

# OPEN ENROLLMENT

FY 2009/2010

C.O.B.R.A.

# What's new?



STARTS  
MAY 18<sup>TH</sup>

ENDS  
MAY 29<sup>TH</sup>

EMPLOYEE HEALTH INSURANCE PROGRAM

## MEDICAL PLAN SUMMARY CHART

Benefit Provision	CIGNA Medical Group High (CMG High):	CIGNA Medical Group Low (CMG Low):	Open Access Plus In-Network (OAPIN):
Type of Plan	<i>HMO</i>	<i>HMO</i>	<i>HMO</i> with Open Access to Specialists
Service Area Where Care Must be Received	Maricopa County only, except for emergency care	Maricopa County only, except for emergency care	Nationally
Residency Requirement	Must work or reside in Maricopa County	Must work or reside in Maricopa County	None
Primary Care Physician (PCP) Required	Yes; May only use PCP's who practice in CIGNA Medical Group Centers	Yes; May only use PCP's who practice in CIGNA Medical Group Centers	No
Referral Required	Yes, except to obstetrician/gynecologist, urgent care, emergency care, chiropractic care, & alternative medicine	Yes, except to obstetrician/gynecologist, urgent care, emergency care, chiropractic care, & alternative medicine	No
Out-of-Network Coverage	No	No	No
Network	AZ-CIGNA Medical Group Network AZ812	AZ-CIGNA Medical Group Network AZ812	National Open Access Plus AZ300
Prior Authorization	Provider's responsibility	Provider's responsibility	Provider's responsibility

Find out how the plans work and compare plans to determine which plan works best for you. Log on to [www.mycignaplans.com](http://www.mycignaplans.com) between May 4, 2009 through June 30, 2010 using **Open Enrollment ID:** *Maricopa2009* and **Open Enrollment password:** *cigna*

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## MEDICAL PLAN SUMMARY CHART

Benefit Provision	Open Access Plus High (OAP High):	Open Access Plus Low (OAP Low):	Choice Fund-HSA <sup>1</sup> :
Type of Plan	<i>HMO</i> with Open Access to Specialists	<i>HMO</i> with Open Access to Specialists	<i>High-deductible PPO</i> plan with partially funded Health Savings Account <sup>1</sup>
Service Area Where Care Must be Received	Nationally	Nationally	Nationally
Residency Requirement	None	None	None
PCP Required	No	No	No
Referral Required	No	No	No
Out-of-Network Coverage	Yes	Yes	Yes
Network	National Open Access AZ300	National Open Access AZ300	National Preferred Provider Network AZ011
Prior Authorization	Provider's responsibility when in-network. Your responsibility when out-of- network. 50% penalty for no prior authorization.	Provider's responsibility when in-network. Your responsibility when out-of- network. 50% penalty for no prior authorization.	Provider's responsibility when in-network. Your responsibility when out-of- network. 50% penalty for no prior authorization.

Find out how the plans work and compare plans to determine which plan works best for you. Log on to [www.mycignaplans.com](http://www.mycignaplans.com) between May 4, 2009 through June 30, 2010 using **Open Enrollment ID:** *Maricopa2009* and **Open Enrollment password:** *cigna*

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# MEDICAL COPAY/CO-INSURANCE COMPARISON CHART

Benefit Provision		CIGNA Medical Group High (CMG High)	CIGNA Medical Group Low (CMG Low)	Open Access Plus In-Network (OAPIN)
		<i>In-Network Coverage Only</i>		
Deductible (Only applies to inpatient and outpatient hospital facilities)	Individual	\$100	\$300	\$100
	Family	\$200	\$600	\$200
Standard Percent of Co-insurance		N/A	90%	N/A
Out-of-Pocket Maximum	Individual	\$1,000	\$5,000	\$1,000
	Family	\$2,000	\$10,000	\$2,000
Pre-existing Condition Limitation		None	None	Yes, same as for OAP High & Low Options
Preventive Care		\$0 (FREE)	\$0 (FREE)	\$0 (FREE)
Primary Care Physician Services <sup>1</sup>		\$15	\$25	\$20
Convenience Care Clinic Visit (only applies to Take Care and Care Today Clinics)		\$5	\$15	\$10
Specialty Care Physician Services		\$25* / \$40	\$45* / \$60	\$30* / \$45
Advanced Radiological Imaging: CT, PET, MRI, MRA Scans/type of scan/day and nuclear cardiac studies**		\$50	\$100	\$100
Allergy Injections		\$8* / \$23	\$13* / \$28	\$10* / \$25
Outpatient Lab and X-ray at free-standing facility		\$0	\$0	\$0
Inpatient Hospital Facility Charges		Deductible and \$100/admit	Deductible, \$500/admit, then 10%	Deductible and \$200/admit
Inpatient Physician and Surgeon's Services		\$0	\$0	\$0
Outpatient Hospital Facility Services		Deductible and \$100 copay	Deductible, \$250 copay, then 10%	Deductible and \$100 copay
Pre- & Postnatal Exams (after pregnancy has been determined)		\$25* / \$40, waived after 1st visit	\$45* / \$60, waived after 1st visit	\$30* / \$45, waived after 1st visit
Delivery - Inpatient Hospital Charge		Deductible and \$100/admit	Deductible, \$500/admit, then 10%	Deductible and \$200/admit
Urgent Care (Copay reimbursed if referred directly to Emergency Room)		\$75, waive if admitted to hospital	\$75, waive if admitted to hospital	\$75, waive if admitted to hospital
Emergency Room		\$150, waived if admitted	\$150, waived if admitted	\$150, waived if admitted
Ambulance		\$0	\$0	\$0
Durable Medical Equipment No annual limit (copay applies to each item)		\$75	\$75	\$75
External Prosthetics		\$0	\$0	\$0
Chiropractic Services, Pulmonary Rehab, Physical, Speech, Occupational and Cognitive Therapy 120 visits maximum combined/yr. except as noted		\$25/provider per day***	\$45/provider per day***	\$30/provider per day
Cardiac Rehab; 36 visits/yr.		\$25 per visit	\$45 per visit	\$30 per visit
Alternative Medicine; 20 visits/yr. \$60 credit for supplies/products		\$15 per visit	\$25 per visit	\$20 per visit
Behavioral Health/Pharmacy		Magellan/WHI		

