Mandatory Retirement and Long-term Disability

Faculty and staff must complete enrollment in mandatory retirement and long-term disability insurance plans within 30 calendar days of their hire/eligibility date if they are expected to work 20 hours or more per week for 20 weeks in a fiscal year [ARS §38-711(23), §38-727].

Classified Staff and University Staff Category 01
You must participate in the Arizona State Retirement System (ASRS) and long-term disability plans.

Faculty, Administrators, Academic Professionals and University Staff Category 02, 03, 04 or 05
You can choose to participate in either the Arizona State Retirement System (ASRS) or the Optional Retirement Plan (ORP) and the respective long-term disability plan.

IMPORTANT: Your initial election is irrevocable for the duration of your continuous employment in the Arizona University System, as long as you remain in an ORP-eligible position. Failure to elect a retirement plan during the 30-day enrollment period will forfeit your option to participate in the ORP Plan and result in ASRS participation.

Police Officers and Recruits
You must participate in the Public Safety Personnel Retirement System (PSPRS) and the respective long-term disability plan.

Postdoctoral Scholars
You are not eligible to participate in the mandatory ASRS, ORP or PSPRS plans [ARS §38-727(6)]; however, if you are benefits-eligible, you are automatically enrolled in the respective long-term disability plan effective on your hire/eligibility date. At any time, you may enroll in the voluntary retirement plans.

Undergraduate and Graduate Student Employees
F-1, J-1, M-1 and Q-1 Visa Holders
You are not eligible to participate in the mandatory retirement or long-term disability plans. At any time, you may enroll in the voluntary retirement plans.

Age 65 or Older Opt-out Option
If you meet the following criteria and want to decline participation in the ASRS and ORP, complete the ASRS 65+ Membership Waiver Form and fax to HR Retirement at 480-993-0008 within one week of employment. You must be:

- age 65 or older;
- not an active, inactive, disabled or retired ASRS member; AND
- hired on or after Aug. 2, 2012.

Enrollment and Participation Effective Dates

INSTRUCTIONS: cfo.asu.edu/hr-enrollmentpackets

Within 30 calendar days of eligibility or written notice, your mandatory retirement plan (ASRS, ORP or PSPRS) enrollment must be completed and submitted to the OHR Benefits Design and Management department.

- Arizona State Retirement System (ASRS) retirement and long-term disability participation begins on the first day of the pay period following a 182-calendar day waiting period. ASRS Participation Dates
  EXCEPTION: If you have an active ASRS account or were hired before July 20, 2011, participation begins on your hire or eligibility date. Retroactive contributions may be required.

- Optional Retirement Plan (ORP) and long-term disability participation begins on the first day of the pay period following completion of enrollment.
  NOTE: Completed enrollment means you elected ORP through the enrollment website OR you submitted a completed election form to OHR Benefits AND you established an ORP account with your chosen investment provider.

- Public Safety Personnel Retirement System (PSPRS) and long-term disability participation begins on the first day of eligible employment.
Voluntary Retirement

Faculty, staff and student employees in all job classifications may enroll in the Voluntary 403(b) Plan and/or Deferred Compensation 457(b) Plan at any time. MORE INFO: Benefits Guide | Retirement

NO WAITING PERIOD - ENROLL TODAY

Benefits

Faculty and staff may enroll in health, life, short-term disability, flexible spending accounts and/or the health savings account (if enrolled in the Aetna HSA Option) benefit plans within 30 calendar days of their hire/eligibility date if they are regularly scheduled to work 20 hours or more per week for 90 days or longer.

- Coverage is effective the first day of the pay period following the hire/eligibility date and completion of enrollment, whichever is later, provided enrollment is completed within 30 calendar days of hire or eligibility date. Benefits are not effective on the hire or eligibility date.

- COMPLETION OF ENROLLMENT means submittal of a completed Benefits Enrollment/Change Form and supporting documentation within 30 calendar days of hire/eligibility date, whether coverage is elected or waived. DO NOT DELAY the submission of this form, even if you are waiting to receive the required supporting documentation. After the 30-day deadline, elections may be made only during the Annual Open Enrollment period or with a qualified life event.

NOTE: Allow 10 business days for benefits processing following completion of enrollment.

INSTRUCTIONS: cfo.asu.edu/hr-enrollmentforms

Mandatory Retirement and Benefits for Rehires and Transfers

Coverage and enrollment for rehired or transferred employees within the Arizona University System (ASU, ABOR, NAU and UA) or from an Arizona state agency are as follows:

- If you are rehired within 30 days of separation from benefits-eligible employment, your coverage may be effective on your date of hire. An enrollment form is required, BUT elections must remain the same.

- If you are transferred within 30 days of separation from benefits-eligible employment, your coverage may be effective on your hire date or the first day of the pay period following termination of prior coverage, whichever is later. There may be a lapse in coverage. An enrollment form is required, BUT elections must remain the same.

