Arizona State Retirement System Health Plan

WRAP PLAN DOCUMENT

January 1, 2025

This document, together with the relevant Summary Plan Description and/or Evidence of Coverage document for the various Component Benefit Programs is your Plan Document. If you need a copy of a Summary Plan Document and/or Evidence of Coverage document, you should contact the ASRS.

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1. Introduction

The Arizona State Retirement System (ASRS), as Plan Sponsor, establishes and maintains the Arizona State Retirement System Health Plan for the exclusive benefit of its Members and their Dependents. This Wrap Plan Document, along with the relevant Summary Plan Description and/or Evidence of Coverage documents ("Governing Documents") for the various Component Benefit Programs, set forth the terms of the Plan as of January 1, 2025 and replaces all other plan documents and applicable amendments to those documents previously provided to Plan Participants and beneficiaries.

You are being provided this Wrap Plan Document to give you an overview of the Plan and to address certain information that may not be addressed in the relevant Governing Documents. This document is a "wrap" plan document that is not intended to give you any substantive rights to benefits that are not provided in relevant Governing Documents. You must read the this Wrap Plan Document together with the relevant Governing Documents to understand your benefits.

The Plan provides benefits through the following Component Benefit Programs:

- Medical Plans (including Prescription Drug coverage)
- Dental Plans

Each of these Component Benefit Programs is summarized in the relevant Governing Document. When the Plan refers to an insurance contract, it also refers to any attachments to such contract, as well as documents incorporated by reference into such contract (such as the application and the certificate of insurance booklet). This Wrap Plan Document, together with any relevant Governing Document constitute the Plan Document. A copy of each Governing Document is provided when you enroll. Please contact ASRS if you need a copy.

This Wrap Plan Document will help you understand and use the benefits provided by the Arizona State Retirement System Health Plan. You should review it and share it with those members of your family who are or will be covered by the Plan. It will give all of you an understanding of the Component Benefit Programs, the procedures to follow in submitting claims, and your responsibilities to provide necessary information to the Plan.

All provisions of this document contain important information.

If you have any questions about your coverage or your obligations under the terms of the Plan, be sure to seek help or information. The Quick Reference Chart to sources of help or information about the Plan follows this section.

Quick Reference Chart

When you need information, please check this booklet first. If you need further help, call the people listed in the following summary:

SUMMARY OF BENEFITS AND INFORMATION ON CONTACTS AND ADMINISTRATION

For Information on:	You Should Contact:
Enrollment/Eligibility	Arizona State Retirement System 602-240-2000 Phoenix Area 800-621-3778 Out-of-Area AzASRS.gov Public Safety Personnel Retirement System (PSPRS), Corrections Officer Retirement Plan (CORP) & Elected Officials' Retirement Plans (EORP) Benefits Office: 602-255-5575
Plan Administrator • Eligibility Claims/Appeals • Premium Benefit • Premium Payments • COBRA Administration	Arizona State Retirement System 602-240-2000 Phoenix Area 800-621-3778 Out-of-Area AzASRS.gov Mailing Address: P.O. Box 33910 Phoenix, AZ 85067-3910
Medical Plan (pre-Medicare) • Benefits/Summary Plan Description • Participating Provider Directory • Preauthorization/Utilization Management • Prescription Drug Benefits • Medical/Prescription Drug Claims/Appeals	UnitedHealthcare 800-509-6729 whyuhc.com/asrs
Medical Plan (Medicare Advantage Plans) • Benefits/Summary Plan Description • Participating Provider Directory • Preauthorization/Utilization Management • Prescription Drug Benefits • Medical/Prescription Drug Claims/Appeals	UnitedHealthcare 844-876-6161 uhcretiree.com/asrs Virtual Education Center: Uhcvirtualretiree.com/asrs
PPO Dental Plan • Benefits/Evidence of Coverage • Participating Provider Directory • Dental Premium Payments • Dental Claims/Appeals	Delta Dental of Arizona 833-335-8201, TTY: 711 deltadentalaz.com/asrs

For Information on:	You Should Contact:
HMO Dental Plan • Benefits/Evidence of Coverage • Participating Provider Directory • Dental Premium Payments • Dental Claims/Appeals	Cigna 800-244-6224 Cigna.com/asrs
HIPAA Privacy Officer	Ryan Guerra Arizona State Retirement System P.O. Box 33910 Phoenix, AZ 85067-3910

2. Eligibility and Participation Requirements

Eligibility

You are eligible with respect to the Plan if:

- you are a Member who retired from the ASRS, Public Safety Personnel Retirement System (PSPRS), Elected Officials' Retirement Plan (EORP), Corrections Officer Retirement Plan (CORP), or the Optional Retirement Plans (ORP); or

- are a Member who is receiving long-term disability benefits pursuant to Arizona Revised Statutes section 38-651.03 or article 2.1 of Arizona Revised Statutes, Title 38, Chapter 5; or

- are a designated beneficiary of a deceased Member who is receiving a survivor benefit pursuant to Arizona Revised Statutes section 38-762, subsection C, or section 38-763, subsection B as monthly income (hereinafter referred to as a Surviving Dependent); and

do not otherwise elect to obtain coverage under a group health and accident insurance plan or program, and are eligible to participate in and receive benefits under one or more of the Component Benefit Programs in accordance with the terms and conditions of the Plan (including the terms of the applicable Component Benefit Program).

Dual Enrollment

The ASRS provides the opportunity for its Members to enroll in the plan, but there are eligibility restrictions for individuals enrolled in other health plans (known as "Dual Enrollment"). ASRS retired Members, Members on ASRS Long Term Disability, Surviving Dependents of ASRS Members, and their Dependents may not be enrolled in the ASRS health plan at the same time they are enrolled in another group health and accident plan or program.

Similarly, retired Members of the PSPRS, the EORP Plan, the CORP, the ORP, or other retirement plans that might be offered by the community college districts, and their Dependents may not be enrolled in an ASRS health plan while also enrolled in a health plan offered by the Arizona Department of Administration (ADOA).

Some Members may have more than one source of eligibility, however, individuals are limited to one enrollment at a time. For example, you may be eligible to enroll in a plan due to your participation in the ASRS and another eligible retirement plan, but you may only be enrolled in a plan in one capacity at a time—either as a Member or Dependent.

Additionally, if you and your spouse are both eligible to enroll in a plan, you cannot enroll each other as Dependents, nor have your children enrolled twice. One spouse may elect coverage for the entire family, or each spouse may elect their own coverage. Dependent children can be on one spouse's policy or divided between spouses, but cannot be enrolled as a Dependent of both spouses.

If the ASRS determines a Participant has prohibited dual coverage, enrollment in the ASRS Plan will be terminated, no refunds for any premiums you paid will be issued, and overpayments made by the ASRS plan will be recovered.

Eligible Dependents

Other individuals, such as a spouse or dependent children of a Member who is retired or a Member on ASRS Long Term Disability, may be eligible to participate in and receive benefits under one or more of the Component Benefit Programs. Dependents eligible for coverage include:

- Your legal spouse;
- Your natural child, legally adopted or placed for adoption child, or stepchild under the age of 26;
- Foster children under the age of 26;
- A child for whom legal guardianship has been awarded to you or your legal spouse, under the age of 26. You will be required to submit documentation as proof of legal guardianship;
- A child for whom insurance is required through a Qualified Medical Child Support Order, court order, or administrative order;
- A child of any age who is, or becomes, disabled and is dependent upon you. All disabled children age 26 or older must be approved by the Plan as a disabled dependent.[1]

Note: Participants eligible for coverage as a Surviving Dependent are not themselves eligible to enroll dependents except as required under COBRA.

Enrollment and Qualifying Live Events

A qualifying life event allows you the opportunity to enroll and/or make changes to existing coverage for yourself or your dependents outside of the annual Open Enrollment period. You must make these changes no later than 31 calendar days from the date the qualifying event took place, unless a different deadline is indicated for a specific qualifying life event. The following are the Qualifying Life Events recognized by the ASRS for enrollment and/or changes to your existing coverage outside of the annual Open Enrollment period. ASRS has the sole discretion to determine whether a Qualifying Life Event has occurred and whether your situation allows you to enroll or make changes to existing coverage.

[1] If your dependent child turning age 26 is disabled and you want your disabled child to continue coverage, you must notify the Plan Administrator and provide a written application within 60 days of your child's 26th birthday. Medical history from a physician regarding your child's disabled status may be required as part of this application. You are encouraged to obtain such information in advance of any application to prevent any lapse in coverage.

Retirement

New retirees are able to enroll and add dependent coverage in any plan they are eligible for at the time of their retirement. Supporting documentation will not be required, unless you wish to cover a dependent child over the age of 26.

Your insurance application must be submitted within 31 days of your retirement date. Coverage will be effective on the first day of the month following your retirement date. Health insurance premium deductions (retroactive to your coverage effective date) will not be deducted from your monthly pension payment until your retirement benefit has been finalized.

Change in marital status

You may change plans, and/or add dependent coverage for new dependents resulting from a new marriage, including the spouse if you are a current participant under the Plan. Retirees who are not current participants must wait until the next open enrollment period to add spouse and new dependents as a result of a new marriage.

If the change in marital status results in the loss of other coverage (for example due to divorce, legal separation, annulment, or the death of a spouse), you and your dependents may enroll in a plan or change plans. You may (and must in the case of a spouse) also remove a dependent due to a change in marital status such as divorce, legal separation, annulment, or death of a spouse.

You will be asked to provide documentation that supports the occurrence of this qualifying life event.

Your enrollment application must be submitted within 31 days of the date of your qualifying life event. Coverage will be effective on the first day of the month after you submit your enrollment application.

Change in dependent status

You may enroll in a plan, change plans and/or add dependent coverage for new dependents resulting from a change in dependent status such as a birth or adoption, even if you declined to enroll in a plan during the previous Open Enrollment Period. In such cases, you may also add a dependent not previously covered.

You may also remove dependent coverage in the event of a change in dependent status. You will be asked to provide documentation that supports the occurrence of this qualifying life event.

Your enrollment application must be submitted within 31 days of the date of your qualifying life event. Coverage will be effective as of the date of the change in dependent status (i.e. on the date of birth, adoption, or placement for adoption), provided you submit your enrollment application for coverage within the 31 days.

Change Relating to Medicaid or Children's Health Insurance Program (CHIP)

If you or your dependents become eligible for a Medicaid or CHIP subsidy or lose coverage under Medicaid or CHIP, you may enroll in a plan, change plans, and/or add or remove dependent coverage. Supporting documentation will be required.

Your enrollment application can be submitted within 60 days of the date you or your dependent is determined to be eligible for the subsidy or the date coverage is terminated. Coverage will be effective on the first day of the month after you submit your enrollment application.

Change in primary residence

You may change plans, and/or add or remove dependents if you have a change in your place of residence affecting your current coverage through ASRS. Your address on file with the ASRS must correspond to the coverage area in which you are enrolling (Arizona or nationwide).

Your enrollment application must be submitted within 31 days of the date of your qualifying life event. Coverage will be effective on the first day of the month after you submit your enrollment application for coverage.

Change in Medicare eligibility

You may enroll in a Medicare medical plan when you become Medicare eligible. If you and/or your dependent are already enrolled in non-Medicare medical coverage through the ASRS, you and/or your dependent must switch to a Medicare plan upon becoming Medicare eligible. Failure to enroll in a Medicare plan will result in the termination of coverage for you and/or your dependent. If this occurs, you may not be able to re-enroll in an ASRS medical plan unless you have a Qualifying Life Event or until the next Open Enrollment Period.

Please note: Medicare eligibility is NOT a Qualifying Life Event for dental plans - only for medical plans.

Your enrollment application can be submitted 90 days prior to your Medicare eligibility date. Coverage will be effective on the first day of the month you become Medicare eligible.

If you are already enrolled in a Medicare Advantage plan you may be able to make changes to your plan outside of the annual Open Enrollment Period in other special circumstances. Please refer to Medicare.gov for more information regarding special circumstances.

You can also speak with a Medicare specialist by calling (800) 432-4040 if you reside in Arizona, or you can check the Medicare.gov website for contact information if you reside outside of Arizona.

Loss of other coverage and other events (spouse, employer, COBRA)

You may enroll in a plan, change plans and/or add dependent coverage when:

- you or your dependent has lost group or individual health insurance coverage due to a loss of eligibility for the coverage (including termination of employment or reduction in hours, but not including a failure to pay premiums, voluntary termination of coverage and termination of coverage for cause, such as for fraud),

- the group medical plan option in which you or your dependent are enrolled terminates or ends,
- you or your dependent's coverage under a non-calendar year plan ends at the end of that plan's year and you or your dependent do not renew coverage under that plan, resulting in a loss of coverage.
- You or your dependent exhaust COBRA continuation coverage under a different plan.
- The employer sponsoring the medical group plan in which you or your dependent are enrolled ceases making contributions towards the cost of coverage—even if you do not actually lose coverage.

Please note: You will be asked to provide documentation that supports the qualifying life event. Voluntarily terminating your non-ASRS group or individual medical insurance plan is not a qualifying life event.

Your enrollment application must be submitted within 31 days of the date of your qualifying life event. Coverage will be effective on the first day of the month after you submit your enrollment application.

Long Term Disability

If you are approved for the ASRS Long Term Disability Program, you may enroll yourself and your dependents in any plan for which you are eligible. Supporting documentation will not be required, unless you wish to cover a dependent child over the age of 26.

Your enrollment application must be submitted within 31 days of your disability benefit effective date. Coverage will be effective on the first day of the month after you submit your enrollment application.

To request special enrollment or obtain more information, contact the Plan Administrator.

Note: Participants eligible for coverage as a Surviving Dependent are not themselves eligible to enroll Dependents except as required under COBRA.

Termination of Coverage

When a Member's participation in the Plan terminates, benefits under the Plan for the Member and the Member's Dependents covered under the Plan will cease, unless the Member has died and Dependents are eligible to continue coverage as Surviving Dependents. Termination of participation in a Component Benefit Program occurs in accordance with the terms and conditions established for that Component Benefit Program.

All benefits under the Component Benefit Program will cease upon termination of the Plan.

Other circumstances can result in the termination of benefits. The relevant Governing Documents for the Component Benefit Programs provide additional information.

Keep the Plan Informed

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator. The contact information for the Plan Administrator can be found in the Quick Reference Chart at the front of this document.

3. Leaves of Absence

If your continued eligibility is related to your active employment status, you may be entitled to continued eligibility for coverage under the Plan when on leave from work due to either family and medical leave reasons or service in the uniformed services of the United States. In those limited circumstances, the following provisions regarding leave will apply.

Family and Medical Leave

Under the Family and Medical Leave Act of 1993 (FMLA), you may be able to take up to 12 weeks of unpaid leave during any 12-month period:

- to care for a newly born or adopted child;
- to care for a spouse, parent or child who has a serious health problem;
- if you have a serious health problem that prevents you from performing your job; or
- a qualifying exigencies arising out of the fact that the active Participant's spouse, son, daughter, or parent is on active duty or has been notified of an impending call or order to active duty, in support of a contingency operation.