For more detail, review the medical plan summaries on the EHI Home Page or go to [www.mycignaplans.com](http://www.mycignaplans.com) to compare plans.

\*CIGNA Care Network Specialist.

\*\*Advanced radiology copays apply in addition to inpatient, outpatient and emergency room copays or co-insurance.

\*\*\*Chiropractic visits have a separate 60 visit limit per plan year. Other therapies have a combined 60 visit limit per plan year.

<sup>1</sup>A limited number of primary care physicians are contracted with CIGNA as specialists. In this case the applicable CCN or non-CCN specialist copay applies.

# MEDICAL COPAY/CO-INSURANCE COMPARISON CHART

Open Access Plus High (OAP High)		Open Access Plus Low (OAP Low)		Choice Fund-HSA:	
In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
\$100	\$500	\$300	\$1,000	\$1,200 (cross accumulated)	\$1,200 (cross accumulated)
\$200	\$1,000	\$600	\$2,000	\$2,400 (cross accumulated)	\$2,400 (cross accumulated)
N/A	70% of reasonable & customary	90%	70% of reasonable & customary	90%	70% of reasonable & customary
\$1,500	\$3,000	\$5,000	\$10,000	\$2,000 (cross accumulated)	\$2,000 (cross accumulated)
\$3,000	\$6,000	\$10,000	\$20,000	\$4,000 (cross accumulated)	\$4,000 (cross accumulated)
12 months for treatment in prior 60 days. Waived with certificate of creditable coverage and for employees currently covered by a county medical plan for at least 12 months. Certificate of creditable coverage must be sent to CIGNA and also provided to the EHI Department.					
\$0 (FREE)	Covered in-network only	\$0 (FREE)	Covered in-network only	\$0 (FREE)	Covered in-network only
\$25	30% after deductible	\$35	30% after deductible	10% after deductible	30% after deductible
\$15	30% after deductible	\$25	30% after deductible	10% after deductible	10% after deductible
\$35* / \$50	30% after deductible	\$50* / \$65	30% after deductible	10% after deductible	30% after deductible
\$100	30% after deductible	10%	30% after deductible	10% after deductible	30% after deductible
\$13* / \$28	30% after deductible	\$18* / \$33	30% after deductible	10% after deductible	30% after deductible
\$0	30% after deductible	10%	30% after deductible	10% after deductible; \$0, no deductible if preventive	30% after deductible
Deductible and \$250/admit	30% after deductible	Deductible, \$1,000/admit, then 10%	Deductible, \$2,000/admit, then 30%	10% after deductible	30% after deductible
\$0	30% after deductible	10%	30% after deductible	10% after deductible	30% after deductible
Deductible and \$100 copay	30% after deductible	Deductible, \$500 copay, then 10%	Deductible, \$1,000 copay, then 30%	10% after deductible	30% after deductible
\$35* / \$50, waived after 1st visit	30% after deductible	\$50* / \$65, then 10%	30% after deductible	10% after deductible	30% after deductible
Deductible and \$250/admit	30% after deductible	Deductible, \$1,000/admit, then 10%	Deductible, \$2,000/admit, then 30%	10% after deductible	30% after deductible
\$75, waive if admitted to hospital	\$75, waive if admitted to hospital	\$75, waive if admitted to hospital	\$75, waive if admitted to hospital	10% after deductible	10% after deductible
\$150, waived if admitted	\$150, waived if admitted	\$150, waived if admitted	\$150, waived if admitted	10% after deductible	10% after deductible
\$0	\$0	10%	10%	10% after deductible	10% after deductible
\$75	30% after deductible	\$75 and 10%	30% after deductible	10% after deductible	30% after deductible
\$0	30% after deductible	10%	30% after deductible	10% after deductible	30% after deductible
\$35/provider per day	30% after deductible/provider per day	\$50/provider per day	30% after deductible/provider per day	10% after deductible/provider per day	30% after deductible/provider per day
\$35 per visit	30% after deductible	\$35 per visit	30% after deductible	10% after deductible	30% after deductible
\$25 per visit	Covered in-network only	\$35 per visit	Covered in-network only	\$15 per visit	Covered in-network only
Magellan/WHI				CIGNA Behavioral Health/CIGNA Pharmacy	

For more detail, review the medical plan summaries on the EHI Home Page or go to [www.mycignaplans.com](http://www.mycignaplans.com) to compare plans.