- If you are rehired after 30 days but before one year following separation, an enrollment form is required. You may make new elections (except for flexible spending accounts). Your coverage is effective the first day of the pay period following:
  1. your rehire date and
  2. receipt of the enrollment form and required supporting documents
Eligible Dependents

A. Your legal spouse
B. Your child (who is not eligible for coverage through their employer) is defined as:
   a. Your natural, adopted and/or stepchild who is under 26 years old.
   b. A person under the age of 26 for whom you have court-ordered guardianship
   c. Your foster children under the age of 26
   d. A child placed in your home by court order pending adoption
   e. Your natural, adopted and/or stepchild
      i. Who was disabled as defined by 42 U.S.C. 1382C before the age of 26;
      ii. Who continues to be disabled as defined by 42 U.S.C. 1382c;
      iii. Who is dependent for support and maintenance upon you;
      iv. For whom you had custody before the child was 26.

Dependent Eligibility Documentation Requirements

A. If you enroll a spouse whose last name is different from yours, coverage will not be processed until supporting documentation is provided to OHR Benefits Design & Management. A marriage certificate is acceptable documentation.
B. If you enroll a dependent child(ren) whose last name is different from yours, coverage will not be processed until supporting document is provided to OHR Benefits Design & Management. Acceptable documentation includes a birth certificate, adoption papers, court guardianship papers or a marriage certificate establishing the relationship of a stepchild.
C. If you enroll a spouse or dependent child for coverage on the medical, dental and/or vision plans, you must provide his/her Social Security Number (SSN) to OHR Benefits Design & Management. If your dependent is not eligible for an SSN due to visa status, you must provide substantiating documentation.
D. If your disabled dependent child is approaching age 26, application for continuation of dependent status must be made within 30 calendar days of the child's 26th birthday. You must provide verification to your insurance carrier that your dependent child has a qualifying permanent disability that occurred prior to his or her 26th birthday, in accordance with 42 U.S.C 1382c. Acceptable documentation: SSA/SSI notification indicating the disability and the date of determination.
E. All dependent eligibility documentation must be translated to English, if applicable.

Dependent Eligibility Documentation Deadlines

- **New hires:** Within 30 calendar days of your HRIS start date (not your contract effective date).
- **Newly-eligible faculty and staff:** Within 30 calendar days of your HRIS benefits-eligible position effective date.
- **Qualified life events:** Within 30 calendar days of the qualified life event effective date.
- **Open enrollment:** Within 30 calendar days of the first day of the annual open enrollment period.

**Note:** Failure to submit documentation by the deadline may result in the withdrawal of that dependent's coverage, and you may be responsible for any paid claims.

Qualified Medical Child Support Order (QMCSO)

You may not terminate coverage for a dependent covered by a QMCSO.

If You and Your Spouse Are Both University or State Employees

You cannot enroll as a single subscriber and be enrolled as a dependent on your spouse's policy simultaneously. If you do enroll in this manner, no refunds will be made for the employee contributions.
Correcting or Updating Dependent Data

To correct or update dependent data in HRIS, you must submit a completed Dependent Data Update Form with a copy of the following required documentation to OHR Benefits Design & Management by secure fax, hand-delivery to OHR at the University Center, or US mail (refer to Plan Contacts section of this Guide).

<table>
<thead>
<tr>
<th>Dependent</th>
<th>Correction Needed</th>
<th>Required Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse</td>
<td>Name</td>
<td>Driver’s license or state-issued ID card</td>
</tr>
<tr>
<td></td>
<td>Date of birth</td>
<td>Driver’s license, state-issued ID card or birth certificate</td>
</tr>
<tr>
<td></td>
<td>SSN</td>
<td>Social Security card</td>
</tr>
<tr>
<td></td>
<td>Ineligible for SSN</td>
<td>F2/J2 visa document</td>
</tr>
<tr>
<td>Child</td>
<td>Name</td>
<td>Birth certificate, legal document, driver’s license or state-issued ID card</td>
</tr>
<tr>
<td></td>
<td>Date of Birth</td>
<td>Birth certificate, driver’s license or state-issued ID card</td>
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<tr>
<td></td>
<td>SSN</td>
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</tr>
<tr>
<td></td>
<td>Ineligible for SSN</td>
<td>F2/J2 visa document</td>
</tr>
</tbody>
</table>

**NOTE:** Federal law requires Social Security numbers for all dependents covered by an employer-sponsored medical, dental and/or vision plan.

Eligibility Audit

The State of Arizona Benefit Services Division may audit a member’s documentation to determine whether an enrolled dependent is eligible according to the state-sponsored plan requirements. This audit may occur either randomly or in response to uncertainty concerning dependent eligibility.
This notice contains important information about your right to continue your health care coverage and other health coverage alternatives that may be available through the Health Insurance Marketplace.

What is continuation coverage?

Federal law requires that most group health plans (including this Plan) give employees and their eligible dependents the opportunity to continue their health care coverage when there is a “qualifying event” that would result in a loss of coverage under an employer’s plan. Depending on the type of qualifying event, “qualified beneficiaries” can include the employee (or retired employee) covered under the group health plan, the covered employee’s spouse, and the dependent children of the covered employee.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open enrollment and special enrollment rights.

