



**Employee Health
Insurance Program**

What's New? C.O.B.R.A.

**FY 2010/2011
Open Enrollment**

**Starting April 19
through May 3**

Open Enrollment Material Available at:
<http://www.maricopa.gov/benefits>

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 (as licensed)	<i>HMO</i>	<i>HMO</i>	<i>HMO</i> with Open Access to Specialists (similar to a PPO)
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 starting on April 15, 2010 using ID: *Maricopa2010* and 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:
Type of Plan (as licensed)	<i>HMO</i> with Open Access to Specialists (similar to a PPO)	<i>HMO</i> with Open Access to Specialists (similar to a PPO)	<i>High-deductible PPO</i>
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.

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MEDICAL COPAY/CO-INSURANCE COMPARISON CHART

Benefit Provision		CMG High
		<i>In-Network Coverage Only</i>
Plan Deductible (These work differently for CMG, OAP and HSA Plans. See Deductible Section for details)	Single	\$250 Facility Deductible
	Family	\$500 Facility Deductible
Standard Percent of Co-insurance		N/A
Out-of-Pocket Maximum (See the Out-of-Pocket Section for details)	Single	\$1,000
	Family	\$2,000
Pre-existing Condition Limitation		None
Preventive Care		\$0 (FREE)
Primary Care Physician Services ¹		\$25
Convenience Care Clinic Visit (Only applies to Take Care and Care Today Clinics)		\$15
Specialty Care Physician Services - CCN/Non-CCN		\$35* / \$50**
Advanced Radiological Imaging: CAT, PET, MRI, MRA Scans and nuclear cardiac studies		\$50/type of scan/day***
Allergy Injections - CCN/Non-CCN		\$13* / \$28**
Independent Lab and X-ray facility		\$0
Inpatient Hospital Facility Services (including delivery)		\$50/day, 5 day max, after deductible
Inpatient and Outpatient Professional Services (Surgeon, Radiologist, Anesthesiologist, Pathologist)		\$0
Outpatient Hospital Facility Services		\$100 after deductible
Pre- & Post-natal Exams (after pregnancy has been determined)		\$35*/\$50**, waived after 1st visit
Urgent Care (Copay reimbursed if referred directly to Emergency Room)		\$75, waived if admitted to hospital
Emergency Room		\$175, waived if admitted
Ambulance		\$0
Durable Medical Equipment/Medical Supplies No annual limit (copay applies to each item)		\$75 DME; \$0 consumable supplies
External Prosthetics		\$0
Chiropractic Services, Pulmonary Rehab, Physical, Speech, Occupational and Cognitive Therapy, 120 visits maximum combined/yr. except as noted		\$50**/provider per day****
Cardiac Rehab; 36 visits/yr.		\$50** per visit
Alternative Medicine; 20 visits/yr. maximum \$60 credit for supplies/products		Same as PCP copay
Behavioral Health/Pharmacy		Magellan/Walgreens

For more detail, review the plan summaries on the Benefits Home Page under the Open Enrollment tab, Medical Section or compare plans on www.mycignaplans.com
User ID: Maricopa2010 and Password: cigna

*You pay a lower copay when you use a specialist with the CIGNA Care Network (CCN) designation.

**You pay a higher copay when you use a specialist without the CCN designataion. Not all specialties are included in the CCN. When the specialty is not included in the CCN, the higher Non-CCN copay will apply.

***Does not apply to inpatient facility services; subject to applicable place of service co-insurance & plan deductible; Associated ancillary charges are subject to the the applicable place of service co-insurance & deductible

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

¹A 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

CMG Low	OAPIN
<i>In-Network Coverage Only</i>	
\$300 Facility Deductible	\$250 Annual Deductible
\$600 Facility Deductible	\$500 Annual Deductible
10%	N/A
\$5,000	\$1,500
\$10,000	\$3,000
None	Yes, same as for OAP Low & Choice Fund-HSA Options
\$0 (FREE)	
\$35	\$30
\$25	\$20
\$55* / \$70**	\$40* / \$55**
\$100/type of scan/day***	\$100/type of scan/day***
\$18* / \$33**	\$15* / \$30**
\$0	\$0 after deductible
\$150/day, 5 day max, plus 10% after deductible	\$75/day, 5 day max, after deductible
\$0	\$0 after deductible
\$250 plus 10% after deductible	\$100 after deductible
\$55*/\$70**, waived after 1st visit	\$40*/\$55**, waived after 1st visit after deductible
\$75, waived if admitted to hospital	\$75, waived if admitted to hospital
\$175, waived if admitted	\$175, waived if admitted
\$0	\$0 after deductible
\$75 DME; \$0 consumable supplies	\$75 DME after deductible; \$0 consumable supplies after deductible
\$0	\$0 after deductible
\$70**/provider per day****	\$55**/provider per day
\$70** per visit	\$55** per visit
Same as PCP copay	Same as PCP copay
Magellan/Walgreens	