\*CIGNA Care Network Specialist.

\*\*Advanced radiology copays apply in addition to inpatient, outpatient and emergency room copays or co-insurance.

## DENTAL PLAN SUMMARY CHART

Benefit Provision	EDS	CIGNA Dental*	Delta Dental**
Type of Plan	<i>DCO</i> (Dental Care Organization)	<i>PPO</i>	<i>PPO</i> (but does not use PPO network; see network below.)
Service Area Where Care Must be Received	Maricopa County	Nationally	Nationally
Residency Requirement	No	No	No
Primary Care Dentist Required	Yes, all family members must choose the same dentist	No	No
Referral Required	No	No	No
Out-of-Network Coverage	No	Yes	Yes
Network	EDS Provider Network	CIGNA Dental Network	Delta Premier Network
Prior Authorization	No	No, predetermination recommended for services over \$250	No, predetermination recommended for services over \$250
Location of Provider Directory	<a href="http://www.mydentalplan.net">www.mydentalplan.net</a>	<a href="http://www.cigna.com">www.cigna.com</a>	<a href="http://www.deltadentalaz.com">www.deltadentalaz.com</a>

\*Includes the CIGNA Dental Oral Health Integration Program®.

\*\*Includes enhanced dental benefits for pregnant women and persons with diabetes.

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# DENTAL COPAY/CO-INSURANCE COMPARISON CHART

Benefit Provision		EDS*	CIGNA Dental***		Delta Dental	
		In-Network coverage only	In and Out-of-Network coverage			
Deductible	Individual	\$0	\$50		\$50	
	Family	\$0	\$100		\$100	
Annual Individual Benefit Maximum	Standard	None	\$2,000		\$2,000	
	Orthodontic	None	\$3,000		\$3,000	
Pre-existing Condition Limitation		Procedures in progress at time of enrollment are not covered	5 year waiting period for replacement (major services)		5 year waiting period for replacement (major services)	
<b>Class I - Preventive Care Services</b>			<b>Amount Paid by the Member</b>			
Preventive Care Routine Cleanings Sealants Space Maintainers		\$0 \$12/tooth \$20 + lab fees	In-Network	Out-of-Network**	In-Network	Out-of-Network**
			Deductible waived			
			\$0	20%	\$0	\$0
Diagnostic Exams Evaluations Consultations & X-rays		Copay \$0-\$20	Deductible waived			
			\$0	20%	\$0	\$0
			Deductible waived			
Emergency Palliative Treatment Treatment for the relief of pain		Up to \$200 reimbursement less applicable copay	Deductible waived			
			\$0	20%	\$0	\$0
<b>Class II - Basic Restorative Services</b>			<b>Amount Paid by the Member</b>			
Restorative Fillings		Amalgam \$8-\$21 Resin \$22-\$40	Amalgam 20%	Amalgam 40%	Amalgam 20%	Amalgam 20%
			Resin 50%	Resin 50%	Resin 50%	Resin 50%
Oral Surgery Extractions		From \$35	20%	40%	20%	20%
Endodontics Root Canal Treatment Pulpotomy		Copay \$170-\$265	20%	40%	20%	20%
Periodontics Treatment of gum disease Periodontal Maintenance		Debridement: \$80 Root Planing: \$90	20%	40%	20%	20%
Bridge & Denture Repair		\$10 + lab fees	20%	40%	20%	20%
<b>Class III - Major Restorative Services</b>			<b>Amount Paid by the Member</b>			
Prosthetics Bridges per pontic Partial Dentures Complete Dentures (upper or lower)		\$250 + lab fees \$375 + lab fees \$325 + lab fees	50%		50%	
			50%		50%	
			50%		50%	
Restorative Cast Crowns & Jackets Onlays & Inlays		\$250 + lab fees \$135 - \$170	50%		50%	
			50%		50%	
<b>Class IV - Orthodontic Services</b>			<b>Amount Paid by the Member</b>			
Orthodontic maximum is separate from annual benefit maximum		25% discount children & adults	50% children & adults		50% Adults & children age 8 + older	

\*Specialist Care & treatment of TMJ are offered at a discount.

\*\*If the dentist charges more than the reasonable & customary allowance, you will be liable for the difference between the allowance and the billed amount in addition to the applicable deductible and co-insurance.