How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued for up to a total of 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee’s becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary (note: there are limitations on plans’ imposing a preexisting condition exclusion and such exclusions will become prohibited beginning in 2014 under the Affordable Care Act),
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B or both) after electing continuation coverage, or
- the employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of participant or beneficiary not receiving continuation coverage (such as fraud).

How can you extend the length of COBRA continuation coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify Member Services at 602.542.5008 or 800.304.3687 of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.
COBRA Continuation Coverage Rights

You or another member of your family must notify the ADOA Benefit Services Office of the disability determination by the Social Security Administration before the end of the 18 month COBRA coverage period. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Plan of that fact within 30 days after SSA's determination.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent's child ceasing to be eligible for coverage as a dependent under the Plan.

These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

How can you elect COBRA continuation coverage?

To elect continuation coverage, you must complete the State of Arizona Benefit Options COBRA Enrollment Form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

When and how must payment for COBRA continuation coverage be made?

First payment for continuation coverage
If you elect continuation coverage, you do not have to send any payment with the Enrollment Form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) COBRA begins the day after your active coverage ends and is not effective until payment is made. If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct.

You may contact Member Services at 602.542.5008 or 800.304.3687 to confirm the correct amount of your first payment.
Periodic payments for continuation coverage
After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in this notice. The periodic payments can be made on a monthly basis.

Under the Plan, each of these periodic payments for continuation coverage is due on the 1st day for that coverage period. You may instead make payments for continuation coverage for the following coverage periods, due on the following dates: If you make a periodic payment on or before the first day of the coverage period to which it applies your coverage under the Plan will continue for that coverage period without any break. Billing statements are mailed as a courtesy.

If you do not receive a bill, you may call Member Services at 602.542.5008 or 800.304.3687 for assistance.

Grace periods for periodic payments
Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation 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.

IMPORTANT: If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

Make your first payment (check or money order), out to:
ADOA – HITF for continuation coverage and send it to:
Arizona Department of Administration – Benefit Services c/o COBRA
100 N. 15th Ave., #103
Phoenix, AZ 85007
Phone: 602-542-5008 or 800-304-3687

Send all periodic payments for continuation coverage to:
Arizona Department of Administration – Health Insurance Trust Fund (HITF)
100 N. 15th Ave., #202
Phoenix, AZ 85007
Phone: 602-542-5008 or 800-304-3687

Plan Administrator
Arizona Department of Administration – Benefit Options
100 N. 15th Ave., #103
Phoenix, AZ 85007
Phone: 602-542-5008 or 800-304-3687

Declining COBRA coverage
To decline COBRA coverage, return the COBRA enrollment form with the “I decline COBRA coverage’ option marked. COBRA coverage will not be available to you once it is declined.

If you fail to return an enrollment form, your right to COBRA coverage will expire after 60 days from the date on this notice

QUESTIONS?
www.benefitoptions.az.gov (Click on COBRA in the left-hand navigation bar)
www.cms.gov (Search for Cobra continuation coverage)
More information

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator.

If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, contact:

**Arizona Department of Administration – Benefit Services Office**
100 N. 15th Ave., #103
Phoenix, AZ 85007
Phone: 602-542-5008 or 800-304-3687

For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, visit:

**U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) website**
[www.dol.gov/ebsa](http://www.dol.gov/ebsa)
**Toll-free number:** 1.866.444.3272

There may be other coverage options for you and your family. When key parts of the health care law take effect, you’ll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premiums, deductibles and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage or a tax credit through the Marketplace.

**ADDITIONAL DETAILS**
Health insurance options available through a Health Insurance Marketplace
[www.healthcare.gov](http://www.healthcare.gov)

You also may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse’s plan), even if the plan generally does not accept late enrollees, as long as you request enrollment within 30 days of loss of other coverage.

**Keep Your Plan Informed of Address Changes**

To protect your and your family's rights, you should keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.
Accidental Death and Dismemberment (AD&D)
A type of insurance through which your beneficiary will receive money if your death is accidental or if you are accidentally injured in a specific way.

Actively at Work
Plan provision that requires the employee to be performing the duties of the occupation where the employee normally works for coverage to commence. If the employee is absent due to illness or injury, the coverage does not commence until the employee returns. This rule does not include adding a newborn to health insurance (such as an employee on maternity leave) nor does it extend to absences for annual leave provided the employee was not ill on the last scheduled day before annual leave.

Aggregate Family Deductible
The medical plan does not begin paying the eligible medical expenses of any covered family member until the entire family deductible has been met. The family deductible may be met with expenses from one or a combination of family members.

Allowed Fees
Term used by some dental plans for their participating dentist fees and/or maximum payable for a non-participating dentist.

Appeal
A request to a plan provider for review of a decision made by the plan provider. A process in which a member is billed for the amount of a provider’s fee that remains unpaid by the insurance plan. You should never be balance billed for an in-network service; out-of-network services and non-covered services are subject to balance billing.

Balance Billing
Non-participating provider practice of billing the patient for any difference between the provider’s billed charges and the patient’s insurance plan maximum allowance (indemnity or PPO).

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

Billed Charge
The amount the provider bills for services rendered

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

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

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

Coinsurance
The division of the allowed amount to be paid by the insurance company and the patient, i.e., 80/20 or 90/10. (The first percentage is paid by the company; the second by the employee.)