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Benefit Provision		OAP High	
		<i>In-Network</i>	<i>Out-of-Network</i>
Plan Deductible (These work differently for CMG, OAP and HSA Plans. See Deductible Section for details)	Single	\$350 Annual Deductible	\$700 (one way accumulation)
	Family	\$700 Annual Deductible	\$1,400 (one way accumulation)
Standard Percent of Co-insurance		N/A	30% of max reimbursable charge
Out-of-Pocket Maximum (Refer to the Plan Description for details)	Single	\$2,000	\$4,000
	Family	\$4,000	\$8,000
Pre-existing Condition Limitation		Yes, same as for OAP Low & Choice Fund-HSA Options	
Preventive Care		\$0 (FREE)	Covered in-network only
Primary Care Physician Services ¹		\$35	30% after deductible
Convenience Care Clinic Visit (only applies to Take Care and Care Today Clinics)		\$25	30% after deductible
Specialty Care Physician Services - CCN/Non-CCN		\$45* / \$60**	30% after deductible
Advanced Radiological Imaging: CAT, PET, MRI, MRA Scans and nuclear cardiac studies		\$100/type of scan/day***	30% ***
Allergy Injections - CCN/Non-CCN		\$18* / \$33**	30% after deductible
Independent Lab and X-ray facility		\$0 after deductible	30% after deductible
Inpatient Hospital Facility Services (including delivery)		\$100/day, 5 day max, after deductible	30% after deductible
Inpatient and Outpatient Professional Services (Surgeon, Radiologist, Anestheseologist, Radiologist)		\$0 after deductible	30% after deductible
Outpatient Hospital Facility Services		\$150 after deductible	30% after deductible
Pre- & Postnatal Exams (after pregnancy has been determined)		\$45*/\$60**, waived after 1st visit after deductible	30% after deductible
Urgent Care (Copay reimbursed if referred directly to Emergency Room)		\$75, waived if admitted to hospital	\$75, waived if admitted to hospital
Emergency Room		\$175, waived if admitted	\$175, waived if admitted
Ambulance		\$0 after deductible	\$0 after deductible
Durable Medical Equipment/Medical Supplies No annual limit (copay applies to each item)		\$75 DME after deductible; \$0 consumable supplies after deductible	30% after deductible
External Prosthetics		\$0 after deductible	30% after deductible
Chiropractic Services, Pulmonary Rehab, Physical, Speech, Occupational and Cognitive Therapy 120 visits maximum combined/yr. except as noted		\$60**/provider per day	30% after deductible/provider per day
Cardiac Rehab; 36 visits/yr.		\$60** per visit	30% after deductible
Alternative Medicine; 20 visits/yr. \$60 credit for supplies/products		Same as PCP copay	Covered in-network only
Behavioral Health/Pharmacy		Magellan/Walgreens	