\*\*\*Progressive/Regressive Base Plan. If you enroll in this plan, if you received a preventive service during FY 08-09 plan year you increase your level of coverage by 5% for Class II and Class III services for the next plan year.

For more detail, review the dental plan documents on the [Benefits Dental Page](#).



## PHARMACY PLANS

### **Administered by Walgreens Health Initiatives (WHI) - Rx Bin# 603286 / Rx PCN# 01410000**

If you enroll in a medical plan, except for the Choice Fund HSA plan, you must enroll in one of the pharmacy plans below. However, you may not enroll your dependents in a pharmacy plan if they are not enrolled in your medical plan.

#### **Co-insurance Benefit Plan**

The Co-insurance benefit is a five-level plan in which a co-insurance amount (percentage of the cost<sup>1</sup> of the medication) is charged (unless the applicable minimum or maximum copay applies) based on the classification of the medication per the Preferred Medication List. The list is available on the Benefits Home page. This plan covers generic, preferred brand-name, non-preferred brand-name and specialty medication. Some medications require prior authorization or must be used in a certain order (step therapy). Quantity limits apply for certain medications. Some drugs, such as infertility, oral non-sedating antihistamines, erectile dysfunction, non-steroidal anti-inflammatory and cosmetic medications, are excluded. You are responsible for paying 100% of the contracted cost<sup>1</sup> for excluded medications.

You will be charged the minimum or maximum copay or the co-insurance amount for the medication, based on the medication's level and cost<sup>1</sup>. If you choose a non-preferred brand-name medication when a generic equivalent is available, you will also pay the difference in the cost<sup>1</sup> between the medications.

The co-insurance or the minimum or maximum copay you pay toward any covered medication apply to your out-of-pocket maximum except when a non-preferred brand name medication with a generic equivalent is purchased, the difference between the brand and the generic equivalent will not count. The out-of-pocket limit is \$1,500 for an individual and \$3,000 for a family<sup>2</sup>. Once the out-of-pocket limit is met, covered medications are paid 100% by the plan for the remainder of the plan year, except for the difference between the non-preferred brand and its generic equivalent, which will continue to be your responsibility.

Annual Out-of-Pocket Maximum \$1,500 Single / \$3,000 Family <sup>2</sup>				
	Classification	Up to 30-Day Supply		
Level 1	Generic	\$2 Minimum	25% Co-insurance <sup>1</sup>	\$12 Maximum <sup>3</sup>
Level 2	Preferred Brand	\$5 Minimum	30% Co-insurance <sup>1</sup>	\$40 Maximum <sup>3</sup>
Level 3	Non-Preferred Brand with Generic equivalent	\$40 Minimum	50% Co-insurance <sup>1</sup> + Difference between brand & generic cost	
Level 4	Non-Preferred Brand with No Generic equivalent	\$40 Minimum	50% Co-insurance <sup>1</sup>	
Level 5	Non-Preferred Brand Specialty Drugs	\$50 Copay		

<sup>1</sup> Cost of medication is calculated by average wholesale price - discount or maximum allowable cost + dispensing fee. Discount amount varies by place of service and number of days supplied. To find the lowest cost for medication between retail, Advantage90™ and mail service, go to [www.mywhi.com](http://www.mywhi.com)

<sup>2</sup> Family refers to employee and one or more covered dependents.

<sup>3</sup> Maximums are reduced when mail service is used for a 90-day supply. See information on mail service on page 24.

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Contact Walgreens Health Initiatives for additional information, or view the detailed *Pharmacy Summary Plan* document available on the Internet Benefits site at [www.maricopa.gov/benefits](http://www.maricopa.gov/benefits).

## Consumer Choice Benefit Plan

The Consumer Choice Plan has four levels of coverage:

- Level 1 is a County-funded pharmacy account. The County will place \$300 in an Individual account or \$500 in a Family account (family in this case is defined as more than 1 person covered). In terms of Family coverage, the \$500 is available to whichever family members use the pharmacy benefit on a first come, first served basis.
- Level 2 consists of the Employee deductible portion and begins when the \$300 Individual or \$500 Family amount in Level 1 is exhausted. Employees must then meet their deductible of \$300 for an Individual or \$500 for a Family before moving to the next level.
- Level 3 is traditional insurance coverage where the County pays 80% of the cost<sup>1</sup> of the medication and you pay 20% of the cost<sup>1</sup> for the remainder of the plan year.
- Level 4 is limited to specialty medications only and consists of a \$50 copayment. Specialty medication copayments are not charged or credited against any of the first 3 levels.

The Consumer Choice benefit is geared towards smart spending through the use of the most cost-effective medication. A preferred medication list (PML) is not used to manage this benefit because much of the management is up to you. Some medications require prior authorization or must be used in a certain order (step therapy). Quantity limits apply for certain medications. Some drug classes, such as infertility, cosmetics, non-sedating oral antihistamines, erectile dysfunction, and non-steroidal anti-inflammatory medications are excluded.