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

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

Deductible
Fixed dollar amount a member pays before the health plan begins paying for covered medical services.

Dependent
An individual other than a health plan subscriber who is eligible to receive healthcare services under the subscriber’s contract.

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

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

**EPO (Exclusive Provider Organization)**
A type of health plan that requires members to use a select group of network providers.

**Exclusion**
A condition, service, or supply not covered by the health plan.

**Explanation of Benefits (EOB)**
A statement sent by a health plan to a covered person who files a claim. The EOB lists the services provided, the amount billed and the payment made. The EOB statement must also explain why a claim was or was not paid, and provide information about the individual's rights of appeal.

**Formulary**
The list that designates which prescriptions are covered and at what copay level.

**Generic Drug**
A drug that is chemically equivalent to a brand name drug whose patent has expired and which is approved by the Federal Food and Drug Administration (FDA).

**Grievance**
A written expression of dissatisfaction about any benefits matter other than a decision by a plan provider.

**HSA (Health Savings Account)**
An account that allows individuals to pay for current health expenses and save for future health expenses on a tax-free basis. Only certain plans are HSA-eligible.

**ID Card**
The card provided to you as a member of a health plan. It contains important information such as your member identification number.

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

**Indemnity Plan**
A medical or dental plan that allows you to choose any licensed provider to receive care. Members are reimbursed for eligible medical or dental expenses according to the benefit schedule in effect, including deductibles and coinsurance.

**Long-term Disability**
A type of insurance through which you will receive a percentage of your income if you are unable to work for an extended period of time because of a non-work-related illness or injury.

**Mail-order Pharmacy**
A service through which members may receive prescription drugs by mail.

**Mandatory Retirement Plan**
Arizona law requires certain government employers to provide defined benefit and/or contribution retirement plans to eligible employees.

**Member**
A person who is enrolled in the health plan.

**Medically Necessary**
Services or supplies that are, according to medical standards, appropriate for the diagnosis.

**Member Services**
A group of employees whose function is to help members resolve insurance-related problems.

**Network**
The collection of contracted healthcare providers who provide care at a negotiated rate.

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

**Out-of-pocket Maximum**
The annual amount the member will pay before the health plan pays 100% of the covered expenses. Out-of-pocket amounts do not carry over year to year.

**Over-the-counter (OTC) Drug**
A drug that can be purchased without a prescription.

**PPO (Preferred Provider Organization)**
A type of health plan that allows members to use out-of-network providers but gives financial incentives if members use in-network providers.

**Pre-Authorization**
The process of becoming approved for a healthcare service prior to receiving the service.

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

**Pre-existing Condition**
A condition diagnosed and/or treated prior to the effective date of your coverage or for which a prudent person would have been treated.
**Preferred Provider**
A provider who has signed an agreement with the insurance carrier not to charge more than the insurer’s allowed fees.

**Preferred Provider Organization (PPO) Plan**
A plan that provides benefits in an indemnity fashion, but pays a higher percentage of the cost of services if patients use a PPO-network provider versus non-PPO providers.

**Preventative Care**
The combination of services that contribute to good health or allow for early detection of disease.

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

**Short-Term Disability**
A type of insurance through which you will receive a percentage of your income if you are unable to work for a limited period of time because of a non-work-related illness or injury.

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

**Supplemental Life**
Life insurance in an amount above what the state provides.

**Usual and Customary (UNC) Charges**
The standard fee for a specific procedure in a specific regional area.

**Voluntary Retirement Plan**
Arizona State University provides voluntary retirement plans to its eligible employees to encourage voluntarily participation and saving towards retirement.

**Waiting Period**
The number of calendar days that must elapse before an employee is eligible for a specific benefit.

**Waiver of Premium**
A clause in an insurance policy that waives the policyholder’s obligation to pay any further premiums should he or she become seriously ill or disabled. A waiver of premium allows a person to benefit from an insurance policy, even when he or she cannot work.
The Patient Protection and Affordable Care Act (PPACA) is a federal statute that was signed into law in March 2010. Along with the Health Care and Education Reconciliation Act of 2010, the law includes numerous health-related provisions to take effect over a four-year period, including expanding Medicaid eligibility, subsidizing insurance premiums, providing incentives for businesses to provide health care benefits, prohibiting denial of coverage/claims based on pre-existing conditions, establishing health insurance exchanges, and support for medical research. The costs of these provisions are offset by a variety of taxes, fees and cost-saving measures, such as new Medicare taxes for high-income brackets, taxes on indoor tanning, improved fairness in the Medicare Advantage program relative to traditional Medicare, and fees on medical devices and pharmaceutical companies; there is also a tax penalty for citizens who do not obtain health insurance (unless they are exempt due to low income or other reasons). The Congressional Budget Office estimates that the net effect (including the Reconciliation Act) will be a reduction in the federal deficit by $143 billion over the first decade.

Grandfather Status Notice
Our plan is a “grandfathered health plan” under PPACA. As permitted by the PPACA, a grandfathered health plan can preserve certain health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means your plan may not include certain requirements of the PPACA that apply to other plans; for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other requirements in the PPACA; for example, the elimination of lifetime limits on benefits.