In addition, the FMLA may enable you to take up to 26 weeks of unpaid leave during any 12-month period to care for a service member if that individual is your spouse, son/daughter, parent or next of kin, is undergoing treatment or therapy for an illness or injury that occurred in the line of duty, and is an outpatient or on the armed services' temporary disability retired list.

To be eligible for an FMLA leave, you must have worked for your employer for 1,250 hours during the 12 consecutive month period before your leave is scheduled to begin. Any paid or unpaid leave time taken during the year is counted against your annual FMLA allowance. You must provide 30 days of notice when the need for an FMLA leave is foreseeable. When the need for a leave comes up unexpectedly, you must provide as much advance notice as possible. Medical certification regarding your or a family member's serious health condition will be required.

If you qualify for FMLA leave, the Plan will maintain the coverage you were eligible for at the time of your leave until the end of your leave.

Leave for Military Service

If you voluntarily or involuntarily leave your employment position to undertake military service, the Uniformed Services Employment and Reemployment Rights Act ("USERRA") of 1994 requires an employer to grant you unpaid military leave for up to five years and to continue to subsidize your health care coverage for up to 31 days from the first day of your military leave. If your military service exceeds 31 days, you should receive military health care coverage from the U.S. Government at no cost. However, you may also elect to continue your coverage under this Plan for you and your Dependents covered under the Plan for a maximum period of 24 months

from the first day of your military leave. You must notify the Benefits Office at the beginning of your military leave and fill out an election form in order to receive this continuation of coverage.

Once the Plan Administrator receives notice that the Member has been called to active duty, the Plan will offer the right to elect USERRA coverage for the Member (and any Dependents covered under the Plan on the day the leave started). If the Member does not elect USERRA for the Dependents, those Dependents cannot elect USERRA separately. Contact the Plan Administrator to obtain a copy of the USERRA election forms. Completed USERRA election forms should be submitted to the Plan as soon as possible, but in no event more than 90 days after the Plan offers the right to elect USERRA coverage.

The Participant (and any Dependents covered under the Plan on the day the leave started) can continue health care coverage under this Plan during that leave period if the Participant continues to pay the appropriate contributions for that coverage during the period of that leave. If the Participant elects USERRA temporary continuation coverage, the Participant (and any Dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to twenty-four (24) months measured from the date the Member stopped working. USERRA coverage will be 102% of the cost of coverage. Coverage under USERRA will terminate due to non-payment of premiums, subject to a 30-day grace period.

In addition, your Dependent(s) may be eligible for health care coverage under TRICARE. This Plan will coordinate coverage with TRICARE. Coverage will not be offered for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services. The Uniformed Services and the Department of Veterans Affairs will provide care for service-connected disabilities.

If your continued eligibility is related to your active employment, then when you are discharged (not less than honorably) from military service, your full eligibility will be reinstated on the day you return to employment with the ASRS, provided that you return to employment within:

- 90 days from the date of discharge if the period of service was more than 180 days; or
- 14 days from the date of discharge if the period of service was at least 31 days, but less than 180 days; or
- at the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional eight hours) if the period of service was less than 31 days.

If you are hospitalized or convalescing from an injury caused by active duty, these time limits are extended up to two years.

You must notify the Plan Administrator in writing within the time periods listed above. Upon reinstatement, coverage will not be subject to any exclusions or waiting periods other than those that would have been imposed had the coverage not terminated. If you have any questions about how a leave of absence affects your coverage, please contact the Plan Administrator. Your USERRA rights are subject to change. Coverage will be provided only as required by law. If the law changes, your rights will change accordingly.

Keep the Plan Informed

In order to protect your family's rights, keep the Plan Administrator informed of any changes for participants such as addresses and your marital status. You should also keep a copy, for your records, of any notices you send to the Plan Administrator. The contact information for the Plan Administrator can be found in the Quick Reference Chart at the front of this document.

4. COBRA Continuation of Coverage

In General

If you are enrolled in a non-Medicare health plan or a dental plan, your Dependents can continue health care and/or dental coverage temporarily in certain circumstances where coverage would otherwise end. This extended health care coverage is called "COBRA coverage," named for the federal law that sets forth the rules for continuation coverage (the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)). COBRA coverage is identical to the coverage provided under this Plan and may be available at the enrollees' own expense provided coverage is lost due to a "COBRA Qualifying Event."

Note for Retirees: When you retired, you (the Member) were offered a choice between electing a temporary continuation of your active group health coverage ("COBRA Continuation Coverage") or electing retiree health coverage. As you elected retiree health coverage, you have no further COBRA continuation rights. However, your Dependent(s) may experience a COBRA Qualifying Event as described in this section.

Under the law, only "Qualified Beneficiaries" are entitled to elect COBRA coverage. Depending on the type of COBRA Qualifying Event, a Qualified Beneficiary can include any Dependent who is covered by the Plan when a COBRA Qualifying Event occurs. Qualified Beneficiaries have the same rights as Members or Dependents including special and open enrollment rights. For example, a child who becomes a Dependent by birth, adoption, or placement for adoption to someone enrolled under COBRA is also a Qualified Beneficiary. As with any Qualifying Life Events, you must provide written notice to the Plan Administrator within 31 days of such an event.

If COBRA coverage applies, your Dependents have the option to continue the same medical and/or dental coverage they had prior to the COBRA Qualifying Event.

Alternatives to Coverage

There may be other health coverage alternatives to COBRA available that can be purchased through the Health Insurance Marketplace. Also, in the Marketplace, there may be available tax credits that lower your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit eligibility for coverage for a tax credit. For more information about the Health Insurance Marketplace, visit www.healthcare.gov. Also, you or your Dependents may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), if you request enrollment in that plan within 30 days, even if that plan generally does not accept late enrollees.

COBRA Qualifying Events

To be eligible to elect COBRA coverage, your Dependent must **lose** coverage due to any one of the following COBRA Qualifying Events:

COBRA Qualifying Event	Who May Purchase Continuation Coverage?	For How Long?
You become legally separated or divorced from your spouse	Eligible spouse and stepchildren (only step-children will lose coverage upon legal separation or divorce)	36 months
Your dependent child is no longer considered a Dependent under this Plan's definition (e.g., he or she reaches the maximum age limit)	Eligible dependent child	36 months

Availability of COBRA Coverage

The Plan will offer COBRA coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a COBRA Qualifying Event has occurred. You or your family should notify the Plan Administrator promptly if any such COBRA Qualifying Event occurs in order to avoid confusion over the status of your health care in the event there is a delay or oversight in providing that notice.

Notice of COBRA Qualifying Events

You must notify the Plan Administrator in writing no later than 60 days after the COBRA Qualifying Event occurs. The notice of occurrence of any of these events must be provided to the Plan Administrator in writing. Notice may be provided by the Participant or Qualified Beneficiary with respect to the COBRA Qualifying Event, or any representative acting on behalf of the Participant or Qualified Beneficiary. Notice from one individual will satisfy the notice requirement for all related Qualified Beneficiaries affected by the same COBRA Qualifying Event. You must provide the Plan Administrator written notice of the following COBRA Qualifying Events:

1. When a Participant divorces or legally separates from his or her spouse, written notice must be sent no later than 60 days after the date upon which coverage would be lost under the Plan as a result of the COBRA Qualifying Event. A copy of the court document acknowledging the legal separation or divorce must be included with the notice.

2. When a dependent child ceases to be covered under the Plan (including turning age 26), written notice must be sent no later than 60 days after the date upon which coverage would be lost under the Plan as a result of the COBRA Qualifying Event.

Failing to provide written notice to the Plan Administrator within the timeframe described above may prevent your Dependents from obtaining or extending the COBRA coverage. After receiving written notice of a COBRA Qualifying Event, the Plan will provide an election notice for a Qualified Beneficiary within 14 days.

Further, when a dependent child who is covered turns 26 years old, they are no longer eligible to be covered under the ASRS plans. Dependent children who are age 26 will be automatically terminated from coverage. There will not be any notification of this required

change. To ensure that you are aware of upcoming changes, please keep track of your Dependents' eligibility based on age.

Notice of Unavailability of COBRA Coverage

In the event the Plan Administrator is notified of a potential COBRA Qualifying Event but the Plan Administrator determines that an individual is not entitled to the requested COBRA coverage, the individual will be sent an explanation indicating why the COBRA coverage is not available. This notice of the unavailability of the COBRA coverage will be sent within 14 days after the Plan Administrator receives written notice of a potential COBRA Qualifying Event.

How is COBRA Coverage Provided?

When the Plan Administrator is notified that a COBRA Qualifying Event has occurred, the Plan Administrator will then provide you and/or your Dependents with notice of the date on which coverage will end, and the information and election form that individuals will need in order to elect COBRA coverage. Under the law, you and/or your Dependents will then have only 60 days from the later of the date they ordinarily would have lost coverage because of the COBRA Qualifying Events, or the date your Dependents received the notice, to apply for COBRA coverage.

Each Qualified Beneficiary has an independent/separate right to elect COBRA coverage. COBRA coverage may be elected for some members of the family and not others. In addition, one or more Dependents may elect COBRA even if others eligible to elect COBRA do not. However, in order to elect COBRA coverage, the family members must have been covered by the Plan on the date of the COBRA Qualifying Event or became a Dependent by birth, adoption, or placement for adoption during the period of COBRA coverage.

Payment for COBRA Coverage

When your Dependents become entitled to this coverage, the Plan Administrator will provide notice regarding the COBRA premium amounts. Those who continue coverage under COBRA are responsible for the entire cost of COBRA coverage and pay for the coverage on a monthly basis. The cost of COBRA is up to 102% of the Plan's cost.

If your Dependents elect COBRA coverage, no payment needs to be sent along with the Election Form. However, the first COBRA payment must be sent to the Plan Administrator not later than 45 days after the date of the COBRA election (which is the date the Election Notice is post-marked, if mailed). If the first payment for COBRA is not paid in full within 45 days after the date of the COBRA election, all continuation coverage rights under the Plan will be lost.

Grace Period for Payments

Although payments are due on the first day of the month, there will be given a grace period of 30 days after the first day of the coverage period to make each payment. COBRA coverage will be provided for each coverage period as long as payment for that coverage period is made before

the end of the grace period for that payment. If the Plan Administrator has not received a COBRA payment by the due date (the first of the month), COBRA coverage will be cancelled on the first day of the month. However, if the COBRA premium is paid within the 30-day grace period coverage will be reinstated back to the first day of that COBRA coverage period. Payment is considered made when it is postmarked.

Early Termination of COBRA Coverage

COBRA coverage will terminate on the last day of the maximum period of coverage unless it is cut short for any of the following reasons:

- The first date of the time period for which COBRA premiums are not paid within the required timeframe after electing COBRA.
- The date, after the date of the COBRA election, in which your Dependent(s) first become covered by another group health Plan.
- The date, after the date of the COBRA election, on which your Dependent(s) first become entitled to Medicare (usually age 65); or
- The date the Plan terminates its group health plan and no longer provides group health insurance coverage to its Members.

Notice of Early Termination of COBRA Coverage

The Plan Administrator will notify the Qualified Beneficiary(ies) if COBRA coverage terminates earlier than the end of the maximum period of coverage applicable to the COBRA Qualifying Event that entitled the Qualified Beneficiary(ies) to COBRA coverage. This written notice will explain the reason COBRA terminated earlier than the maximum period, the date COBRA coverage terminated and any rights the Qualified Beneficiary(ies) may have under the Plan to elect alternate or conversion coverage. The notice will be provided as soon as practicable after the Plan Administrator determines that COBRA coverage will terminate early.

Other Coverage Options Besides COBRA Continuation Coverage

Instead of enrolling in COBRA continuation coverage, there may be other coverage options through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

COBRA Questions or to Give Notice of Changes in Your Circumstances

For more information about rights under COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office

of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep the Plan Informed

In order to protect your family's rights, keep the Plan Administrator informed of any changes for participants such as addresses and your marital status. You should also keep a copy, for your records, of any notices you send to the Plan Administrator. The contact information for the Plan Administrator can be found in the Quick Reference Chart at the front of this document.

5. Plan Benefits

Available Benefits

The Plan makes available to you and your eligible family members medical and dental insurance. The Governing Document for each Component Benefit Program, describing the benefits provided under the program, was provided along with this Wrap Plan Document when you enrolled. You should contact ASRS if you need a copy of any Governing Document.

Payment of Premiums

Your ASRS health insurance premiums will be automatically deducted each month from your ASRS pension payment, if your pension payment amount is greater than the net cost of your insurance premiums. The premium benefit may be delayed for one to three months while your pension is finalized. However, the eligible amount will be reimbursed or adjusted, as applicable, and will be retroactive to the beginning of the coverage.

The medical and/or the dental benefit administrator/carrier will mail a bill directly to you and it will be your responsibility to pay premiums directly to the administrator/carrier if you are:

- On Long Term Disability
- Choosing your employer's options (State of Arizona is an exception. The payment will be withheld from your ASRS pension payment)
- Receiving a pension payment that does not cover the net cost of your insurance premiums.

Premium Benefit

As part of your benefits, the ASRS provides a health insurance premium benefit to supplement the cost of retiree health insurance. The premium benefit is effective on the first day of the month following your initial enrollment or special enrollment. Members who are either retirees or on Long Term Disability, and have five or more years of credited service who have health insurance through the ASRS or non-subsidized coverage through their former ASRS employer are eligible for a monthly premium benefit, which is paid to the health insurer or your former employer. A premium benefit also applies to eligible retirees participating in the ASRS health insurance plans from EORP, CORP and PSPRS.

If you are a new ASRS retiree, you may elect to receive a reduced premium benefit that, upon your death, may be continued to your beneficiary. This Optional Premium Benefit is only available to retirees who select a Term Certain or Joint & Survivor Annuity option. It is not available to retirees who select the Straight Life Annuity. You have a one-time opportunity to elect this benefit when you retire. You may rescind election at a later date and the unreduced premium benefit will be reinstated and applied for life.

The amount of the Optional Premium Benefit reduction is based on your age and the age of your beneficiary. You can find out what your reduction would be by visiting the Calculating Your Optional Premium Benefit page of our website at www.bit.ly/Premium-Calc.

Administrative Requirements and Timelines

As described in the Governing Documents for each Component Benefit Program, there may be reasons that a claim for benefits under a particular Component Benefit Program is not paid, or is not paid in full. For example, claims must generally be submitted for payment within a certain period of time, and failure to submit within that time period may result in the claim being denied. For details regarding administrative requirements that may impact benefit availability, please see governing documents for the relevant Component Benefit Program.

Rebates, Refunds and Similar Payments

Any refund, rebate, dividend, experience adjustment, or other similar payment under a group insurance contract shall be allocated consistent with applicable fiduciary obligations.