The amounts you pay toward any covered medication will apply to your plan year out-of-pocket maximum. The out-of-pocket maximum is \$1,500 for individual coverage or \$3,000 for family<sup>2</sup> coverage. Once the out-of-pocket maximum is met, covered prescriptions are paid 100% by the plan for the remainder of the plan year.

Annual Out-of-Pocket Maximum \$1,500 Single / \$3,000 Family <sup>2</sup>					
<i>Certain generic preventive medications are provided at no cost and are not charged or credited against any levels. List available on the EHI Home Page.</i>					
Level 1	Pharmacy Account	Individual Family <sup>2</sup>	<b>\$300 Individual</b> <b>\$500 Family</b>	100% Employer paid <sup>1</sup>	Any unused amount is carried over to next plan year
Level 2	Employee Responsibility	Individual Family <sup>2</sup>	<b>\$300 Individual</b> <b>\$500 Family</b>	100% Employee paid <sup>1</sup>	
Level 3	Traditional Insurance Coverage			20% <sup>1</sup> covered by Employee	80% <sup>1</sup> covered by Employer
Level 4	Specialty Drug	\$50 copay; does not apply to pharmacy account, employee responsibility or insurance levels; Copay applies to out-of-pocket maximum.			

<sup>1</sup> Cost of medication is calculated by average wholesale price - discount or maximum allowable cost + dispensing fee. Discount amount varies by place of service and number of days supplied. To find the lowest cost for medication between retail, Advantage90™ and mail service, go to [www.mywhi.com](http://www.mywhi.com)

<sup>2</sup> Family refers to employee and one or more covered dependents.

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**Co-insurance Benefit Plan & Consumer Choice Benefit Plan**

**THREE-MONTH SUPPLY AT CERTAIN RETAIL PHARMACIES – ADVANTAGE90™** When you need maintenance medications for chronic or long-term health conditions, you must purchase a three-month supply at any pharmacy located in a retail pharmacy participating in Advantage90™ or through mail service, after two fills of 30 or less days supply of a maintenance medication at a retail pharmacy. The physician must write your prescription for an 84-91 day supply. Refer to [www.mywhi.com](http://www.mywhi.com) for a list of pharmacies participating in Advantage90™. Your co-insurance cost for a three-month supply at an Advantage90™ retail pharmacy may be slightly less than three times the one-month supply copay or co-insurance.

**THREE-MONTH SUPPLY THROUGH THE MAIL SERVICE PHARMACY** Prescriptions for maintenance medications or long-term health conditions can be ordered through the Walgreens Mail Service pharmacy. Besides being convenient, you could save more money! Maximum copayments and co-insurance percentages for the Co-insurance plan are reduced when mail service is used. Level One (generic) has 15% co-insurance with a maximum of \$28, and Level Two (preferred brand) has 25% co-insurance with a maximum of \$70. For the Consumer Choice Plan, you may save money as many of the medications, especially generics, have a higher discounted contracted cost than medications filled at a retail or Advantage90™ pharmacy. You must use a specific order form when placing your first order so as to provide Walgreens Mail Service with important health, allergy and plan information. This form is called the Tempe Registration and Order Form and is available online at the [Benefits Home Page](#) or at [www.mywhi.com](http://www.mywhi.com).

If purchasing medication in a three-month supply is financially problematic, please consider enrolling in the Choice Fund HSA medical plan that uses the CIGNA pharmacy plan and does not require you to purchase maintenance medication in three-month quantities.

**Note:** Diabetic supplies and medications may be obtained at a CIGNA Medical Group pharmacy for \$10 per item for a 30-day supply. Please show your CIGNA ID card since these costs will be charged to your medical plan instead of your pharmacy plan.


**Administered by CIGNA - Rx Bin# 600428 / Rx PCN# 02150000**

**CIGNA Pharmacy Plan for Choice Fund HSA Plan**

If you enrolled in the Choice Fund HSA Medical plan, your pharmacy benefit is provided through CIGNA instead of WHI. The CIGNA plan consists of three-levels where co-insurance is charged after the deductible is met except for preventive medications. The cost of medication will vary per pharmacy. Refer to [www.mycigna.com](http://www.mycigna.com) for a cost comparison tool located under “My Plans-Pharmacy” tab. The tool is called “Prescription Drug Price Quotes”. By clicking on this link, you will be able to get the cost of your prescriptions drugs, check for generic drug equivalents, and find out if a specific drug is covered.

<b>CIGNA Pharmacy Plan for Choice Fund HSA Plan</b>		
Level 1	Generic	30% after deductible
Level 2	Preferred Brand	40% after deductible
Level 3	Non-Preferred Brand	50% after deductible
Certain generic and preferred brand preventive medications are provided at no cost (Deductible does not apply to these preventive medications).		