Notice of Rescission
Under the PPACA, an individual’s coverage cannot retroactively be canceled or terminated, except in cases of fraud and similar situations. In the event that the plan rescinds coverage under the allowed grounds, affected individuals must be provided at least 30 days advanced notice.

Form W-2 Notice
Pursuant to the PPACA for tax years starting on and after January 1, 2011, in addition to the annual wage and tax statement employers must report the value of each employee’s health coverage on form W-2, although the amount of health coverage will remain tax-free. The W-2s due in early 2012 will be the first to report coverage costs for the prior calendar year.

THE AFFORDABLE CARE ACT MARKETPLACE
GET MORE INFO
www.healthcare.gov
800-318-2596

The Affordable Care Act Marketplace Notice
www.asu.edu/hr/documents/2013marketplacenotice.pdf

Review a summary of benefits and coverage
cfo.asu.edu/hr-health
This notice describes how medical information about you may be used and disclosed, how you may gain access to this information and the measures taken to safeguard your information. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires health plans to notify plan participants and beneficiaries about its policies and practices to protect the confidentiality of their health information. For purposes of this Notice, health information refers to any information that is considered Protected Health Information (PHI) as defined in the Privacy Rule of the Administrative Simplification provision of HIPAA.

**How the Plan May Use and Disclose Health Information**

To **make or obtain payment** or collect payment from third parties, such as other health plans or providers, for the care you receive.

To **conduct health care operations** and, as necessary, to provide coverage and services to all participants. Healthcare operations include activities such as:

- Quality assessment and improvement activities;
- Activities designed to improve health or reduce health care costs;
- Clinical guideline and protocol development, case management and care coordination;
- Contacting health care providers and participants with information about treatment alternatives and other related functions;
- Health care professional competence or qualifications review and performance evaluation;
- Accreditation, certification, licensing or credentialing activities;
- Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits;
- Reviews and auditing, including compliance reviews, medical reviews, legal services and compliance programs; and business planning and development including cost management and planning analyses and formulary development.

In addition, summary health information may be provided to third parties in connection with the solicitation of health plans or the modification or amendment of the existing plan; and

- Business management and general administrative activities, including customer service and resolution of internal grievances.

For **treatment alternatives**: To tell you about or recommend possible treatment options or alternatives that may be of interest to you.

For **distribution of health-related benefits and services** that may be of interest to you.

When legally required by any federal, state or local law.

To **conduct health oversight activities** for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. However, we may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

In **connection with judicial and administrative proceedings** in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process.

For **law enforcement purposes** for certain law enforcement purposes, including but not limited to, if there is a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

In **the event of a serious threat to your health or safety** or to the health and safety of the public.

For **specified government functions** related to the military and veterans, to national security and intelligence activities, to protective services for the president and others, and to correctional institutions and inmates.

For **workers’ compensation** to the extent necessary to comply with laws related to workers compensation or similar programs.
Your Rights with Respect to Your Health Information

Right to Authorize the Use or Disclosure of Health Information
Other than as previously stated, your health information will not be disclosed without your written authorization; you may revoke that authorization in writing at any time.

Right to Request Restrictions
You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on disclosure of your health information to someone involved in the payment of your care. However, your request is subject to approval.

Right to Receive Confidential Communications
To safeguard the confidentiality of your health information, you may request that communication be conducted in a specified manner or at a specified location. Alternatively, for example, you may request that all health information be mailed to your work location rather than your home. If you wish to receive confidential communications, please make your request in writing. Your reasonable requests will be accommodated when possible.

Right to Inspect and Copy Your Health Information
You have the right to inspect and copy your health information. If you request a copy of your health information, a reasonable fee may be charged for copying, assembling costs and, if applicable, postage associated with your request.

Right to Amend Your Health Information
If you believe that your health information records are inaccurate or incomplete, you may request that the records be amended. That request may be made as long as the information is maintained by the State of Arizona Department of Administration (ADOA). Your request may be denied if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created by ADOA, if the health information you are requesting to amend is not part of ADOA's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if it is determined the records containing your health information are accurate and complete.

Right to Request Accounting
You have the right to request a list of disclosures of your health information made for any reason other than for treatment, payment or health operations. The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time going back more than six (6) years. The first accounting you request during any 12-month period will be without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.

Right to a Paper Copy of This Notice
You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically.

The privacy of your health information as set forth in this Notice is required by law. The terms of this Notice may be changed and revised provisions will be effective for all health information maintained. If policies and procedures are changed, this Notice will be revised and you will be provided a copy of the revised Notice within 60 days of the change. You have the right to express complaints to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. You will not be penalized or retaliated against in any way for filing a complaint.
Legal Disclosures

The information contained in this Benefits Guide is designed to provide an overview of the benefits offered through Arizona State University and/or the State of Arizona. ABOR policies, ASU policies, state policies and statutes, federal regulations, plan descriptions, and vendor contracts govern benefits and retirement eligibility and coverage and are subject to modification or termination at any time. Please read the applicable documents for complete information.