Right to Recover Benefit Overpayments and Other Erroneous Payments

If, for any reason, any benefit under the Plan is erroneously paid or exceeds the amount appropriately payable under the Plan to a Participant, the Participant shall be responsible for refunding the overpayment to the Plan. In addition, if the Plan makes any payment that, according to the terms of the Plan, should not have been made, the Plan Administrator, the ASRS (or designee), or the applicable insurance company may recover that incorrect payment, whether or not it resulted from the insurance company's or Plan Administrator's (or its designee's) own error, from the person to whom it was made or from any other appropriate party. As may be permitted in the sole discretion of the Plan Administrator, the refund or repayment may be made in one or a combination of the following methods: (a) in the form of a single lump-sum payment, (b) as a reduction of the amount of future benefits otherwise payable under the Plan, (c) as automatic deductions from pay or (d) any other method as may be required or permitted in the sole discretion of the Plan Administrator or the applicable insurance company. The Plan may also seek recovery of the erroneous payment or benefit overpayment from any other appropriate party to the fullest extent permitted by applicable law.

With respect to a Component Benefit Program provided through insurance, the contract language may contain information regarding the Plan's right to subrogate or seek reimbursement of erroneously paid benefits (including payments in excess of the amount appropriately payable). With respect to self-insured Component Benefit Program, subrogation or reimbursement rights may be set forth in the Governing Documents for the Component Benefit Programs.

Participant Responsibilities

Each Participant shall be responsible for providing the Plan Administrator and the ASRS and, if required by an insurance company with respect to a fully insured benefit, the insurance company with his or her current address and, if required, with the address of any individual covered through the Participant. Any notices required or permitted to be given to a Participant hereunder shall be deemed given if directed to the address most recently provided by the Participant and mailed by first-class United States mail. The insurance companies, the Plan Administrator, and the ASRS shall have no obligation or duty to locate a Participant.

Right to Information and Fraudulent Claims

Any person claiming benefits under the Plan shall furnish the Plan Administrator or, with respect to a fully insured benefit, the insurance company with such information and documentation as may be necessary to verify eligibility for or entitlement to benefits under the Plan.

The Plan Administrator (and, with respect to a fully insured benefit, the insurance company) shall have the right and opportunity to have a Participant examined when benefits are claimed, and when and so often as it may be required during the pendency of any claim under the Plan. The Plan Administrator and, with respect to a fully insured benefit, the insurance company also shall have the right and opportunity to have an autopsy done in the case of death, where it is not forbidden by law.

If a person is performs an act, practice or omission that constitutes fraud or makes an intentional mispresentation of material fact (such as, but not limited to, falsifying any document in support of a claim for benefits or coverage under the Plan, or failing to have corrected information which such person knows or should have known to be incorrect, or failing to bring such misinformation to the attention of the Plan Administrator or the insurance company), the Plan Administrator may, without the consent of any person and to the fullest extent permitted by applicable law, terminate the person's Plan coverage, including retroactively rescinding coverage. In addition, the insurance company may refuse to honor any claim for benefits under the Plan for the Participant related to the person's fraud or misrepresentation of material fact. Such person shall be responsible to provide restitution, including monetary repayment to the Plan, with respect to any overpayment or ineligible payment of benefits.

HIPAA Nondiscrimination

This Plan will not discriminate against similarly situated individuals in eligibility, continued eligibility for benefits, individual premiums or contribution rates due to health factors such as health status, medical condition, claims experience, receipt of health care, medical history, genetic information or evidence of insurability. Benefits provided are uniformly available and any benefit restrictions are uniformly applied to all similarly situated individuals.

Newborns' and Mothers' Health Protection Act

Under federal law, group health plans, like this Plan, generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the Plan may pay for a shorter stay if the attending Physician (e.g., Physician, or Health Care Practitioner), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, the Plan may not, under federal law, require that a Physician or other Health Care Practitioner obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

This Plan covers a Hospital stay of at least 72 hours following a modified radical mastectomy and a Hospital stay of at least 48 hours following a simple mastectomy. A shorter length of stay may be covered if the patient, in consultation with her physician, determines that it is Medically Necessary and Appropriate. The patient's Provider does not need to obtain Prior Authorization for prescribing 72 or 48 hours, as appropriate, of Inpatient care.

This Plan complies with the Women's Health and Cancer Rights Act (WHCRA) that indicates that for any Participant who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with it, coverage will be provided in a manner determined in consultation with the attending physician and the patient, including:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses; and
- The treatment of physical complications at all stages of the mastectomy, including lymphedemas in a manner determined in consultation with the attending provider and the patient.

Benefits for these services shall be subject to the same Deductible, Copayments and/or Coinsurance as for other services covered under this Plan.

Genetic Information Nondiscrimination Act

The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects employees against discrimination based on their genetic information. Unless otherwise permitted, an employer may

not request or require any genetic information from you or your family members. The Plan will not, with respect to you or your dependents:

- Discriminate on the basis of genetic information;
- Collect genetic information prior to in connection with enrollment or for underwriting purposes; or
- Require you or your dependent to undergo a genetic test.

Mental Healthy Parity

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers that offer mental health and substance use disorder benefits to offer those benefits without imposing less favorable benefit limitations on those benefits than medical/surgical benefits. If the Plan provides mental health/substance use disorder benefits in any classification of benefits, the Plan will provide mental health/substance use disorder benefits in every classification in which medical/surgical benefits are provided. The Plan will ensure that financial requirements (such as co-pays and deductibles) and quantitative treatment limitations (such as annual visits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements of limitations applied to substantially all medical/surgical benefits. The Plan will not impose non-quantitative limitations with respect to mental health/substance abuse disorder benefits in any classification unless under the terms of the Plan, the processes, strategies, evidentiary standards and other factors used in applying the non-quantitative limitation are comparable and no more stringently applied that with respect to medical/surgical benefits in the classification. As a government plan, the Plan is not subject to ERISA. However, participants shall have the right to request plan documents and information from the Plan pertaining to whether the plan is providing benefits in accordance with mental health parity.

No Surprises Act

The No Surprises Act protects employees from surprise medical bills (balance billing, out-of-network cost-sharing) when they receive emergency care, non-emergency care from out-of-network providers at in-network facilities, and air ambulance services from out-of-network providers. Beginning January 1, 2022, if you receive plan-covered services that are also covered by the No Surprises Act, your cost-sharing will be the same as if you had received those services from an in-network provider. The Plan will also provide continuity of coverage for continuing care patients where a termination of a provider's contractual arrangement changes the network status of the provider.

Qualified Medical Child Support Orders (QMSCOs)

According to Federal law, you might be required to enroll your children in the Plan due to a Qualified Medical Child Support Order (QMCSO), including a National Medical Support Order (NMSO). These are support orders of a court or state administrative agency that usually results

from a divorce or legal separation. The Benefits Office has the following QMCSO Procedures described below.

A Qualified Medical Child Support Order is a judgment, decree or order (issued by a court or resulting from a state's administrative proceeding) that creates or recognizes the rights of a child, also called the "alternate recipient," to receive benefits under a group health plan, typically the non-custodial parent's plan. (A QMCSO also includes a National Medical Support Notice.) A QMCSO usually results from a divorce or legal separation and typically:

- Designates one parent to provide for a child's health plan coverage;
- Indicates the name and last known address of the parent required to provide the coverage and the name and mailing address of each child covered by the QMCSO;
- Contains a reasonable description of the type of coverage to be provided under the designated parent's health care plan or the manner in which such type of coverage is to be determined;
- States the period for which the QMCSO applies; and
- Identifies each health care plan to which the QMCSO applies.

An order is not a QMCSO if it requires the Plan to provide any type or form of benefit or any benefit option that the Plan does not otherwise provide, except as required by a state's Medicaid-related child support laws. For a state administrative agency order to be a QMCSO, state statutory law must provide that such an order will have the force and effect of law, and the order must be issued through an administrative process established by state law.

If a court or state administrative agency has issued an order with respect to health care coverage for any child of the Member, the Plan Administrator or its designee will determine if that order is a QMCSO as defined by federal law. That determination will be binding on the Member, the other parent, the child, and any other party acting on behalf of the child. The Plan Administrator or its designee will notify the parents and each child if an order is determined to be a QMCSO, and if the Member is covered by the Plan, and advise them of the procedures to be followed to provide coverage for the child(ren).

If the Plan has determined that an order is a valid QMCSO it will accept enrollment of the alternate recipient as of the earliest possible date following the date the Plan determined the order was valid, without regard to typical enrollment restrictions. The Benefits Office will accept enrollment of the alternate recipient specified by the QMCSO from either the Member or the custodial parent. Coverage of the alternate recipient will become effective as of the date specified on the QMCSO or if not specified, the date the enrollment request and required documentation are received by the Plan Administrator. If you have not enrolled in the Plan, you will be required to enroll when you enroll your child. Coverage will be subject to all of the Plan's otherwise applicable terms, provisions, limitations and rules.

No coverage will be provided for any alternate recipient under a QMCSO unless the all of the Plan's requirements for enrollment and coverage of that alternate recipient have been satisfied.

Generally, coverage under the Plan terminates for an alternate recipient when the period of coverage required under the QMCSO ends or for the same reasons coverage terminates under the

Plan for other children. This includes termination of coverage for failure to pay any required contributions. When coverage terminates, alternate recipients may be eligible for COBRA Continuation Coverage. See the COBRA Continuation of Coverage section for more information.

6. How the Plan is Administered

Plan Operations and Administration

Because benefits under the Plan are provided both through insurance contracts and on a self-funded basis, the Plan is administered by the ASRS (for the insured and self-funded Component Benefit Programs) and the insurance companies (for the insured Component Benefit Programs).

The ASRS is the Plan Administrator. As the Plan Administrator, the ASRS is responsible for satisfying certain legal requirements with respect to the Plan (for example, distributing certain notices).

The principal duty of the Plan Administrator is to see that the Plan functions according to its terms and for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, authorizing benefit payments, and gathering information necessary for administering the Plan. The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s), and expressly describes the nature and scope of the delegated responsibility.

To the fullest extent permitted by law, the Plan Administrator, and any other fiduciary with respect to the Plan to the extent that such individual or entity is acting in its fiduciary capacity, shall have full and sole discretionary authority to interpret all plan documents and to make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan (including Component Benefit Programs), and to determine all questions arising in connection with the administration, interpretation, and application of the Plan (including Component Benefit Programs), including the eligibility and coverage of individuals and the authorization or denial of payment or reimbursement of benefits.

Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties. Any interpretation, determination, or other action of the Plan Administrator shall be subject to review only if it is arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator makes, in its sole discretion and, further, constitutes agreement to the limited standard and scope of review described by this section.

The ASRS will bear its incidental costs of administering the Plan.

Power and Authority of Insurance Companies

Certain benefits under the Plan are fully insured. These benefits are provided under group insurance contracts entered into between the ASRS and the applicable insurance companies.

Claims for benefits under these component programs are submitted to the insurance companies. The insurance companies, not the ASRS, are responsible for determining and paying claims.

The insurance companies are responsible for (a) determining eligibility for a benefit and the amount of any benefits payable under the Plan; and (b) providing the claims procedures to be followed and the claims forms to be used by eligible individuals with respect to insured component benefits under the Plan. (See the Claims Procedures section below for more information about claims.)

As the named fiduciary for benefit determinations for the insured component benefits, the insurance companies, to the fullest extent permitted by law, have the discretionary authority to interpret the Plan in order to make benefit determinations. The insurance companies also have the authority to require eligible individuals to furnish them with such information as they determine necessary for the proper administration of the Plan.

7. Circumstances That May Affect Benefits

Denial, Loss, and Recovery of Benefits

Your benefits (and the benefits of your covered family members) will cease when your participation in the Plan terminates, including upon termination of the Plan.

Other circumstances can result in the termination, reduction, or denial of benefits. The Plan also has the right to recover overpaid benefits and to seek subrogation or reimbursement in certain circumstances and with respect to certain Component Benefit Programs. The applicable Governing Documents provide additional information about the termination, denial, or loss of benefits, and about the Plan's recovery, subrogation, and reimbursement rights.

Plan Termination

Benefits will cease upon termination of the Plan.

Coordination of Benefits

As noted above (see Section 2), there are eligibility restrictions for individuals enrolled in other health plans (known and "Dual Enrollment"). Dual Enrollment eligibility is determined by the Arizona State Retirement System and applicable State of Arizona law. In the event this and another plan provide coverage, Coordination of benefits (COB) provisions establish the order in which plans pay their claims, and permits secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses. COB under the Plan is determined in accordance with the COB rules of the applicable Component Benefit Program. Before relying on the coordination of benefits and dual coverage descriptions, participants should first make a determination whether dual coverage eligibility exists. Contact the Arizona State Retirement System for assistance.

8. Amendment or Termination of the Plan

The ASRS, as Plan Sponsor, has the right to amend or terminate the Plan at any time. The Plan may be amended or terminated by a written instrument duly adopted by the ASRS or any of its delegates. For this purpose, amending the Plan includes making changes to a Component Benefit Program. Terminating a Component Benefit Program (including terminating an insurance contract through which such benefits are provided) is not a termination of the Plan. Rather, it is an amendment to the Plan.

The ASRS may sign insurance contracts for this Plan, including amendments to those contracts, and may adopt (by a written instrument) amendments to the Plan that he or she considers to be administrative in nature or advisable to comply with applicable law.

9. Claims and Appeals Information

Eligibility determinations to participate in a Component Benefit Program are made by the ASRS. Appeals of plan eligibility determinations are handled by the ASRS following its rules. For claims and appeals regarding benefits provided through a Component Benefit Program, the ASRS has delegated to each contracted plan provider or insurer the authority to interpret and apply the terms of each Component Benefit Program. The contracted plan provider or insurer shall be the Claims Administrator for their respective Component Benefit Programs. For a complete explanation of your rights regarding specific benefits claims and appeals under a Component Benefit Program, please refer to the relevant Governing Documents. These materials, outlining the claims and appeals procedures for each of these plans are provided when your enroll, without charge, as separate documents.

Eligibility Determinations and Appeals

The ASRS makes initial eligibility determinations for enrollment in the various Component Benefit Programs. If you disagree with an initial eligibility determination, you have the right to appeal the ASRS determination. You may initiate this appeal process by writing a letter of appeal to Plan Administrator whose contact information is listed on the Quick Reference Chart in this document. Details regarding the process for appealing eligibility determinations are available at www.azasrs.gov/content/member-appeals.

Claims and Appeals for Benefits Under Component Benefit Programs

For purposes of determining the amount of and entitlement to benefits of the Component Benefit Programs, the respective contracted plan provider or insurer is the Claims Administrator and fiduciary under the Plan, and has the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable Component Benefit. To obtain benefits of a Component Benefit Program, you must follow the claims procedures. (See relevant Governing Document for more information.)

The Claims Administrator will decide your claim in accordance with its reasonable claims procedures, as required by applicable law. The Claims Administrator has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim. If the Claims Administrator denies your claim in whole or in part, you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the Claims Administrator for a review of the denied claim. The Claims Administrator will decide your appeal in accordance with its reasonable claims procedures, as required by applicable law. If you do not appeal on time, you may lose your right to file suit in a state or federal court, because you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing suit in state or federal court). Note that under certain Component Benefit Programs you may also have the right to obtain external review (that is, review outside of the Plan). See the relevant Summary Plan Description or Evidence of Coverage document for more information about the claims process for insured benefits.

Claims Deadline

Unless specifically provided otherwise in a Component Benefit Program or pursuant to applicable law, a claim for benefits under this Plan (including the Component Benefit Programs) must be made within one year after the date the expense was incurred that gives rise to the claim. It is the responsibility of the Participant or covered family member, or his or her designee, to make sure this requirement is met.

Limitations on Filing Suit

Unless specifically provided otherwise in a Component Benefit Program or pursuant to applicable law, a lawsuit for benefits under this Plan must be brought within one year after the date of a final decision on the claim in accordance with the applicable claims procedures.

Language Assistance

If you are not proficient in English and have questions about a claim denial, contact the Plan Administrator to find out if assistance is available.

- SPANISH (Español): Para obtener asistencia en Español, llame al 800-621-3778.
- TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 800-621-3778.
- CHINESE (中文): **如果需要中文的帮助**，请拨打这个号码 800-621-3778.
- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800-621-3778.

10. General Information

Plan Amendments or Termination of Plan

The ASRS reserves the right to amend or terminate this Plan, or any part of it, at any time without advance notice to participants. This includes the discretionary right to interpret, revise, supplement or rescind any or all portions of the Plan.

Amendments to the Plan may be made in writing by the ASRS and become effective upon the date as may be specified in the document amending the Plan.

The Plan or any coverage under it may be terminated by the ASRS, and new coverages may be added by the ASRS. Upon termination, discontinuance or revocation of participation in the Plan, all elections and reductions in compensation related to the Plan will terminate.

Allocation and Disposition of Assets Upon Termination

In order for the ASRS to carry out its obligation to provide the maximum possible benefits to all Participants within the limits of its resources, the Plan Administrator has the right to take any of the following actions, even if claims that have already accrued are affected:

- To terminate any benefits provided by these Plan Rules.
- To alter or postpone the method of payment of any benefit.
- To amend or rescind any provision of these Plan Rules.

In addition, the Plan may be terminated by the Plan Administrator, provided that the termination is not effective until 60 days after the mailing of such notice. In the event the Plan terminates, the Plan Administrator, in its full discretion, will determine the disposition of any assets remaining after all expenses of the Plan have been paid; provided that any such distribution will be made only for the benefit of former participants and for the purposes set forth in the Plan. Upon termination of the Plan, the Plan Administrator (with full power) will continue in such capacity for the purpose of dissolution of the Plan.

Non-Assignment

The Plan and the Plan Sponsor categorically prohibit and will not accept in any circumstance any assignment or attempt to assign any benefits claims, right to coverage, or any other type of claims, regardless of the nature of such claims and any attempt to do so will be void and will not apply. Benefits payable shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge by any person, including the Participant, a Dependent or creditor of the Participant without the express written permission of the Plan Sponsor; however, a Participant may direct that benefits due him/her, be paid to a Health Care Provider in consideration for hospital, medical, dental and/or vision care services rendered, or to be rendered.

The payment of benefits to a healthcare provider shall be done solely as a convenience and does not constitute an assignment of any right under this Plan or under any law, is not authority to act on a Participant's behalf in pursuing and appealing a benefit determination under the Plan, is not an assignment of rights respecting anyone's fiduciary duty, is not an assignment of any legal or equitable right to institute any court proceeding against the Plan or the Plan Sponsor, and in no way shall be construed or interpreted as a waiver on the Plan's and Plan Sponsor's prohibition on assignments. The Plan and Plan Sponsor are not responsible for paying healthcare provider invoices that are balance billed to a Plan Participant.

Discretionary Authority of Plan Administrator and Designees

In carrying out their respective responsibilities under the Plan, the Plan Administrator or its delegate/designee, other Plan fiduciaries, and the insurers or administrators of each Program of the Plan, have full discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. The Plan Administrator also has the discretion to make all factual determinations arising under the Plan and any claims for benefits thereunder.

Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Any interpretation or determination by the Plan Administrator or its delegate/designee, made in good faith which is not contrary to law, is conclusive on all persons affected.

Statement of the ASRS Rights

The ASRS makes no representation that employment with it represents lifetime security or a guarantee of continued employment. Further, your eligibility or rights to benefits under this Plan should not be interpreted as a guarantee of employment.

The ASRS, as Plan Sponsor, intends that the terms of this Plan described in this document, including those relating to coverage and benefits, are legally enforceable, and that each plan is maintained for the exclusive benefit of participants, as defined by law.

Any written or oral statement other than a written statement signed by any agent of the ASRS that is contrary to the provisions of this subchapter **is invalid**, and no prospective, active or former employee or retiree should rely on any such statement.

The terms of this Plan Document supersede the terms of any contrary information about the Plan, or the Plan's eligibility, benefits, limits or exclusions that is provided orally or in writing to a participant by an employer or anyone other than the Plan Administrator.

No Liability for Practice of Medicine

The Plan, Plan Administrator or any of their designees are **not** engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you by any Health Care Provider. Neither the Plan, Plan Administrator, nor any of their designees, will have any liability whatsoever for any loss or injury caused to you by any Health Care Provider by reason of negligence, by failure to provide care or treatment, or otherwise.

Right of Plan to Require a Physical Examination

The Plan reserves the right to have the person, who is totally disabled or who has submitted a claim for benefits and is undergoing treatment under the care of a Physician, to be examined by a Physician selected by the Plan Administrator or its designee at any time during the period that benefits are extended under this Plan. This right extends to the right and opportunity to request an autopsy or other forensic exam in case of death where it is not forbidden by law. The cost of such an examination will be paid by the Plan. The Plan's right to require a physical examination does not extend to the individual's eligibility to enroll or continued eligibility to participate in the Plan.

Type of Administration

The ASRS self-funds medical and prescription drug benefits under the Plan for some Component Benefit Programs. Claims for these benefits are administered by independent claims administrators as listed on the Quick Reference Chart section. The funding for the benefits is derived from the Arizona State Retirement System Health Trust.

Independent insurance companies (whose name and address are listed on the Quick Reference Chart in the front of this document) administer the fully insured benefits of this Plan (including the Dental PPO and Dental HMO benefits) and provide payment of claims associated with these benefits.

Claims Review Fiduciary (Claims Administrator)

Benefit Programs	**Funding**	**Claims Administrator** (Contact information listed on the Quick Reference Chart in the front of this document)
Medical (pre-Medicare)	Self-funded	UnitedHealthcare
Prescription Drug (pre-Medicare)	Self-funded	UnitedHealthcare
Medical (Medicare Advantage)	Insured	UnitedHealthcare
Prescription Drug (Medicare Advantage)	Insured	UnitedHealthcare

Benefit Programs	Funding	Claims Administrator (Contact information listed on the Quick Reference Chart in the front of this document)
Dental PPO	Insured	Delta Dental
Dental HMO	Insured	Cigna

No Guarantee of Tax Consequences

Notwithstanding any provision in the Plan (including the Component Benefit Programs) to the contrary, neither the Plan nor the ASRS makes any commitment or guarantee that any amounts paid to or on behalf of a Participant under the Plan will be excludable from gross income for federal or state income tax purposes.

Governing Law

The Plan shall be construed and enforced according to the laws of Arizona, except to the extent required by federal law.

Severability

In the event that any provision of this Plan (including the Component Benefit Programs) is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining provisions of this Plan. The provision shall be fully severable. The Plan shall be construed and provisions enforced as if such invalid or illegal provision had never been part of the Plan.

NOTICE REGARDING WELLNESS PROGRAM

The Real Appeal program is a voluntary wellness program available to all enrollees in the ASRS medical plan. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You are not required to complete the HRA or otherwise provide medical information.

However, Participants who choose to participate in the wellness program will receive an incentive of a success kit including a weight and food scale, exercise DVDs, personal blender, and personalized coaching for losing weight and keeping it off. Although you are not required to complete the HRA or otherwise provide medical information, only Participants who do so will receive the incentive.

The information from your HRA will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as personalized coaching. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and the ASRS may use aggregate information it collects to design a program based on identified health risks in the workplace, Real Appeal will never disclose any of your personal information either publicly or to the ASRS, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) the health coaches in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the ASRS at 800-621-3778.

11. HIPAA Privacy and Security

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), requires that group health plans maintain the privacy of your personally identifiable health information (called Protected Health Information or PHI).

The term PHI includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form. PHI does not include health information contained in employment records held by the ASRS or an employer in its role as an employer, including but not limited to health information on disability, work-related illness/injury, sick leave, and Family and Medical Leave (FMLA).

A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices, which was distributed to you upon enrollment in the Plan and is also available from the Plan Administrator. Information about HIPAA in this document is not intended to and cannot be construed as the Plan's Notice of Privacy Practices.

The Plan, and the Plan Sponsor will not use or further disclose PHI except as necessary for treatment, payment, health care operations and Plan administration, or as permitted or required by law. In particular, the Plan will not, without your written authorization, use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

Except as permitted by HIPAA, the Plan will only use or disclose your PHI for marketing purposes or sell (exchange) your PHI for remuneration (payment), with your written authorization. The Plan may disclose PHI to the Plan Sponsor for the purpose of reviewing a benefit claim, appeal or for other reasons related to the administration of the Plan.

The Plan's Use and Disclosure of PHI

The Plan will use PHI, without your authorization or consent, to the extent and in accordance with the uses and disclosures permitted by the privacy regulations under the HIPAA. Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations (sometimes referred to as TPO), as defined below.

- Treatment is the provision, coordination, or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your health care providers. The Plan rarely, if ever, uses or discloses PHI for treatment purposes.

- Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits with activities that include, but are not limited to, the following:

- Determination of eligibility, coverage, cost sharing amounts (e.g. cost of a benefit, Plan maximums, and copayments as determined for an individual's claim), and establishing Member contributions for coverage;

- Claims management and related health care data processing, adjudication of health benefit claims (including appeals and other payment disputes), coordination of benefits, subrogation of health benefit claims, billing, collection activities and related health care data processing, and claims auditing; and

- Medical necessity reviews, reviews of appropriateness of care or justification of charges, utilization management, including precertification, concurrent review and/or retrospective review.

- Health Care Operations includes, but is not limited to:

  - Business planning and development, such as conducting cost-management and planning-related analyses for the management of the Plan, development or improvement of methods of payment or coverage policies, quality assessment, patient safety activities;

  - Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions;

  - Underwriting (the Plan does not use or disclose PHI that is genetic information as defined in 45 CFR 160.103 for underwriting purposes as set forth in 45 CFR 164.502(a)(5)(1)), enrollment, premium rating, and other activities relating to the renewal or replacement of a contract of health insurance or health benefits, rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;

  - Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

  - Business management and general administrative activities of the Plan, including, but not limited to management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification, customer service, resolution of internal grievances, or the provision of data analyses for policyholders, Plan sponsors, or other customers.

When an Authorization Form is Needed

Generally, the Plan will require that you sign a valid authorization form (available from the Plan Administrator) in order for the Plan to use or disclose your PHI other than when you request your own PHI, a government agency requires it, or the Plan uses it for treatment, payment or health care operations or other instance in which HIPAA explicitly permits the use or disclosure without authorization.

When the Plan Will Disclosure PHI to the Plan Sponsor

The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions. With respect to PHI, the Plan Sponsor agrees to:

Not use or disclose the information other than as permitted or required by the Plan Document or as required by law;

Ensure that any agents, including their subcontractors, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information. This Plan hires professionals and other companies, referred to as Business Associates, to assist in the administration of benefits. The Plan requires these Business Associates to observe HIPAA privacy rules;

- Not use or disclose the information for employment-related actions and decisions;
- Not use or disclose the information in connection with any other benefit or employee benefit Plan of the Plan Sponsor, (unless authorized by the individual or disclosed in the Plan's Notice of Privacy Practices);
- Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- Make PHI available to the individual in accordance with the access requirements of HIPAA;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- Make available the information required to provide an accounting of PHI disclosures;
- Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of the Dept. of Health and Human Services (HHS) for the purposes of determining the Plan's compliance with HIPAA;
- If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
- Notify you if a breach of your unsecured protected health information (PHI) occurs.

In order to ensure that adequate separation between the Plan and the Plan Sponsor is maintained in accordance with HIPAA, only the following employees or classes of employees may be given access to use and disclose PHI:

1. The Plan Administrator,
2. Staff designated by the Plan Administrator

3. Business Associates under contract to the Plan including but not limited to the medical claims administrator, preferred provider organization network, utilization management company.

The persons described above may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan. If these persons do not comply with this obligation, the Plan Sponsor has designed a mechanism for resolution of noncompliance. Issues of noncompliance (including disciplinary sanctions as appropriate) will be investigated and managed by the Plan's Privacy Officer, whose address and phone number are listed on the Quick Reference Chart in the front of this document.

Hybrid Entity

For purposes of complying with the HIPAA Privacy rules, this Plan is a "hybrid entity" because it has both group health plan functions (a health care component of the entity) and non-group health plan functions. The Plan designates that its health care group health plan functions are covered by the privacy rules. The health care group health plan functions include the self-funded medical plan options with outpatient prescription drug benefits, and COBRA administration.

HIPAA Security

In compliance with HIPAA Security regulations, the Plan Sponsor will:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the group health plan,

- Ensure that the adequate separation discussed in D above, specific to electronic PHI, is supported by reasonable and appropriate security measures,

- Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and

- Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

12. Definitions

"Claims Administrator" means the person or persons delegated responsibility and fiduciary authority by the ASRS to administer claims and appeals under the different Component Benefit Programs.

"Component Benefit Program" is a vehicle through which the Plan provides substantive rights to benefits. Each Component Benefit Program is summarized in a Summary Plan Description and/or Evidence of Coverage document, insurance contract, plan document, or another governing document.

"Dependent" means an individual, such as a Member's spouse, children, or other family members, who may be eligible to participate in and receive benefits under one or more of the Component Benefit Programs due to their relationship to a Member.

"**Member**" means a person who participates in the Arizona State Retirement System (ASRS), Public Safety Personnel Retirement System (PSPRS), Elected Officials' Retirement Plan (EORP), Corrections Officer Retirement Plan (CORP), or the Optional Retirement Plans of the Arizona University System (ORP).

"**Participant**" means a Member who is retired or on Long Term Disability, or their Dependent who are covered under the Plan.

"Plan" means the Arizona State Retirement System Health Plan.

"**Plan Administrator**" means the Arizona State Retirement System (ASRS).

"**Plan Sponsor**" means the Arizona State Retirement System (ASRS).

"**Plan Year**" means the 12-month period beginning each January 1 and ending each December 31.