The pharmacy benefit for Choice Fund HSA is administered by:



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# BEHAVIORAL HEALTH & SUBSTANCE ABUSE BENEFIT

## *Behavioral Health & Substance Abuse Benefit Administered by Magellan Health Services*

If you enroll in a medical plan, except for the Choice Fund HSA plan, you will automatically be enrolled in the behavioral health and substance abuse benefit plan administered by Magellan Health Services. This benefit provides services that support your well-being, and to help you deal with a wide range of issues, including but not limited to:

- Depression
- Severe stress and anxiety
- Alcohol or drug dependency
- Eating disorders
- Grief and loss

Through these services you can receive confidential counseling whenever you and/or your eligible dependents are faced with a personal challenge. Protecting your confidentiality is Magellan's top priority. All records, including personal information, referrals and evaluations, are kept confidential in accordance with federal and state laws.

For more information regarding the Magellan behavioral health and substance abuse benefit, claims payment, to obtain prior authorization or to find a participating provider, contact Magellan, 24 hours a day, seven days a week at 1-888-213-5125.

### Behavioral Health Summary

Level of Care	In-Network Benefit	In-Network Rules	Out-of-Network Benefit	Out-of-Network Rules
<b>Inpatient Hospitalization</b>	30 days per year are shared between in and out-of-network benefits \$25 co-pay per day	Preauthorization required	30 days per year are shared between in and out-of-network benefits \$500 deductible Plan pays \$250 per day after deductible is met. All other costs after plan payment of \$250 are member's responsibility	Preauthorization required It is the member's responsibility to obtain preauthorization for initial and concurrent reviews Failure to obtain pre-authorization results in no reimbursement
<b>Partial Hospitalization</b>	Benefit is derived from trading unused inpatient hospitalization days for up to 30 partial hospitalization days per year 30 partial day per year are shared between in and out-of-network benefits Trade at 2 partial days for 1 inpatient day \$20 co-pay per day	Preauthorization required	Benefit derived from trading unused inpatient hospitalization days for up to 30 partial hospitalization days per year 30 partial days per year are shared between in and out-of-network benefits Trade at 2 partial days for 1 inpatient day \$250 deductible Plan pays \$125 per day after deductible. All costs after plan payment of \$125 are member's responsibility	Preauthorization required It is the member's responsibility to obtain preauthorization for initial and concurrent reviews Failure to obtain preauthorization results in no reimbursement
<b>Residential</b>	60 days per year \$12.50 co-pay per day	Preauthorization required	No benefit	N/A
<b>Intensive Outpatient (IOP)</b>	45 IOP visits per year are shared between in and out-of-network benefits \$100 co-pay per program	Preauthorization required \$100/program co-pay applies to a continuous episode of care in IOP. If patient discontinues & restarts program, a new \$100 co-pay is applied	45 IOP visits per year are shared between in and out-of-network benefits Plan pays \$40 per visit. All other costs after plan payment of \$40 per visit are member's responsibility	Preauthorization required It is the member's responsibility to obtain preauthorization for initial and concurrent reviews Failure to obtain preauthorization results in no reimbursement
<b>Outpatient therapy (individual, family, and medication evaluation)</b>	30 visits per year are shared between in and out-of-network benefits \$20 co-pay per visit	Preauthorization required	30 visits per year are shared between in and out-of-network benefits Plan pays \$25 per visit. All other costs after plan payment of \$25 per visit are member's responsibility	No preauthorization
<b>Outpatient Group Psychotherapy</b>	60 visits per year are shared between in and out-of-network benefits \$5 co-pay per visit	Preauthorization required	60 visits per year are shared between in and out-of-network benefits Plan pays \$15 per visit. All other costs after plan payment of \$15 per visit are member's responsibility	No preauthorization
<b>Ongoing Medication Management</b>	\$10 co-pay per visit Not subject to Outpatient visit limits	Preauthorization required	Plan pays \$25 per visit. All other costs after plan payment of \$25 per visit are member's responsibility Not subject to Outpatient visit limits	No preauthorization
<b>Lifetime Maximums</b>	No lifetime maximum		\$5 million lifetime maximum	

For details about the Magellan behavioral health and substance abuse benefit, you may refer to the Behavioral Health Benefits Summary on the Internet Benefits site at [www.maricopa.gov/benefits](http://www.maricopa.gov/benefits).

**Behavioral Health & Substance Abuse Benefit for the Choice Fund HSA Plan Administered by CIGNA**

If you enrolled in the Choice Fund HSA Medical plan, you are automatically enrolled in the behavioral health and substance abuse benefit administered through CIGNA instead of Magellan Behavioral Health.

**Behavioral Health Benefits for CIGNA Choice Fund HSA Plan**

Mental Health and Substance Abuse	In-network	Out-of-network
Inpatient	90% after plan deductible; 60 days combined maximum per plan year	70% after plan deductible; 60 days combined maximum per plan year
Outpatient	90% after plan deductible; 20 visits combined maximum per plan year	70% after plan deductible; 60 days combined maximum per plan year
Outpatient Group Therapy Mental Health (MH) <i>(One group therapy session equals one individual therapy session)</i>	90% after plan deductible	Subject to the same co-insurance and medical plan deductible as Outpatient MH visits
Intensive Outpatient Mental Health <i>Maximum: Up to 3 programs per plan year based on ratio of 1:1 with outpatient MH visits</i>	50% after plan deductible	50% after plan deductible



# VISION PLAN

## *Administered by EyeMed Vision Care*

If you enroll in any County medical plan, you must enroll (cannot waive) in the vision benefit. The County also offers this plan as a separate (stand-alone) vision plan for employees who choose to waive their medical benefits and wish to enroll in the vision plan. However, you may not enroll your dependents in a vision plan if they are not enrolled in your medical plan.