Persons with a disability may request reasonable accommodation if this information is needed in an alternate format by contacting the HR Employee Service Center at 480-965-2701.

Arizona Senate Bill 1614

Effective July 20, 2011, this bill establishes a 90-day waiting period for health/welfare benefits and a 182-day waiting period for Arizona State Retirement System (ASRS) participation.

Arizona House Bill 2002

Effective September 12, 2013, this budget bill eliminates the requirement that university employees wait 90 days for health/welfare benefits.

Autism Coverage

Arizona state law prohibits some group health plans from denying coverage, imposing dollar limits, or charging higher deductible/copays based solely on the diagnosis of autism spectrum disorder. It also requires plans to cover the cost of behavior therapy up to $50,000 per year for a child up to age 19 and $25,000 per year of a child age 9–16.

Genetic Information Nondiscrimination Act (GINA)

Under federal law, group health plans are prohibited from adjusting premiums or contribution amounts for a group on the basis of genetic information. A health plan is also prohibited from requiring an individual or his/her family member to undergo a genetic test, although the plan may request that a voluntary test be taken for research purposes.

HEART Act

In accordance with the Heroes Earnings Assistance and Relief Tax Act of 2008, qualified military reservists who participate in a flexible spending account (FSA) program may withdraw FSA funds (and avoid the use-it-or-lose-it rules) when they are called to active duty for 180 days or more or for an indefinite period. The withdrawal must be made during a period beginning on the day the reservist is called to active duty and ending on the last day of the coverage period of the FSA plan that occurs during the period of active duty.
Designating Your Benefits Plan Beneficiaries

If you fail to designate a beneficiary for applicable plans, benefits will be paid in accordance with the Plan documents. You may change your beneficiaries at any time by going to:

My ASU > My Employment > Benefits > My Benefits Summary.

Designating Your Retirement Plan Beneficiaries

- ORP and 403(b) plan beneficiary designations are made directly with Fidelity, TIAA-CREF and/or VALIC.
- 457(b) plan beneficiary designations are made directly with Nationwide Retirement Solutions.
- ASRS beneficiary designations are made directly with the ASRS.
- PSPRS beneficiary designations are made through ASU using a standard PSPRS-issued form; contact HR Benefits.
# Plan Contacts

<table>
<thead>
<tr>
<th>NAME</th>
<th>CONTACT</th>
<th>OTHER INFO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ASU and Arizona Department of Administration (ADOA) Benefit Services Division</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>ASU Benefits</strong></td>
<td>Ask HR</td>
<td>cfo.asu.edu/hr-benefits</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Secure FAX</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Benefits/Leaves 480-993-0007</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Retirement 480-993-0008</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Hand Delivery</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1100 E. University Drive, Building A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tempe, AZ</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>U.S. Mail</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>PO Box 871304</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tempe, AZ 85287-1304</td>
</tr>
<tr>
<td><strong>ASU HR Employee Services</strong></td>
<td>855-278-5081</td>
<td><a href="mailto:HRESC@asu.edu">HRESC@asu.edu</a></td>
</tr>
<tr>
<td><strong>ASU Faculty Services</strong></td>
<td>480-727-9900</td>
<td><a href="mailto:HRESC@asu.edu">HRESC@asu.edu</a></td>
</tr>
<tr>
<td><strong>ADOA Benefit Options</strong></td>
<td>602-542-5008</td>
<td>benefitoptions.az.gov</td>
</tr>
</tbody>
</table>

## DISABILITY (Long- and Short-term)

### Long-term Disability Plans

| **Sedgwick CMS** (ASRS participants) | 800-495-9301 | www.vpaweb.com |
| **The Hartford** (ORP/PSPRS and Postdoctoral Scholars) | 866-712-3443 | groupbenefits.thehartford.com/arizona |
| | Policy # | GLT-395211 |

### Short-term Disability Plans

| **Unum** | 800-799-4455 | unum.com |
| **The Hartford** | 866-712-3443 | groupbenefits.thehartford.com/arizona |
| | GRH-395211 |

## FLEXIBLE SPENDING ACCOUNT

| **ASIFlex** | 800-659-3035 | asiflex.com |
## HEALTH (Dental, Medical, Vision, Pharmacy)