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OAP Low		Choice Fund-HSA	
<i>In-Network</i>	<i>Out-of-Network</i>	<i>In-Network</i>	<i>Out-of-Network</i>
\$500 Annual Deductible	\$1,000 (one way accumulation)	\$1,200 (cross accumulated) Annual Deductible	
\$1,000 Annual Deductible	\$2,000 (one way accumulation)	\$2,400 (cross accumulated) Annual Deductible	
10%	30% of max reimbursable charge	10%	30% of max reimbursable charge
\$5,000	\$10,000	\$2,000 (cross accumulated)	\$2,000 (cross accumulated)
\$10,000	\$20,000	\$4,000 (cross accumulated)	\$4,000 (cross accumulated)
12 months if treatment was received in prior 90 days. Waived (on month by month basis) with Certificate of Creditable Coverage and for employees & dependents currently covered by a County medical plan for at least 12 months. Certificate of Creditable Coverage must be sent to CIGNA.			
\$0 (FREE)	Covered in-network only	\$0 (FREE) no deductible	Covered in-network only
\$45	30% after deductible	10% after deductible	30% after deductible
\$35	30% after deductible	10% after deductible	10% after deductible
\$60* / \$75**	30% after deductible	10% after deductible	30% after deductible
10%***	30%***	10% after deductible	30% after deductible
\$23* / \$38**	30% after deductible	10% after deductible	30% after deductible
10% after deductible	30% after deductible	10% after deductible; \$0, no deductible if preventive	30% after deductible
\$350/day, 5 day max, plus 10% after deductible	\$700/day, 5 day max, plus 30% after deductible	10% after deductible	30% after deductible
10% after deductible	30% after deductible	10% after deductible	30% after deductible
\$500 + 10% after deductible	\$1000 + 30% after deductible	10% after deductible	30% after deductible
\$60*/\$75** + 10% after deductible	30% after deductible	10% after deductible	30% after deductible
\$75, waived if admitted to hospital	\$75, waived if admitted to hospital	10% after deductible	10% after deductible
\$175, waived if admitted	\$175, waived if admitted	10% after deductible	10% after deductible
10% after deductible	10% after deductible	10% after deductible	10% after deductible
\$75 + 10% DME after deductible; \$0 consumable supplies after deductible	30% after deductible	10% after deductible	30% after deductible
10% after deductible	30% after deductible	10% after deductible	30% after deductible
\$75**/provider per day	30% after deductible/provider per day	10% after deductible/provider per day	30% after deductible/provider per day
\$75** per visit	30% after deductible	10% after deductible	30% after deductible
Same as PCP copay	Covered in-network only	\$10% after deductible	Covered in-network only
Magellan/Walgreens		CIGNA Behavioral Health/CIGNA Pharmacy	

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DENTAL PLAN SUMMARY CHART

Administered by:	Employers Dental Solutions (EDS)	CIGNA Dental*	Delta Dental**
Type of Plan	DCO (Dental Care Organization)	PPO	PPO (but does not use PPO network; see network below.)
Service Area Where Care Must be Received	Maricopa County	National	National
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	www.mydentalplan.net	www.cigna.com	www.deltadentalaz.com

*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)	
Class I - Preventive Care Services			Amount Paid by the Member			
Preventive Care		\$0 \$12/tooth \$20 + lab fees	In-Network	Out-of-Network**	In-Network	Out-of-Network**
Routine Cleanings			Deductible waived			
Sealants Space Maintainers			\$0	20%	\$0	\$0
Diagnostic		\$0-\$15	Deductible waived			
Exams Evaluations Consultations & X-rays			\$0	20%	\$0	\$0
Emergency Palliative Treatment Treatment for the relief of pain			Up to \$200 reimbursement less applicable copay	Deductible waived		
		\$0	20%	\$0	\$0	
Class II - Basic Restorative Services			Amount Paid by the Member			
Restorative		Amalgam \$9-\$21 Resin \$22-\$52	Amalgam 20%	Amalgam 40%	Amalgam 20%	Amalgam 20%
Fillings			Resin 50%	Resin 50%	Resin 50%	Resin 50%
Oral Surgery		\$35 - \$120	20%	40%	20%	20%
Extractions						
Endodontics		\$170 - \$265 \$30 - \$85	20%	40%	20%	20%
Root Canal Treatment Pulpotomy						
Periodontics		Debridement: \$80 Root Planing: \$90/quadrant	20%	40%	20%	20%
Treatment of gum disease Periodontal Maintenance						
Bridge & Denture Repair		\$10 + lab fees	20%	40%	20%	20%
Class III - Major Restorative Services			Amount Paid by the Member			
Prosthodontics		\$250 + lab fees \$375 + lab fees \$325 + lab fees	50%		50%	
Bridges per pontic Partial Dentures Complete Dentures (upper or lower)						
Restorative						
Cast Crowns & Jackets Onlays & Inlays		\$250 + lab fees \$135 - \$170				
Class IV - Orthodontic Services			Amount Paid by the Member			
Orthodontic maximum is separate from annual benefit maximum		25% discount adult & children	50% adults & childrens		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 effective July 1, 2008. If you enroll in this plan and you or your covered dependents receive a preventive service during the plan year, the level of coverage is increased for that person by 5% for Class II and Class III services for the next plan year up to a 10% maximum. If you don't receive a preventive service during the plan year, the level of coverage is decreased by 5% for these services for the next plan year. However, level of coverage will not go below that listed above.

For more detail, review the dental plan documents on the [Employee Benefits Dental Page](#), or contact the vendor (refer to "Who to Contact" section).

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PHARMACY PLANS

ADMINISTERED BY WALGREENS HEALTH INITIATIVES (WHI)

Rx Bin#603286/Rx PCN# 01410000

If you (and your dependents) enroll in a County-sponsored medical plan, except for the Choice Fund HSA plan, you (and your dependents) must enroll in one of the pharmacy plans below.

Co-insurance Benefit Plan

The Co-insurance benefit is a five-level plan in which a co-insurance amount (percentage of the cost¹ 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. This list is available on the Employee Benefits Home page. This plan covers generic, preferred brand-name, non-preferred brand-name and specialty medication. Some medication requires prior authorization or must be used in a certain order (step therapy). Quantity limits apply for certain medications. Some drug classes, 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 cost¹ for excluded medication.

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. However, if you choose a non-preferred brand-name medication when a generic equivalent is available, you will also pay the difference in the cost between the generic and non-preferred brand-name medication.

The co-insurance or the minimum or maximum copay for covered medication applies 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 family². 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 ²				
	Classification	Up to 30-Day Supply		
Level 1	Generic	\$2 Minimum	25% Co-insurance ¹	\$12 Maximum ³
Level 2	Preferred Brand	\$5 Minimum	30% Co-insurance ¹	\$40 Maximum ³
Level 3	Non-Preferred Brand with Generic equivalent	\$40 Minimum	50% Co-insurance ¹ +	Difference between NP brand & generic cost
Level 4	Non-Preferred Brand with No Generic equivalent	\$40 Minimum	50% Co-insurance ¹	
Level 5	Non-Preferred Brand Specialty Drugs	\$50 Copay		

¹ Cost of medication is calculated by average wholesale price minus discount percentage or maximum allowable cost. To find the cost for medication, go to www.mywhi.com.

² Family refers to employee and one or more covered dependents.

³ Maximums are reduced when mail service is used.

Contact Walgreens (refer to "Who to Contact" section) for additional information, or view the detailed **Pharmacy Summary Plan** description available on the Employee Benefits Home Page at www.maricopa.gov/benefits.

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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 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 meet their \$300 or \$500 deductible before moving to the next level.
- Level 3 is traditional insurance coverage where the County pays 80% of the cost and you pay the remaining 20% for the remainder of the plan year.
- Level 4 is limited to specialty medications only for which a \$50 copayment is charged. Specialty medication copayments do not apply to Levels 1 - 3.

For further clarification on the Consumer Choice Pharmacy Plan, refer to the Pharmacy Benefit Plan description found on the Employee Benefits Home page.

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, oral non-sedating antihistamines, erectile dysfunction, non-steroidal anti-inflammatory and cosmetic medications, are excluded. You are responsible for paying 100% of the cost¹ for excluded medications.

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 family² 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 ²					
<i>Certain generic preventive medications are provided at no cost and are not charged or credited against any Levels. The list is available on the Employee Benefits Home page.</i>					
Level 1	Pharmacy Account	Individual Family ²	\$300 Individual \$500 Family	100% Employer paid ¹	Any unused amount is rolled over to next plan year
Level 2	Employee Deductible	Individual Family ²	\$300 Individual \$500 Family	100% Employee paid ¹	
Level 3	Traditional Insurance Coverage			20% ¹ covered by Employee	80% ¹ covered by Employer
Level 4	Specialty Drug	\$50 copay; does not apply to Levels 1 - 3; rollover amount is not available for specialty drugs. Copay applies to out-of-pocket maximum.			

¹ Cost of medication is calculated by average wholesale price minus discount or maximum allowable cost. To find the cost of medication, go to www.mywhi.com.

² Family refers to employee and one or more covered dependents.

Contact Walgreens (refer to “Who to Contact” section) for additional information, or view the detailed **Pharmacy Summary Plan** description available on the Employee Benefits Home Page at www.maricopa.gov/benefits.

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Co-insurance & Consumer Choice Benefit Plans

THREE-MONTH SUPPLY AT WALGREENS PHARMACIES-WAG90 When you need maintenance medications for chronic or long-term health conditions, you must purchase a three-month supply at Walgreens 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.

THREE-MONTH SUPPLY THROUGH THE MAIL SERVICE- Prescriptions for maintenance medications or long-term health conditions can be ordered through the Walgreens Mail Service pharmacy. Besides being convenient, you could save money! Maximum copayments and co-insurance percentages for the Co-insurance plan are reduced when mail service is used. Level 1 (generic) has 15% co-insurance with a maximum of \$28, and Level 2 (preferred brand) has 25% co-insurance with a maximum of \$70. 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 Employee Benefits Home Page or at www.mywhi.com.

If purchasing medication in a three-month supply is financially problematic, 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. Show your CIGNA ID card since these costs will be charged to your medical plan instead of to your pharmacy plan.

PHARMACY PLAN FOR CHOICE FUND HSA PLAN

ADMINISTERED BY CIGNA - Rx Bin# 600428/Rx PCN# 02150000

If you enrolled in the Choice Fund HSA medical plan, your pharmacy benefit is provided through CIGNA. The CIGNA plan consists of three-levels where co-insurance is charged after the plan deductible is met, except for preventive medications. The cost of medication may vary by pharmacy. Refer to www.mycigna.com for a cost comparison tool located under “My Plans” tab and then the “Pharmacy” tab. Click on the link “Get a prescription drug price quote” under the “Price a Medication” heading. By clicking this link, you will be able to obtain the cost of your prescription drugs, check for generic drug equivalents, and find out if a specific drug is covered. There is not a separate premium charge for this plan because it is included in the medical premium.

CIGNA Pharmacy Plan for Choice Fund HSA Plan

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).		





BEHAVIORAL HEALTH PLAN & SUBSTANCE ABUSE BENEFIT

ADMINISTERED BY MAGELLAN HEALTH SERVICES

BEHAVIORAL HEALTH AND SUBSTANCE ABUSE

The behavioral health benefit provides services that support your well-being. These services help you deal with a wide range of issues, including:

- | | | |
|---------------------------|------------------|----------------|
| Substance abuse | Anger management | Depression |
| Severe stress and anxiety | Eating disorders | Grief and loss |

Through these services, you 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.

The table below is a summary of your benefits. **All in-network services require prior approval by Magellan before services are received.** Higher levels of care for out-of-network providers (such as inpatient, residential, intensive outpatient, and partial hospitalization) also require prior approval. However, out-of-network outpatient individual or group counseling services do not require prior approval.

For more information regarding the Magellan behavioral health and substance abuse benefit, claims payment, to obtain prior approval or to find a participating provider, contact Magellan, 24 hours a day, seven days a week. Refer to “Who to Contact” section. Claims should be mailed to: Magellan, P.O. Box 1098, Maryland Heights, MO 63043.

MAGELLAN BEHAVIORAL HEALTH AND SUBSTANCE ABUSE BENEFITS

Level of Care	In-Network Benefit	In-Network Rules	Out-of-Network Benefit	Out-of-Network Rules
Inpatient Hospitalization	30 days per year are shared between in and out-of-network benefits \$25 copay 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
Partial Hospitalization	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 copay 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
Residential	60 days per year \$12.50 copay per day	Preauthorization required	No benefit	N/A
Intensive Outpatient (IOP)	45 IOP visits per year are shared between in and out-of-network benefits \$100 copay per program	Preauthorization required \$100/program copay applies to a continuous episode of care in IOP. If patient discontinues & restarts program, a new \$100 copay 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

The information and benefits described herein are brief summaries of the County’s official plan documents and contracts that govern the plans. If there is a discrepancy between the information in this booklet and the official documents, the official documents will govern.

MAGELLAN BEHAVIORAL HEALTH AND SUBSTANCE ABUSE BENEFITS

Level of Care	In-Network Benefit	In-Network Rules	Out-of-Network Benefit	Out-of-Network Rules
Outpatient therapy (individual, family, and medication evaluation)	Unlimited visits per year \$20 copay per visit	Preauthorization required	Unlimited visits per year Plan pays \$25 per visit. All other costs after plan payment of \$25 per visit are member's responsibility	No preauthorization
Outpatient Group Psychotherapy	Unlimited visits per year \$5 copay per visit	Preauthorization required	Unlimited visits per year Plan pays \$15 per visit. All other costs after plan payment of \$15 per visit are member's responsibility	No preauthorization
Ongoing Medication Management	\$10 copay 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
Lifetime Maximums	No lifetime maximum		\$5 million lifetime maximum	
Annual Limits:	Autism coverage is limited to \$115,000 per plan year through age 9 and \$50,000 per plan year between the ages of 10-18.			

The premium for the behavioral health benefit is included in the medical premium.

CIGNA BEHAVIORAL HEALTH AND SUBSTANCE ABUSE BENEFITS FOR 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; unlimited visits per plan year	70% after plan deductible; unlimited visits 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
Annual Limits:	Autism coverage is limited to \$115,000 per plan year through age 9 and \$50,000 per plan year between the ages of 10-18.	

The premium for the behavioral health benefit is included in the medical premium.

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VISION PLAN

ADMINISTERED BY EYEMED VISION CARE

You will automatically be enrolled in the vision benefit at no additional cost to you. If enrolled in a County medical plan, enrollment in the vision benefit cannot be waived. If you waived the County medical plan, you can enroll in the vision plan.

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Exam with Dilation as Necessary	\$10 Copay	\$30
Exam Options: Standard Contact Lens Fit and Follow-Up*	Up to \$40	N/A
Premium Contact Lens Fit and Follow-Up**	10% off retail price	N/A
Frames: Any available frame at provider location	\$130 allowance, 20% off balance over \$130	\$50
Standard Plastic Lenses: Single Vision	\$10 Copay	\$25
Bifocal	\$10 Copay	\$40
Trifocal	\$10 Copay	\$55
Lenticular	\$10 Copay	\$55
Lens Options: UV Coating	\$15	N/A
Tint (Solid and Gradient)	\$15	N/A
Standard Scratch-Resistance	\$15	N/A
Standard Polycarbonate	\$0	Up to \$25
Standard Polycarbonate for Children under 19	\$0	Up to \$25
Standard Anti-Reflective Coating	\$45	N/A
Standard Progressive (Add-on to Bifocal)	\$75	Up to \$40
Premium Progressive	\$75, 80% of charge less \$120 Allowance	Up to \$40
Other Add-ons and Services	20% off retail price	N/A
Contact Lenses: (Contact lens allowance covers materials only)		
Conventional	\$0 Copay, \$130 allowance, 15% off balance over \$130	\$130
Disposables	\$0 Copay, \$130 allowance; plus balance over \$130	\$130
Medically Necessary	\$0 Copay, Paid-in-Full	\$250
LASIK and PRK Vision Correction	\$150 allowance; once per lifetime per eye	N/A
Frequency: 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.)

Acute Care Benefit: To enable continuity of eye health care services, an Acute Primary eye care program is available to you when you use a contracted provider. The purpose of this program is to provide coverage for acute eye care conditions identified as part of the vision exam as well as those progressive conditions that could result in vision loss. You are covered for urgent eye care conditions, such as ‘pink eye’, as well as those progressive conditions that result in vision loss. Treatment for chronic conditions such as glaucoma or diabetes (except refraction) must be received through your medical benefit and medical provider.

Additional Discounts

Additional Eyewear - Save up to 40% off additional complete pairs of glasses after the initial benefit has been used. Available at any participating provider.

Eye Care Supplies - Receive 20% off retail price for eye care supplies like cleaning cloths and solutions purchased at participating providers (not valid on doctor’s services or contact lenses).

Laser Vision Correction - Save 15% off the retail price or 5% off the promotional price for LASIK or PRK procedures from US Laser Network.

Replacement Contact Lens Purchases - Visit www.eyemedcontacts.com to order replacement contact lenses for shipment to your home at less than retail price.

For more detail, review the vision plan documents on the Employee Benefits Home Page, or contact EyeMed (refer to “Who to Contact” section).

The information and benefits described herein are brief summaries of the County’s official plan documents and contracts that govern the plans. If there is a discrepancy between the information in this booklet and the official documents, the official documents will govern.



July 1, 2010 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	
Employee	\$501.16
Employee + Spouse	\$997.52
Employee + Child(ren)	\$822.27
Employee + Family	\$1,326.92

CMG High

CMG High option + Consumer Choice Rx	
Employee	\$448.21
Employee + Spouse	\$891.59
Employee + Child(ren)	\$734.94
Employee + Family	\$1,186.62

CMG Low option + Co-insurance Rx	
Employee	\$360.09
Employee + Spouse	\$718.98
Employee + Child(ren)	\$593.01
Employee + Family	\$957.21

CMG Low

CMG Low option + Consumer Choice Rx	
Employee	\$307.14
Employee + Spouse	\$613.05
Employee + Child(ren)	\$505.68
Employee + Family	\$816.91

OAP In-Network + Co-insurance Rx	
Employee	\$553.08
Employee + Spouse	\$1,117.72
Employee + Child(ren)	\$919.68
Employee + Family	\$1,487.20

OAPIN

OAP In-Network + Consumer Choice Rx	
Employee	\$500.13
Employee + Spouse	\$1,011.79
Employee + Child(ren)	\$832.35
Employee + Family	\$1,346.90

OAP High option + Co-insurance Rx	
Employee	\$565.15
Employee + Spouse	\$1,151.07
Employee + Child(ren)	\$960.07
Employee + Family	\$1,548.79

OAP High

OAP High option + Consumer Choice Rx	
Employee	\$512.20
Employee + Spouse	\$1,045.14
Employee + Child(ren)	\$872.74
Employee + Family	\$1,408.49

OAP Low option + Co-insurance Rx	
Employee	\$345.77
Employee + Spouse	\$703.82
Employee + Child(ren)	\$586.55
Employee + Family	\$946.22

OAP Low

OAP Low option + Consumer Choice Rx	
Employee	\$292.82
Employee + Spouse	\$597.89
Employee + Child(ren)	\$499.22
Employee + Family	\$805.92

Choice Fund HSA + CIGNA Rx	
Employee	\$413.13
Employee + Spouse	\$847.41
Employee + Child(ren)	\$694.49
Employee + Family	\$1,174.13

Choice Fund HSA

Dental

EDS	
Employee	\$10.16
Employee + Spouse	\$19.30
Employee + Child(ren)	\$25.34
Employee + Family	\$29.17

CIGNA Dental	
Employee	\$32.09
Employee + Spouse	\$70.77
Employee + Child(ren)	\$76.54
Employee + Family	\$98.41

Delta Dental	
Employee	\$45.31
Employee + Spouse	\$99.94
Employee + Child(ren)	\$108.08
Employee + Family	\$138.96

Stand-Alone Vision

EyeMed Vision Care	
Employee	\$10.93
Employee + Spouse	\$20.64
Employee + Child(ren)	\$21.62
Employee + Family	\$31.74



WHO TO CONTACT



Maricopa County Employee Benefits Division

Maricopa County Chambers Building
301 South 4th Avenue, Suite B100
Phoenix, Arizona 85003-2145

Phone: (602) 506-1010 ~ Fax: (602) 506-2354 ~ TTY: (602) 506-1908

www.maricopa.gov/benefits
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
www.mycigna.com
www.mycignaplans.com
www.cigna.com/cmgaaz
(username: Maricopa2010 / 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
Walgreens Onsite Pharmacy - (602) 283-9925
www.mywhi.com

Behavioral Health / EAP*

Magellan Health Services - Group# N/A
(888) 213-5125
www.magellanhealth.com

Vision

EyeMed Vision Care - Group# 9750076-Comprehensive Eye Exam;
9750092-LASIK; 9750118-Acute Care
Customer Service - (866) 723-0514
Pre-Enrollment Questions - (866) 299-1358
LASIK - (877) 5LASER6
www.eyemedvisioncare.com

Dental

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

Retirement

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

Other

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

ADP Dependent Audit Services

Maricopa County DAS Center
ADP - DAS
PO Box 2338
Alpharetta GA 30023-2338
(800) 553-3823
Fax: (866) 400-1686

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