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
<b>Exam with Dilation as Necessary</b>	\$10 Copay	\$35
<b>Exam Options:</b> Standard Contact Lens Fit and Follow-Up*		
Premium Contact Lens Fit and Follow-Up**	Up to \$40 10% off retail price	N/A N/A
<b>Frames:</b> Any available frame at provider location	\$130 allowance, 20% off balance over \$130	\$50
<b>Standard Plastic Lenses:</b> Single Vision	\$10 Copay	\$25
Bifocal	\$10 Copay	\$40
Trifocal	\$10 Copay	\$55
Lenticular	\$10 Copay	\$55
<b>Lens Options:</b> UV Coating	\$15	N/A
Tint (Solid and Gradient)	\$15	N/A
Standard Scratch-Resistance	\$15	N/A
Standard Polycarbonate	\$0	\$25
Standard Anti-Reflective Coating	\$45	N/A
Standard Progressive (Add-on to Bifocal)	\$65	N/A
Other Add-ons and Services	20% off retail price	N/A
<b>Contact Lenses:</b> (Contact lens allowance covers materials only)	\$0 Copay, \$130 allowance, 15% off balance over \$130	
Conventional	\$0 Copay, \$130 allowance, plus balance over \$130	\$130
Disposable	\$130	\$130
Medically Necessary	\$0 Copay, Paid-in-Full	\$250
<b>Laser Vision Correction</b>	\$150 allowance; once per lifetime per eye	N/A
<b>Frequency:</b> Examination	Once every 12 months	
Frame	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	

\*Standard Contact Lens Fitting - spherical clear contact lenses in conventional wear and planned replacement (Examples include but not limited to disposable, frequent replacement, etc.)

\*\*Premium Contact Lens Fitting - all lens designs, materials and specialty fittings other than Standard Contact Lenses (Examples include toric, multifocal, etc.)

### **Additional Discounts:**

Member will receive a 20% discount on items not covered by the plan at network providers, which may not be combined with any other discounts or promotional offers, and the discount does not apply to EyeMed Provider's professional services, or contact lenses. Retail prices may vary by location. Discounts do not apply for benefits provided by other group benefit plans. Allowances are one-time use benefits; no remaining balance. Lost or broken materials are not covered. Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the annual benefit has been used.

Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA vision. Since Lasik or PRK vision correction is an elective procedure, performed by specially trained providers, this discount may not always be available from a provider in your immediate location. For a location near you and the discount authorization please call 1-877-5LASER6.

After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at [www.eyemedvisioncare.com](http://www.eyemedvisioncare.com). The contact lens benefit allowance is not applicable to this service.



# July 1, 2009 Maricopa County Monthly COBRA Premiums

Monthly Total Rates for Non-Tobacco Users  
(Medical, pharmacy, behavioral health, vision)

Add \$40.80 per household for tobacco-users (employees and/or covered dependents)

## Medical

CMG High option + Co-insurance Rx	Full-time
Employee	\$471.85
Employee + Spouse	\$951.13
Employee + Child(ren)	\$783.34
Employee + Family	\$1,265.02

**CMG High**

CMG High option + Consumer Choice Rx	Full-time
Employee	\$426.93
Employee + Spouse	\$861.31
Employee + Child(ren)	\$709.31
Employee + Family	\$1,146.07

CMG Low option + Co-insurance Rx	Full-time
Employee	\$340.52
Employee + Spouse	\$686.99
Employee + Child(ren)	\$566.26
Employee + Family	\$914.35

**CMG Low**

CMG Low option + Consumer Choice Rx	Full-time
Employee	\$295.60
Employee + Spouse	\$597.17
Employee + Child(ren)	\$492.23
Employee + Family	\$795.40

OAP In-Network + Co-insurance Rx	Full-time
Employee	\$541.93
Employee + Spouse	\$1,091.62
Employee + Child(ren)	\$899.27
Employee + Family	\$1,451.79

**OAPIN**

OAP In-Network + Consumer Choice Rx	Full-time
Employee	\$497.01
Employee + Spouse	\$1,001.80
Employee + Child(ren)	\$825.24
Employee + Family	\$1,332.83

OAP High option + Co-insurance Rx	Full-time
Employee	\$567.34
Employee + Spouse	\$1,142.54
Employee + Child(ren)	\$940.71
Employee + Family	\$1,518.88

**OAP High**

OAP High option + Consumer Choice Rx	Full-time
Employee	\$522.42
Employee + Spouse	\$1,052.72
Employee + Child(ren)	\$866.67
Employee + Family	\$1,399.93

OAP Low option + Co-insurance Rx	Full-time
Employee	\$345.60
Employee + Spouse	\$696.33
Employee + Child(ren)	\$574.04
Employee + Family	\$926.43

**OAP Low**

OAP Low option + Consumer Choice Rx	Full-time
Employee	\$300.68
Employee + Spouse	\$606.51
Employee + Child(ren)	\$500.00
Employee + Family	\$807.47

Choice Fund HSA + CIGNA Rx	Full-time
Employee	\$434.05
Employee + Spouse	\$875.71
Employee + Child(ren)	\$720.75
Employee + Family	\$1,165.29

**Choice Fund HSA**

## Dental

EDS	Full-time
Employee	\$10.20
Employee + Spouse	\$19.38
Employee + Child(ren)	\$25.46
Employee + Family	\$29.34

CIGNA Dental	Full-time
Employee	\$34.31
Employee + Spouse	\$75.66
Employee + Child(ren)	\$81.84
Employee + Family	\$105.22

Delta Dental	Full-time
Employee	\$43.88
Employee + Spouse	\$96.80
Employee + Child(ren)	\$104.67
Employee + Family	\$134.58

## Stand-Alone Vision

Stand-Alone Vision	Full-time
Employee	\$10.36
Employee + Spouse	\$19.54
Employee + Child(ren)	\$20.48
Employee + Family	\$30.07



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# WHO TO CONTACT

## Maricopa County Employee Health Initiatives Department (Benefits Office)

Maricopa County Chambers Building  
301 South 4th Avenue, Suite B100  
Phoenix, Arizona 85003-2145  
(602) 506-1010  
Fax: (602) 506-2354  
TTY: (602) 506-1908

EHI Home { [www.maricopa.gov/benefits](http://www.maricopa.gov/benefits)  
Pages { <http://ebc.maricopa.gov/ehi>  
[BenefitsService@mail.maricopa.gov](mailto:BenefitsService@mail.maricopa.gov)

### Medical Plans

**CIGNA - Group #3205496**  
Customer Service - (800) 244-6224  
Pre-Enrollment Questions - (800) 401-4041  
24-Hour Health Information Line - (800) 564-8982  
HSA Banking Unit Customer Service Line - (866) 524-2483  
Well Aware Disease Management - (800) 249-6512 to enroll  
or (877) 888-3091 for questions  
Healthy Pregnancies, Healthy Babies - (800) 615-2906  
Healthy Rewards - (800) 870-3470  
[www.cigna.com](http://www.cigna.com)  
[www.mycigna.com](http://www.mycigna.com)  
[www.mycignaplans.com](http://www.mycignaplans.com)  
(username: Maricopa2009 / password:cigna)

### Pharmacy Plans\*

**Walgreens Health Initiatives - Group #512229**  
Member Services - (800) 207-2568  
Prior Authorization - (877) 665-6609  
Walgreens Mail Service Member Service - (888) 265-1953  
Mail Service Refills - (800) 797-3345  
Specialty Pharmacy - (888) 782-8443  
Medication Therapy Management - (866) 352-5310  
[www.mywhi.com](http://www.mywhi.com)

### Behavioral Health / EAP\*

**Magellan Health Services - Group# N/A**  
(888) 213-5125  
[www.magellanhealth.com](http://www.magellanhealth.com)

### Vision

**EyeMed Vision Care - Group# 9750076-Refraction;**  
9750092-LASIK; 9750118-Acute Care  
Customer Service - (866) 723-0514  
Pre-Enrollment Questions - (866) 299-1358  
LASIK - (877) 5LASER6  
[www.eyemedvisioncare.com](http://www.eyemedvisioncare.com)

### Dental

**Employers Dental Services - Group #11931-Plan #300R**  
(602) 248-8912 or (800) 722-9772  
[www.mydentalplan.net](http://www.mydentalplan.net)  
**CIGNA Dental - Group # 2465354**  
(888) 336-8258  
[www.mycigna.com](http://www.mycigna.com)  
**Delta Dental - Group # 4500**  
(602) 938-3131 or (800) 352-6132  
[www.deltadentalaz.com](http://www.deltadentalaz.com)

\*Contact CIGNA for pharmacy & behavioral health for the Choice Fund HSA plan



### Retirement

**Arizona State Retirement System - (602) 240-2000**  
Outside Phoenix - (800) 621-3778  
[www.azasrs.gov/web/index.do](http://www.azasrs.gov/web/index.do)  
**Public Safety Retirement System**  
(602) 255-5575  
[www.psprs.com](http://www.psprs.com)  
**Nationwide Retirement Solutions:**  
**Deferred Compensation**  
(602) 266-2733  
(800) 598-4457  
[www.maricopadc.com](http://www.maricopadc.com)

### Other

**Automatic Data Processing, Inc. (ADP)**  
**COBRA Administrator**  
(800) 770-7981  
<https://www.benedirect.adp.com>