<table>
<thead>
<tr>
<th>NAME</th>
<th>CONTACT</th>
<th>OTHER INFO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dental Plans</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Delta Dental</strong></td>
<td>602-588-3620 866-9STATE9 deltadentalaz.com</td>
<td>Policy # 77777-0000 Member# 99#</td>
</tr>
<tr>
<td><strong>Total Dental Administrators (TDAHP)</strong></td>
<td>602-381-4280 866-921-7687 <a href="http://www.tdadental.com/adoa">www.tdadental.com/adoa</a></td>
<td>Policy # 680100 Member# 99#</td>
</tr>
<tr>
<td>**Medical Networks</td>
<td>EPO, PPO, HSA**</td>
<td></td>
</tr>
<tr>
<td><strong>Aetna</strong></td>
<td>866-217-1953 Members aetna.com</td>
<td>Members Policy # 476687 Member # 99#</td>
</tr>
<tr>
<td></td>
<td>Non-members aetnastateaz.com</td>
<td>Non-members For EPO: Aetna Select (Open Access); For PPO and HSA: Aetna Choice POS II (Open Access)</td>
</tr>
<tr>
<td><strong>CIGNA</strong></td>
<td>800-968-7366 Members <a href="http://www.mycigna.com">www.mycigna.com</a> Non-members <a href="http://www.cigna.com/stateofaz">www.cigna.com/stateofaz</a></td>
<td>Policy # 3331993 Member# 99#</td>
</tr>
<tr>
<td><strong>UnitedHealthcare</strong></td>
<td>800-896-1067 Members: myuhc.com Non-members stateofaz.welcometouhc.com/home</td>
<td>Members Policy # 705963 Member # Unique (UHC assigned)</td>
</tr>
<tr>
<td><strong>Vision Plan (includes Discount Hearing Benefit)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Avesis, Inc.</strong></td>
<td>888-759-9772 avesis.com</td>
<td>Advantage Policy # 11001-2178 Plan 938 Member # Member # 99# V NOTE: You must add a V to the end of your Member# for the system to find your information Discount 10000-4</td>
</tr>
<tr>
<td><strong>EPIC Hearing</strong></td>
<td>866-956-5400</td>
<td></td>
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</tbody>
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# Plan Contacts

<table>
<thead>
<tr>
<th>NAME</th>
<th>CONTACT</th>
<th>OTHER INFO</th>
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<tbody>
<tr>
<td><strong>Pharmacy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MedImpact</td>
<td>888-648-6769</td>
<td></td>
</tr>
<tr>
<td><strong>Members</strong>:</td>
<td>mp.myrxinfo.com</td>
<td></td>
</tr>
<tr>
<td><strong>Non-members</strong></td>
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<tr>
<td>View the MedImpact Formulary List</td>
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</tr>
<tr>
<td>Walgreens Health Initiatives</td>
<td>BIN: 003585 Medical</td>
<td></td>
</tr>
<tr>
<td>Mail Order</td>
<td>866-304-2846</td>
<td>PCN 28914</td>
</tr>
<tr>
<td></td>
<td>walgreenshealth.com</td>
<td></td>
</tr>
<tr>
<td>Specialty Drugs</td>
<td>888-782-8443</td>
<td></td>
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<tr>
<td></td>
<td>walgreenshealth.com</td>
<td></td>
</tr>
<tr>
<td><strong>HEALTH SAVING ACCOUNT</strong></td>
<td></td>
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<tr>
<td>PayFlex</td>
<td>888-678-8242</td>
<td>M-F: 7am-7pm (CST)</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.payflexdirect.com">www.payflexdirect.com</a></td>
<td>SAT: 9am-2pm (CST)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>SUN: Closed</td>
</tr>
<tr>
<td><strong>LIFE INSURANCE</strong></td>
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</tr>
<tr>
<td>Aetna Life Insurance</td>
<td>800-523-5065</td>
<td>Policy#: GPO58331</td>
</tr>
<tr>
<td></td>
<td>EOI Fax: 800-792-9710</td>
<td></td>
</tr>
<tr>
<td>The Hartford</td>
<td>866-712-3443</td>
<td>Policy#: GL-395211</td>
</tr>
<tr>
<td></td>
<td>groupbenefits.thehartford.com/arizona</td>
<td></td>
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<tr>
<td><strong>MANDATORY RETIREMENT PLANS</strong></td>
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</tr>
<tr>
<td>Arizona State Retirement System (ASRS)</td>
<td>602-240-2000</td>
<td></td>
</tr>
<tr>
<td></td>
<td><a href="mailto:AskMac@azasrs.gov">AskMac@azasrs.gov</a></td>
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<td></td>
<td>azasrs.gov</td>
<td></td>
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<tr>
<td>Public Safety Personnel Retirement System (PSPRS)</td>
<td>602-255-5575</td>
<td></td>
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<tr>
<td></td>
<td>psprs.com</td>
<td></td>
</tr>
</tbody>
</table>

Schedule a One-on-One Consultation with an Investment Provider

*See page 22*
## MANDATORY RETIREMENT PLANS

### Optional Retirement Plan (ORP)

<table>
<thead>
<tr>
<th>Fidelity</th>
<th>800-343-0860</th>
<th>Plan ID 67444</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Damond Petersen 480-284-1847 <a href="mailto:Damond.J.Petersen@fmr.com">Damond.J.Petersen@fmr.com</a></td>
<td>ESTABLISH ACCOUNT nb.fidelity.com/public/nb/aus/home</td>
</tr>
<tr>
<td></td>
<td>Nathan Merrill 480-267-7079 <a href="mailto:nathan.merrill@fmr.com">nathan.merrill@fmr.com</a></td>
<td>ACCESS ACCOUNT login.fidelity.com/ftgw/Fas/Fidelity/NBPart/Login/Init?ISPBypass=true</td>
</tr>
<tr>
<td>TIAA-CREF</td>
<td>800-842-2776</td>
<td>Access Code AZQ190</td>
</tr>
<tr>
<td></td>
<td>Donn Fitch 480-350-3209 <a href="mailto:DFitch@tiaa-cref.org">DFitch@tiaa-cref.org</a></td>
<td>ESTABLISH ACCOUNT www1.tiaa-cref.org/tcm/arizona</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ACCESS ACCOUNT ais4.tiaa-cref.org</td>
</tr>
<tr>
<td>VALIC</td>
<td>800-892-5558, x89005</td>
<td>ACCESS ACCOUNT <a href="http://www.valic.com/home_3240_422903.html">www.valic.com/home_3240_422903.html</a></td>
</tr>
</tbody>
</table>

**NOTE:** Effective September 2011, Valic no longer accepts payroll-deducted contributions.

## VOLUNTARY RETIREMENT PLANS

### Arizona University System Voluntary 403(b)

<table>
<thead>
<tr>
<th>Fidelity Investments</th>
<th>SELF-SERVICE <a href="http://www.netbenefits.com/aus">www.netbenefits.com/aus</a></th>
<th>ESTABLISH ACCOUNT nb.fidelity.com/public/nb/aus/home</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Information/Technical Assistance 800-343-0860</td>
<td>ACCESS ACCOUNT login.fidelity.com/ftgw/Fas/Fidelity/NBPart/Login/Init?ISPBypass=true</td>
</tr>
<tr>
<td></td>
<td>Damond Petersen 480-284-1847 <a href="mailto:Damond.J.Petersen@fmr.com">Damond.J.Petersen@fmr.com</a></td>
<td>Plan ID 55468</td>
</tr>
<tr>
<td></td>
<td>Nathan Merrill 480-267-7079 <a href="mailto:nathan.merrill@fmr.com">nathan.merrill@fmr.com</a></td>
<td></td>
</tr>
<tr>
<td>TIAA-CREF</td>
<td>800-842-2776</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Donn Fitch 480-350-3209 <a href="mailto:DFitch@tiaa-cref.org">DFitch@tiaa-cref.org</a></td>
<td></td>
</tr>
<tr>
<td>VALIC</td>
<td>800-892-5558, x89005</td>
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</tbody>
</table>

**NOTE:** Effective July 2014, VALIC is no longer a 403(b) investment provider.
## Plan Contacts

<table>
<thead>
<tr>
<th>NAME</th>
<th>CONTACT</th>
<th>OTHER INFO</th>
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<tbody>
<tr>
<td><strong>VOLUNTARY RETIREMENT PLANS continued</strong></td>
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<tr>
<td><strong>Deferred Compensation 457(b)</strong></td>
<td></td>
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</tr>
<tr>
<td>Nationwide Retirement Solutions</td>
<td>800-796-9753</td>
<td>ACCESS ACCOUNT</td>
</tr>
<tr>
<td></td>
<td>Leah Halonen 602-293-1170 480-236-6412 cell <a href="mailto:halonel@nationwide.com">halonel@nationwide.com</a></td>
<td>arizonadc.com</td>
</tr>
<tr>
<td></td>
<td>Jacklyn Ferner 888-401-5272 480-236-6412 cell <a href="mailto:nrsforu@nationwide.com">nrsforu@nationwide.com</a></td>
<td>Access Code ASU</td>
</tr>
<tr>
<td><strong>VOLUNTARY BENEFITS</strong></td>
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<tr>
<td><strong>Home and Auto</strong></td>
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<tr>
<td>MetLife Home and Auto</td>
<td>800-438-6388</td>
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<tr>
<td></td>
<td>metlife.com/mybenefits</td>
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<tr>
<td><strong>Long-term Care Insurance</strong></td>
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<tr>
<td>Unum</td>
<td>800-227-4165</td>
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</tr>
<tr>
<td></td>
<td>unuminfo.com/arizonastate/index.aspx</td>
<td></td>
</tr>
<tr>
<td><strong>Travel Assistance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Hartford</td>
<td>800-243-6108</td>
<td>395211</td>
</tr>
<tr>
<td></td>
<td>groupbenefits.thehartford.com/arizona</td>
<td></td>
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<tr>
<td></td>
<td>(Life Planning &amp; Services tab)</td>
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</table>

## Schedule a One-on-One Consultation with an Investment Provider

<table>
<thead>
<tr>
<th>NAME</th>
<th>CONTACT</th>
<th>OTHER INFO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fidelity</strong></td>
<td>800-642-7131</td>
<td>fort.fidelity.com</td>
</tr>
<tr>
<td>ORP and 403(b)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Nationwide</strong></td>
<td>602-293-1170</td>
<td>asu.MyRetirementAppt.com</td>
</tr>
<tr>
<td>457(b)</td>
<td><a href="mailto:halonel@nationwide.com">halonel@nationwide.com</a></td>
<td></td>
</tr>
<tr>
<td><strong>TIAA-CREF</strong></td>
<td>866-548-3705</td>
<td><a href="http://www.tiaa-cref.org/public/secure/advice">www.tiaa-cref.org/public/secure/advice</a></td>
</tr>
<tr>
<td>ORP and 403(b)</td>
<td></td>
<td><a href="mailto:dfitch@tiaa-cref.org">dfitch@tiaa-cref.org</a></td>
</tr>
</tbody>
</table>