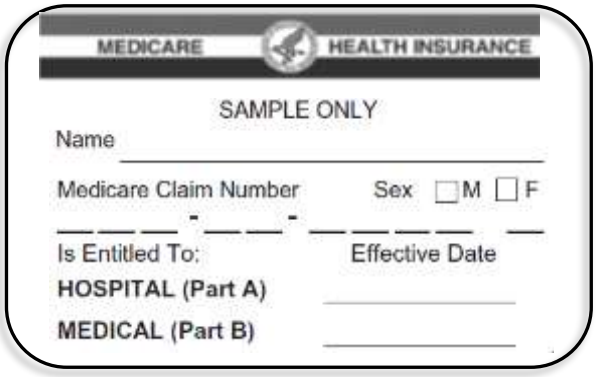
2. MEDICARE INSURANCE INFORMATION

- Please take out your Medicare card to complete this section. Please fill in these blanks to match **your** red, white and blue Medicare card.

–OR –

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

You must have Medicare Part A or Part B to join a Medicare prescription drug plan.



3. PLEASE READ THIS IMPORTANT INFORMATION

If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage Plan that will meet your needs. By joining Medicare GenerationRx your membership in your Medicare Advantage Plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug coverage. Read the information that your Medicare Advantage Plan sends you and if you have questions, contact your Medicare Advantage Plan.

4. ENROLLMENT AUTHORIZATION: By completing this enrollment application, I agree to the following:

a) Medicare GenerationRx is a Medicare-approved Part D Sponsor.

b) I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A or Part B coverage. It is my responsibility to inform Medicare GenerationRx of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare prescription drug plan at a time – if I am currently in a Medicare Prescription Drug Plan, my enrollment in Medicare GenerationRx will end that enrollment.

c) Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Annual Enrollment Period, or based on my open enrollment for my retiree group plan, unless I qualify for certain special circumstances.

d) Medicare GenerationRx serves a specific service area. If I move out of the area that Medicare GenerationRx

serves, I need to notify the plan so I can disenroll and find a new plan in my new area.

e) I understand that I must use network pharmacies except in an emergency when I cannot reasonably use Medicare GenerationRx network pharmacies.

f) Once I am a member of Medicare GenerationRx, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Medicare GenerationRx when I get it to know which rules I must follow to get coverage.

g) I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.

h) I understand that benefits, premiums and cost sharing may change during the employer group's renewal period.

i) I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Medicare GenerationRx, he/she may be paid based on my enrollment in Medicare GenerationRx.

j) Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options, medical assistance through the state Medicaid program, and the Medicare Savings Program.

k) I understand that if I obtain prescriptions outside the Medicare GenerationRx network, I may be required to pay any difference between the billed and allowed amount.

Release of Information: By joining this Medicare prescription drug plan, I acknowledge that Medicare GenerationRx will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Medicare GenerationRx will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.

5. PAYING YOUR PLAN PREMIUM

You pay a combined medical/pharmacy premium. If you have questions, please call the State of Arizona Benefit Options Program at 1-602-542-5008 or toll free at 1-800-304-3687, 8 am to 5 pm, Monday through Friday.

If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount. You will be billed directly by Medicare. Do NOT pay the Part D-IRMAA extra amount to Medicare GenerationRx.

6. PLEASE CAREFULLY READ SECTIONS 4 & 5 OF ENROLLMENT FORM & SIGN BELOW

I understand that my signature (or the signature of the person authorized to act on my behalf under State law where I live) on this application means that I have read and understand the contents of this application. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

Your Signature:	**Today's Date:**

☐ Check if you are the **authorized representative.** You **MUST** sign above and provide the following information:

Name (please print):_____ Phone number:_____

Address:_____ City:_____ State:____ ZIP Code: _____

Relationship to Enrollee:_____

—Office Use Only—		
Plan ID #:		
Group #:	ICEP/IEP:	SEP (type):
Effective Date of Coverage:	AEP:	Not eligible: