

Know Your Benefits

Version 02



Sedgwick CMS



FY 2008 - 2009 Maricopa County Employee Benefit Plan



Envision living "well" into the future...

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The Information in this booklet highlights the Maricopa County benefit plans for employees and their dependents. This booklet is intended to provide you with information needed to make informed decisions regarding the selection of your benefits. The benefits described herein are summaries of the County's official plan documents and contracts that govern the plan. In the event of a discrepancy between the information in this booklet and the official documents, the official documents govern. Maricopa County reserves the right to change or cancel its benefit plans, in whole or in part, at any time.

Participation in any of the County's benefit plans is not a contract of employment.

HOW TO OBTAIN BENEFIT INFORMATION

Information about the benefit plans is available on the Internet at www.maricopa.gov/benefits or on the Electronic Business Center (EBC)/Intranet at ebc.maricopa.gov/ehi.

Both of these Web sites are referred to as the Employee Health Initiatives or EHI Home Page in this document.

You may also e-mail the EHI Department at BenefitsService@mail.maricopa.gov or, for enrollment and plan information, call 602-506-1010 from 8 a.m. to 5 p.m. MST Monday- Friday or visit the EHI Department located at 301 South 4th Avenue, Suite B100, Phoenix.

The EHI Department can assist you with general questions related to premiums, eligibility and enrollment, status changes, and benefits continuation while on or returning from a leave of absence (LOA) and/or upon retirement.

Please contact the specific vendor for answers to detailed benefit questions regarding coverage, costs and claim(s) payments. Vendor contact information is located in the "Who to Contact" section of this booklet.

The words "you" and "your," when used in this document, refer to the employee.

DISCLAIMER

Carefully read the information in this guide.

Do not make a medical or dental election solely on the basis of a healthcare provider's participation with the vendor's network because physicians and dentists may stop participating during the plan year. If a specific physician or dentist is very important to you, consider selecting a product with out-of-network benefits such as an Open Access Plus (OAP) High or Low option or Choice Fund high-deductible medical plan and/or CIGNA or Delta Dental plans. Plans with out-of-network benefits allow you to see providers who do not participate with the vendor's network, at higher out-of-pocket costs to you. Additionally, you should not make your pharmacy election solely on the basis of specific medications on the preferred medication list because medication coverage status may change during the plan year. For example, medications may change from preferred brand name level to a generic or non-preferred brand name level which would cost you more, or may become available over-the-counter and therefore will not be covered under the pharmacy benefit.

Make your election decisions carefully as they cannot be changed until July 1, 2009.

**PRINT YOUR BENEFITS ENROLLMENT SUMMARY PAGE FROM
EMPLOYEE SELF SERVICE AS YOUR VERIFICATION OF YOUR ENROLLMENT ELECTIONS.
KEEP THIS PAGE FOR VERIFICATION PURPOSES TO COMPARE
WITH YOUR CONFIRMATION STATEMENT IN THE EVENT OF AN ERROR.**

Review your confirmation statement immediately and contact EHI within 30 calendar days, if you discover an error. Only errors will be corrected. Your printed Benefits Enrollment Summary page from Employee Self Service will be accepted as verification of your enrollment elections in the event of an error.

Some plans require an election of a PCP with your initial enrollment. Watch for your new ID card in the mail and upon receipt, be sure to check the PCP. Contact your selected medical plan vendor to change your PCP, if applicable. If additional cards are needed, contact the vendor directly either by phone or through their Web site. See the "Who to Contact" section.

GLOSSARY OF TERMS

Biometric Screening Program: Provides employees with screenings for: Blood Pressure, Total/HDL Cholesterol and Ratio, Glucose, Height/Weight, Body Fat Analysis, Waist Circumference and One-on-one Health Coaching Session that includes program referrals and health education/literature on screening results.

CIGNA Care Network (CCN): A high performing cost effective specialty care provider network that includes the following provider specialties: allergy/immunology, pulmonology, vascular surgery, cardiology, neurosurgery, orthopedics and surgery, urology, general surgery, ear, nose and throat, ophthalmology, rheumatology, infectious disease, gastroenterology and dermatology. These providers are identified by a Tree of Life Symbol in the CIGNA provider directory.

CMG (CIGNA Medical Group Network): A network of providers who are employed by CIGNA HealthCare of AZ who practice in the CMG facilities that are owned and operated by CIGNA. Primary and some specialty and ancillary care are provided at the CMG facilities. Some specialty care is provided through the OAP network when a referral is made by the CMG physician.

CMG High and Low Plan: A managed-care plan that requires members to use the CMG facilities for primary and most specialty and other services. Use of non-network providers or providers who practice in their own offices are not covered.

Co-insurance: A cost-sharing requirement under a health insurance policy, which provides that the insured will assume a percentage of the costs of covered services after payment of the deductible, if applicable.

Copay: A cost-sharing arrangement in which the insured pays a specified flat dollar amount for a specific service (such as \$20 for an office visit). The amount does not vary with the cost of the service, unlike co-insurance, which is based on a percentage of cost.

Deductible(s): Under a health insurance policy, amounts required to be paid by the insured either before benefits become payable, after a portion of benefits have been paid or for a specific benefit, before benefits are payable.

Flexible Spending Account (FSA): A plan which provides employees with a way to set aside money on a pre-taxed basis to cover the costs of either health care expenses that are not covered under their health insurance coverage (medical, pharmacy, mental health, dental and vision) or dependent care expenses that enable the employee to work.

Group Insurance Qualified Status Change Form: A form provided by the EHI Department on which the employee requests to add or drop dependents due to a qualified status change.

Health Coaching Program: Coaches work one-on-one with employees to help identify goals and to embrace change.

Health Maintenance Organization (HMO): HMOs offer comprehensive health coverage for both hospital and physician services. An HMO contracts with health care providers, e.g., physicians, hospitals and other health professionals, who participate in their network. The members of an HMO are required to use participating network providers for all health services, and many services must meet further approval by the HMO through its utilization review program. HMOs are the most restrictive form of managed care benefit plans because they manage and restrict the procedures, providers and benefits.

Health Risk Assessment (HRA): A brief online questionnaire that analyzes the health risk of the employee.

Health Savings Account: A tax-exempt trust or custodial account established exclusively for the purpose of paying qualified medical expenses of the account beneficiary who, for the months for which contributions are made to an HSA, is covered under a high-deductible health plan.

High Option: A plan where premiums are higher than a low option plan because the insured shares less of the costs with lower copays.

In-Network (or Network, Participating Provider): Health care provided by a doctor, hospital, pharmacy or other health care provider with whom the plan has contracted to provide services at specified fees.

Insured: A person or organization covered by an insurance policy.

Insurer (Insurance Company or vendor): A corporation, such as CIGNA HealthCare of Arizona, engaged primarily in the business of furnishing insurance to the public.

Low Option: A plan where premiums are reduced in comparison to a high option plan because the insured shares more of the costs in the form of higher copays and co-insurance.

Medical Waiver Payment: Compensation paid to the employee by the County if medical coverage is not elected because of enrollment in other eligible group health insurance. Waiving medical coverage means waiving coverage for all components of the medical plan, which includes medical, vision, pharmacy, and behavioral health and substance abuse benefits.

OAP (Open Access Plus) Plan: A plan that gives options to use a network or non-network physician/provider each time the insured needs medical care, and does not require a referral to see a specialist.

OAPIN (Open Access Plus) In-Network: A plan that uses a network of providers who practice in their own offices and independently contract with CIGNA. Non-network physicians/providers are not covered under this plan. The OAP In-Network also includes the CMG network. A referral is not required to see a specialist.

Out-of-Network (or Non-Participating, Non-Network Provider): Health care received from a provider who is not contracted with the insured's health plan network.

Out-of-Pocket Maximum: The maximum amount the insured pays each year for health care. The maximum may apply only to specific services such as inpatient hospitalizations. After this share of eligible expenses has reached the plan's out-of-pocket maximum per person or per family, the plan pays the full cost of eligible expenses for the rest of that plan year. The out-of-pocket maximum does not include any copays, pharmacy or mental health/substance abuse treatment expenses, or non-certification penalties. Each plan summary lists the expenses that count towards the out-of-pocket maximum.

Plan Year: July 1 through June 30

Preferred Medication List (aka Formulary): List of prescription drugs approved by a pharmacy benefit manager. Drugs on the preferred medication list are generally more cost effective and are as effective as other drugs that are non-preferred in the same therapeutic medication class. The list is available on the EHI Home Page.

Preventive Care Services: This includes all routine preventive services such as Well Baby Care, Well Child Care and Adult Preventive Care as identified by each plan in the plan summary.

Primary Care Physician (PCP): A physician who practices general medicine, family medicine, internal medicine or pediatrics.

Reasonable and Customary Charge (R&C): The prevailing charge of most other providers in the same or similar geographic area for the same or similar service. If the insured receives out-of-network services and the provider's fee is more than the R&C charge, the insured will have to pay the amount of charges above R&C. When care is received from an in-network provider, the eligible expenses are determined from the network provider's contracted rate.

Short-Term Disability (STD) benefits: STD pays a percentage of the insured's salary for up to 23 weeks after a 3-week waiting period if he/she becomes temporarily disabled due to sickness or injury and is not able to perform the essential functions of his/her job. The insured must be under the regular care and treatment of an appropriate provider.

Specialty Medication: Usually are expensive drugs (oral or injectable) that are used to treat complex and rare medical conditions. These drugs may require special care and handling (such as refrigeration) and patient counseling due to their high risk of causing serious side effects or complications.

Term Life Insurance: Term life insurance covers a person for death benefits for a limited time (a term). In the case of the term life insurance coverage provided by The Standard, the term is conditional. You are covered as long as you are employed by Maricopa County. Term life insurance does not have any cash value.

GLOSSARY OF ACRONYMS

Abbreviations used throughout this booklet

A

AD&D: Accidental Death & Dismemberment

AHCCCS: Arizona Health Care Cost Containment System

ARS: Arizona Revised Statutes

ASI: Application Software, Inc.

ASRS: Arizona State Retirement System

C

CCN: CIGNA Care Network

CMG: CIGNA Medical Group

COBRA: Consolidated Omnibus Budget Reconciliation Act

E

EAP: Employee Assistance Program

EBAC: Employee Benefits Advisory Council

EBC: Electronic Business Center (Intranet)

EDS: Employers Dental Services

EE: Employee

EHI: Employee Health Initiatives

EOI: Evidence of Insurability

F

FMLA: Family Medical Leave Act

FML: Family Medical Leave

FSA: Flexible Spending Account

H

HDL: High-density lipoprotein

HIPAA: Health Insurance Portability and Accountability Act

HMO: Health Maintenance Organization

HR: Human Resources

HRA: Health Risk Assessment

HSA: Health Savings Account

I

ID: Identification

IRC: Internal Revenue Code

IRS: Internal Revenue Service

L

LOA: Leave of Absence

M

MH: Mental Health

MST: Mountain Standard Time

N

NAIC: National Association of Insurance Commissioners

NEO: New Employee Orientation

NRS: Nationwide Retirement Solutions

O

OAPIN: Open Access Plus In-Network

OAP: Open Access Plus

OE: Open Enrollment

P

PCP: Primary Care Physician

PHI: Protected Health Information

PML: Preferred Medication List

PPO: Preferred Provider Organization

PSPRS: Public Safety Personnel

Retirement System

PST: Pacific Standard Time

PTO: Paid Time Off

R

RIF: Reduction in Force

RX: Prescription

S

SPD: Summary Plan Document

SSN: Social Security Number

STD: Short-Term Disability

U

UV: Ultraviolet

W

WHI: Walgreens Health Initiatives

INTRODUCTION

Maricopa County recognizes your valuable contributions as an employee by offering comprehensive benefits for you and your dependents through the Employee Health Insurance Program. Maricopa County is committed to helping you manage the high costs of health care, the risks of lost income due to illness and disability, and preparing for a secure retirement. The County's program provides:

Health, Life, Disability Plans & Flexible Spending Accounts

- A choice of six medical plans;
- A choice of two pharmacy plans (unless you elect the high-deductible health plan);
- A vision plan;
- A behavioral health and substance abuse plan;
- A choice of three dental plans;
- Basic and additional life, basic and voluntary accidental death and dismemberment, and dependents life and accidental death and dismemberment insurance plans;
- A short-term disability (STD) plan; and
- Health care and dependent care flexible spending accounts (known as Mariflex).

Other programs and services available to you as an employee include:

- An employee assistance plan (EAP);
- A deferred compensation plan;
- Discounts on auto, home and renters insurance;
- A group legal plan;
- Arizona State Retirement System (ASRS) retirement plan, which include a long-term disability benefit, or Public Safety Personnel Retirement System retirement plan. If you meet eligibility criteria, you must be enrolled in and contribute to the applicable retirement plan.

Who's Eligible?

You can participate in the health, life, disability plans and the flexible spending accounts if you are a regular employee (except some contract employees as specified below) scheduled to work at least 20 hours per week.

For benefit plan purposes, "regular employee" is defined as a full-time or part-time employee who is not temporary, but who may be a contract employee. (When related to benefits administration, the definition herein of a regular employee differs from that which is used in the Merit Rules, available online at http://ebc.maricopa.gov/pp/hr/tocs/EmpMerit_TOC.asp.)

Employees working under specific contracts may or may not be eligible for benefits based on the terms of their contract. Each appointing authority determines if contract employees are benefit eligible.

Regular employees (except some contract employees as described above) who are scheduled to work less than 20 hours per week, all temporary employees, and contract employees whose contract specifies they are not benefit eligible are ineligible to participate in the health, life, disability plans, and the flexible spending accounts. Health plans include medical, pharmacy, vision, behavioral health and substance abuse, and dental coverage.

Are Dependents Eligible?

Your legal spouse (does not include common-law, domestic partner, or significant other) and/or your unmarried dependent child(ren) are eligible for coverage under your health plans and/or dependents life and family accidental death and dismemberment insurance plans. Dependent child(ren) must meet the IRS definition of dependent children pursuant to IRC Section 152 and Maricopa County eligibility requirements below.

The term "child" means your unmarried natural child, stepchild, legally adopted child, child placed with you for adoption or child for whom you have been awarded legal guardianship. The term "dependent" means a child who meets one of the relationships listed above, and who meets the following criteria.

Dependent child(ren) under 19 or under 25 (if full-time student) is subject to all of the following:

1. Must be unmarried;
2. Must reside with the employee for more than one-half of the taxable year (January – December);
 - a. Temporary absences due to school attendance do not violate this residency rule.
 - b. Qualified Medical Child Support Orders or other court/administrative orders do not violate this residency rule.
 - c. Your student dependent child will remain eligible during summer breaks from school provided that he/she will be attending school on a full-time basis during the fall term/semester.

3. Must be under age 19, or a full-time student and under age 25, or any age if permanently and totally disabled;
 - a. For a child 19 or older, to be deemed a full-time student, the school he/she attends must be an accredited institution for higher education and the child must be attending on a full-time basis. The school will define and determine full-time student status.
 - b. For a child who is permanently and totally disabled, the child must have been medically certified as permanently and totally disabled prior to his/her 19th birthday (or prior to his/her 25th birthday if disability began while a full-time student).
4. There is no earning income limit for the dependent child.

Additional rule for dependent child(ren) age 19 or under age 24 and a full-time student

The child must not have provided more than one-half of his/her support during the taxable year (January – December).

Additional rule for dependent child(ren) age 24, but under age 25 and a full-time student

The child must not have received more than one-half of his/her support during the taxable year (January – December) from the employee.

Verification of continued eligibility as a student or disabled child

You must provide verification of continued eligibility as a student or disabled dependent child to the EHI Department at the beginning of each semester for students and as requested for disabled dependent children. Additionally, the medical, dental and life insurance vendors will ask you to provide verification of student dependent status and/or disabled child eligibility. Failure to provide such verification will result in termination of dependent coverage. Should your child not return to full-time student status at the fall term/semester, the child will be deemed retroactively ineligible on the last day of the pay period after the child's last day of school.

You are responsible for ensuring that only eligible dependents are enrolled and immediately notifying the EHI Department when your dependents become ineligible. **You will be liable and responsible for the full cost of claims paid for your dependent after he/she became ineligible. Failure to notify the EHI Department within 30 calendar days of ineligibility forfeits the dependent's rights to COBRA coverage continuation.**

WHEN DOES COVERAGE BEGIN FOR NEWLY ELIGIBLE EMPLOYEES?

You have 30 calendar days from your eligibility date (date of hire for a newly hired employee, or event date of employee going from a benefit ineligible status to a benefit eligible status) to elect and submit your benefit elections online through Employee Self Service at my.maricopa.gov, if you are a new hire, or on a custom enrollment form generated by PeopleSoft if you have changed employment status, and such change resulted in going from benefit ineligible to benefit eligible. To prevent a retroactive premium adjustment to your paycheck and to preserve your choice of benefits, online enrollment should be completed and submitted as soon as possible within the 30-day period. Premium starts accruing on your coverage effective date.

New Hire

Benefit coverage for a newly hired employee begins the first day of the month following the date of hire except for Mariflex coverage, which begins on the date his/her election is processed by the EHI Department. Benefit coverage for a re-hired employee with a break of employment of less than 30 calendar days begins the first day of the pay period following benefit termination. Benefit deductions begin the first day of the pay period in which the coverage effective date falls and are not pro-rated.

Benefit Ineligible to Benefit Eligible Status

Benefit coverage for an employee whose change in employment status renders him/her benefit eligible begins on the date of the change, except for Mariflex coverage, which begins on the date his/her election is processed by the EHI Department. Benefit deductions begin the first day of the pay period in which the coverage effective date falls and are not pro-rated.

Default Coverage

If you do not complete enrollment online through Employee Self Service or on a custom enrollment form generated by PeopleSoft within 30 calendar days of your hire date or your change of status date, your medical coverage will default to the CIGNA Choice Fund Health Savings Account plan for employee only coverage as a tobacco user and as not participating in Biometric Screening and the Health Risk Assessment. Your basic life insurance coverage will be one times your annual salary rounded up to the next thousand. Your default coverage will be effective on the first day of the month following your date of hire for new hires or the date of your employment status change.

Can I change my benefits once I've made my benefit elections?

After benefit elections have been submitted online through Employee Self Service or on a custom enrollment form generated by PeopleSoft, no change (e.g. additions or deletions of covered dependents) in benefits will be allowed until the next open enrollment period, unless you have a qualified status change as defined under the IRC Section 125. If you were employed by Maricopa County,

terminated employment and then were re-hired within 30 calendar days, the benefit elections in place before your termination will be reinstated, with no option of changing your elections. Refer to the following sections in this booklet for more information: “When Can Changes Be Made & When Are They Effective?” and “What is a Qualified Status Change?”

Open enrollment occurs at times designated by the EHI Department. The next open enrollment will be April, 2009 with benefit elections being effective on July 1, 2009. Open enrollment dates are posted in advance on the EBC/Intranet and communicated to each department via e*Nouncements. Please check with your department HR Liaison, Employee Benefits Advisory Council (EBAC) member or the EHI Department to obtain specific dates of the next open enrollment period.

WAIVING INSURANCE COVERAGE

Waiving medical insurance package

If you do not want coverage under the County’s medical insurance package, you may waive coverage under the County’s plan by submitting your request via Employee Self Service, on a Group Insurance Qualified Status Change Form or on a custom enrollment form generated by the PeopleSoft system.

If you elect to waive the medical insurance coverage, you relinquish coverage offered through the County’s medical package, which includes medical, behavioral health, vision, wellness and pharmacy benefits. However, Maricopa County offers separate vision plan coverage to employees who elect to waive the medical insurance package. Refer to the “Vision Benefit Plan” section for premiums for “Vision without Medical Plan”.

Should you decide to waive your coverage because you are covered under other eligible group medical insurance, you may qualify for compensation.

Compensation for waiving medical insurance package

The County will compensate you \$50.00 the first and second paychecks of each month if you are a regular employee scheduled to work at least 30 hours a week or if you are a contract employee with full-time benefits and you waive the medical insurance package coverage because you have coverage under other group medical insurance. In no case is a payment made for the third paycheck of the month or if you do not have payable hours reported during a pay period.

You are required to provide annual documentation of your other group medical insurance coverage to the EHI department to qualify for the medical waiver payment. (Arizona Health Care Cost Containment System (AHCCCS) coverage does not qualify as group medical insurance coverage for this purpose and therefore does not qualify you to receive the medical waiver payment.) The documentation must identify you as a covered member and include the name of the primary insured, the insurance company’s name, address, and phone number, group name and number, member identification number and coverage effective date.

Waiving other insurance coverage when newly eligible

You may elect to waive any or all of the following when you are newly eligible. However, election into the plans following your initial eligibility date is limited.

Short-term Disability: You must wait until the next scheduled open enrollment to elect coverage.

Dental Insurance: You must wait until the next scheduled open enrollment period to elect coverage, unless you experience a qualified status change that is consistent with the need for dental coverage. Refer to “What Coverage Changes Can I Make During the Plan Year?” section.

Additional Life: You may elect or apply for coverage during the plan year. See “Additional Life and Voluntary Accidental Death and Dismemberment (AD&D) Insurance” sub-section in the “Life Insurance Plan” section for further details regarding evidence of insurability requirements.

Dependent Life: You may elect this coverage if you experience a qualified status change.

Mariflex Flexible Spending Accounts: You must wait until the next scheduled open enrollment to elect coverage, unless you experience a qualified status change where you or a dependent lost eligibility to continue participating in a flexible spending account, or attained eligibility where such change is consistent with the need for a flexible spending account. Refer to the “What Coverage Changes Can I Make During the Plan Year?” section.

HOW TO ENROLL WHEN YOU’RE NEWLY ELIGIBLE

You should attend a New Employee Orientation (NEO) meeting to receive benefit plan information. You can complete your enrollment within 30 calendar days of the event either online through Employee Self Service at my.maricopa.gov if you are a new hire or via a custom enrollment form generated by PeopleSoft if you have a status change where you became eligible for benefits. Instructions for online enrollment are provided in the “Online Employee Self Service” section. It is in your best interest to complete and submit your online enrollment or custom enrollment form as soon as possible. Refer to the “When Does Coverage Begin for Newly Eligible Employees?” section for more information.

If you are not scheduled to attend a NEO meeting, you have the following additional enrollment options:

1. Ask your Department's HR Liaison for enrollment materials.
2. Go online to the EHI Home Page to obtain the benefit plan information you need to make your choices.
 - a. The EBC/Intranet address is: <http://ebc.maricopa.gov/ehi/>
 - b. The Internet address is: <http://www.maricopa.gov/benefits>
3. Contact the EHI Department via Outlook e-mail at BenefitsService@mail.maricopa.gov.
4. Call the EHI Department for information at 602-506-1010.
5. Visit the EHI Department at 301 S. 4th Ave., Suite B100, Phoenix, AZ 85003.

WHO PAYS FOR BENEFIT COVERAGE?

Employer contribution

Maricopa County makes a generous contribution toward the cost of your medical and dental plans. You have the option of selecting medical coverage from CIGNA, pharmacy coverage from Walgreens Health Initiatives (except for the Choice Fund HSA plan that has pharmacy coverage through CIGNA), and dental coverage from one of three dental vendors: Employers Dental Services (EDS), Delta Dental or CIGNA Dental. The medical plans are described in the "Medical Plans" section. The dental plans are described in the "Dental Plans" section.

If you are a regular employee normally scheduled to work 30 or more hours per week or if you are a contract employee with full-time benefits, you will receive the maximum Maricopa County contribution towards your premium for the medical package (medical, vision, pharmacy, and behavioral health) for you and your dependents. You pay the "Full-time Premium".

If you are a regular employee scheduled to work 20 to 29.99 hours per week or if you are a contract employee with part-time benefits, you will receive a lower Maricopa County contribution toward your premium for you and your dependents. You pay the "Part-time Premium".

The County contributes the same amount toward your dental elections for the EDS plan regardless of your weekly scheduled hours. If you are a regular employee scheduled to work 20 to 29.99 hours per week or if you are a contract employee with part-time benefits and elect dental coverage through Delta Dental or CIGNA Dental, the County contribution is lower. You pay the "Part-time Premium". If you are a regular employee scheduled to work 30 or more hours per week or a contract employee with full-time benefits, you pay the "Full-time Premium".

Employee contribution

When you elect benefits, you authorize the County to deduct the current employee benefit premiums from your paycheck for each benefit option you elect. Payroll deductions will be made from the first two paychecks of each month, 24 paychecks per year. However, since there are 26 paychecks per year, two paychecks have no benefits deductions, with the exception of those for the Mariflex flexible spending accounts and the health savings account (associated with the CIGNA Choice Fund high-deductible health plan) for which deductions are taken every paycheck, or if you have a balance due in arrears for any of the other benefits (medical, dental, life, etc.).

If at any time you do not receive a paycheck for a pay period that results in no premium payment by either you or your department, you are responsible for notifying the EHI Department within 30 calendar days to arrange for alternate premium payment options.

If payment is not made within 60 calendar days of the coverage period begin date, your benefit coverage will be terminated due to non-payment of premium. You will then be offered COBRA continuation coverage.

You are responsible for reviewing your paycheck to verify that the correct premium deduction amounts are taken for the benefit options you elected. Please refer to the premium rates in the "Pay Period Premium Rates" section.

If the premium deductions on your paycheck are incorrect in that you have been charged a higher amount due to an administrative error, and you identify the problem in writing to the EHI Department within six months from the date the error began, your premiums will be adjusted retroactively to reflect the correct amounts from the date of the error and refunded to you and your department, at the department's request. Incorrect premium payments resulting from you not notifying the EHI Department within 30 calendar days to remove an ineligible dependent will not be refunded to you or your department until a full claims audit has been conducted to determine your liability. Administratively caused premium errors discovered after six months will be corrected on a prospective basis with no refund on the overpaid premium to you or your department.

Regardless of when an error is discovered, if your premium deduction is incorrect in that you have been charged a lower amount than you should have paid, your premiums will be adjusted retroactively to the date of the occurrence and you and your department will be responsible for the cost of the underpaid premiums.

Deductions for the medical package (medical, vision, pharmacy, and behavioral health), dental and health care and/or dependent care FSAs reduce your taxable income, thus saving you money that would otherwise be paid in taxes. This tax advantage is provided under and follows the provisions of IRC Section 125.

DO BENEFITS CONTINUE WHILE ON AN UNPAID LEAVE OF ABSENCE?

General

When you take an approved unpaid leave of absence (LOA) (e.g. personal, medical or military leave) from your position, you must continue to pay your portion of the premiums for your benefits, such as medical and dental, and the full premium amount for additional and dependents life insurance, short-term disability (STD) and other voluntary benefits in order to continue coverage. In order to continue your benefits while on an unpaid leave of absence you must contact the EHI Department and complete a Payment Agreement. Since an unpaid leave of absence is a qualified status change, you may elect to revoke some or all of your benefits during your leave by completing a Group Insurance Qualified Status Change form within 30 calendar days from the beginning date of your unpaid leave.

If you do not elect to continue benefits by completing a Payment Agreement or you do not revoke your benefits by completing a Group Insurance Qualified Status Change form, and if your leave lasts for less than 30 calendar days, the EHI Department will assume that you want to continue your benefits and you will be liable and responsible for paying your portion of all your premiums and your portion of your FSA annual pledge while on a LOA. Upon your return to work, your unpaid health insurance premiums will be deducted from your future paychecks in the amount equal to one pay period's premium. Your FSA annual pledge will be recalculated to fully deduct the remaining portion of your annual pledge through the remaining pay periods in the benefit plan year. If you terminate employment voluntarily or involuntarily, and you have not paid your overdue premiums, you will be subject to collections.

Military Leave

If you are going on military leave, refer to the Military Leave policy HR2417 available online at <http://ebc.maricopa.gov/pp/hr/pdf/h2417.pdf>. This policy requires you to complete a Notification of Uniformed Service Form indicating your intention to waive or continue benefits. Contact your department's HR Liaison to obtain this form. Complete and return this form to your HR Liaison, who will send it to Employee Records. If this form is not completed, your benefits will terminate. Before the military leave begins it is advisable that you work with your HR Liaison to update your contact information such as your address and phone number and provide a person's name and phone number who may be contacted in your absence.

Subject to and in conformance Military Leave Policy HR2417, USERRA and 10 U.S.C. § 1071 et. seq, employees who are members of the uniformed services have the option of obtaining medical and dental benefits for themselves and their dependents through the military health care system or may choose to continue their health and other benefits (restrictions apply to life insurance which must be ported or converted 180 days following the date the military leave of absence began) through Maricopa County's Employee Health Insurance Program at the active employee premium rate for a period of one year to begin when the employee is placed on Leave Without Pay after the commencement of active duty. To continue coverage, the employee must notify the EHI Department within 30 calendar days of the start of his/her unpaid leave, complete the Notification of Uniformed Service Form and make timely premium payments.

Upon conclusion of the one year coverage period, the employee is entitled to continue coverage through the Plan for an additional six months with the employee paying the entire cost of the premiums. Following this 18-month period, a COBRA notice will be mailed to the employee at his/her address on file in the PeopleSoft system.

Life Insurance

Since Maricopa County pays 100% of the premium for your basic life and basic accidental death and dismemberment coverages, these will continue in force while you are on an approved unpaid LOA as follows:

- If you are not working due to injury or sickness, injury or pregnancy, or if you are on a military leave of absence you can continue to be covered through the end of the pay period following 180 days from the date your approved, unpaid leave status began.
- If you are on an approved personal leave of absence, you will be covered through the end of the pay period following 90 days from the date your leave of absence began.

If your leave extends past the coverage end date above and you wish to continue your basic and additional life coverage, you may elect portability or conversion coverage for yourself at a higher premium rate. You and a representative of the EHI Department must complete portions of the Member and Dependent Group Life Insurance Portability form. Refer to the "Life Insurance Plan" section for more details and the time frame in which the form and the premium are due. Dependent coverage can be maintained for as long as the reservist remains as an active employee and pays the applicable premium.

Discontinue coverage while on LOA

If you do not wish to continue some or all of your benefits, you must revoke coverage by completing a Group Insurance Qualified Status Change Form within 30 calendar days of the beginning date of your unpaid LOA. However, your STD coverage may not be revoked, unless you are part of a Reduction in Force (RIF) and chose RIF Option 2 or you are on military leave. Contact the EHI Department or go online to <http://ebc.maricopa.gov/ehi/> to the Forms link to obtain a Group Insurance Qualified Status Change Form.

Refer to the "Return from LOA/Reinstatement of Benefits" sub-section for information on what process to follow in order for benefits to be reinstated upon your return to work.

Continue coverage while on unpaid LOA

If you want to continue your benefit coverage while on an unpaid leave of absence, you must complete a Payment Agreement Form with the EHI Department in advance of your leave, if possible, to decide on premium payment and coverage options. If advance notice is not possible due to your medical condition or other extenuating circumstance, the agreement must be made within 30 calendar days of your leave beginning date.

The following payment options are available and consistent with the federal laws governing cafeteria plans, Family Medical Leave Act (FMLA) and USERRA. Contact the EHI Department, Finance Unit at (602) 506-1010 to advise which payment plan you are selecting.

- Pre-pay with pre-tax dollars for coverage periods within the current and/or new plan year, if you have sufficient taxable earnings.
- Pre-pay with after-tax dollars.
- Pay as you go. Payments must be made on a monthly basis.
- Pay as you go. Payments will be deducted on a pro-rated daily basis from your short-term disability payment.

Premium payment while on LOA

You must continue to pay your portion of the insurance premiums in a timely manner as described above for coverage to continue. The County will not pay its portion of the premium for medical and dental coverage until your full monthly payment is received.

If your premium is not paid within 60 calendar days following the due date, your benefits will be terminated retroactive to the last day of the pay period for which premiums were paid. **When coverage is terminated, you are liable and responsible for all claims incurred after your termination effective date.** Refer to the "Return from LOA/Reinstatement of Benefits" sub-section for information on what process to follow in order for benefits to be reinstated upon your return to work.

Note: If you are receiving short-term disability (STD) benefits, your payments for benefit premiums will be deducted from your STD payments on a pro-rated daily basis unless your Payment Agreement Form specifies otherwise. On a monthly basis, the EHI Department will audit your account to verify premium payments equal the amount due. If the audit results in a premium due, the EHI Department will send you a billing statement. Payment of such premium is due within 15 days from the date of the statement. A refund of any partial premiums you paid will be returned to you within 30 calendar days from the completion of the premium audit.

As a convenience while you are on LOA, the EHI Department will accept premium payments through Visa, American Express or MasterCard. To make your payments in this manner, please contact the EHI Department with your credit card information each month.

Upon receipt of your portion of the monthly premium, the County will make its contribution to medical and dental premiums for you and your dependents while you are on an approved **personal LOA** for up to three months of premiums (6/24ths of the annual premium) in a rolling 12-month period starting the first day of your unpaid leave.

Upon receipt of your portion of the premium, the County will make its contribution to medical and dental premiums for you and your dependents while you are on either an **approved Family Medical Leave Act (FMLA) or non-FMLA medical LOA** for up to six months of premiums (12/24ths of the annual premium) in a rolling 12-month period starting the first day of your unpaid leave.

Note: County contributions toward your medical and dental premiums may not extend beyond six months (12/24ths of the Annual Premium) in a rolling 12-month period by combining a personal leave with a medical leave. If you do not return to work after your FMLA leave entitlement has been exhausted or expires, **in certain situations the County may recover from you** the portion of medical and dental premiums it paid on your behalf while you were on such LOA, in accordance with federal regulations 29 CFR 825.213.

Continuation of coverage beyond county benefit eligibility

If you continue on an approved unpaid LOA beyond the point at which the County's contribution ends or if you terminate or resign employment (either voluntarily or involuntarily), you become ineligible for the County contribution to your medical and dental benefits. (However, if you are included in a RIF, you may be eligible to continue your benefits according to the HR2403 Reduction in Force Policy.) You may be eligible for continuation of coverage under the COBRA of 1985.

A COBRA notice containing enrollment and premium information will be mailed to you at your address on file in the PeopleSoft system if you become ineligible for County contributions toward your benefits. By enrolling in COBRA coverage within the designated period and paying the total monthly premiums and administrative charge, coverage for your health care benefits [medical (pharmacy, vision and behavioral health), dental, vision only, and/or health care FSA] will continue retroactive to the date of ineligibility without a break in coverage through the period of COBRA eligibility.

If you are receiving a payment for short-term disability at the time the County's contribution ends or if you terminate or resign employment, your premium for short-term disability coverage will continue to be deducted from your short-term disability payment throughout your disability benefit payment period.

Refer to the "Life Insurance Plan" section for conversion or portability coverage continuation information.

LOA 30 days or less

If you do not elect to continue coverage by completing a Payment Agreement or you do not revoke your benefits by completing a Group Insurance Qualified Status Change Form within 30 calendar days from the beginning of your unpaid LOA, and if your leave lasts 30 calendar days or less, the EHI Department will assume that you want to continue your benefits and you will be liable and responsible for paying your portion of all your premiums and your Mariflex FSA annual pledge. Upon your return to work, one pay period's premium arrearage will be deducted from each paycheck until the unpaid premium is recovered. Your FSA annual election will be recalculated to fully deduct the remaining portion of your annual pledge through the remaining pay periods in the benefit plan year.

LOA greater than 30 days

If you do not revoke your benefits by completing a Group Insurance Qualified Status Change Form or Notification of Uniformed Service Form within 30 calendar days of the beginning of your unpaid leave, you do not elect to continue coverage by completing a Payment Agreement, your leave lasts more than 30 calendar days and you have not paid your premium(s) within 60 days, the EHI Department will terminate your coverage retroactively to the end of the last day of the pay period in which premiums were paid. **You will be liable and responsible for the full cost of all claims paid for you and your dependents after your termination effective date or the amount of premiums due, whichever is less.**

If you return to work, your FSA annual pledge will be recalculated to fully deduct the remaining portion of your annual pledge through the remaining pay periods in the plan year or the amount of premium due, whichever is less.

If you terminate employment and you have not paid your overdue premiums, your benefits will be terminated retroactively to the end of the last day of the pay period in which premium was paid. **You will be liable and responsible for the costs of all claims paid for you and your dependents after your termination effective date or the amount of premium due, whichever is less.**

Note: In any case where your premium payments are not current, the insurance carrier may interrupt and/or terminate your benefits.

Return from LOA/Reinstatement of benefits

If coverage is terminated because of premium non-payment or revocation of benefits during your LOA, coverage may be reinstated upon your return to benefit-eligible active employment status if you complete a Group Insurance Qualified Status Change Form within 30 calendar days of returning. Failure to complete a Group Insurance Qualified Status Change Form within the 30-day period will result in loss of benefits for the remainder of the plan year. Refer to the "When Can Changes Be Made & When Are They Effective?" section.

WHEN DOES COVERAGE END?

Coverage ends the last day of the pay period in which you and/or your covered dependents cease to be eligible for coverage or for which a premium was paid, whichever comes first except in the case of death the coverage end date is the day following the date of death. **When coverage ends, you are liable and responsible for the cost of all claims paid for you and your dependents after the last day of coverage.**

You are responsible for notifying the EHI Department when a dependent no longer meets the eligibility requirements listed in the "Are Dependents Covered?" section. If you fail to notify the EHI Department within 30 calendar days of ineligibility, medical, other benefit expenses and administrative costs paid or incurred on behalf of an ineligible dependent become your liability and responsibility from the beginning date of ineligibility. Additionally, your dependent will lose eligibility to continue coverage under COBRA.

If you and/or your covered dependents cease to be eligible for medical (including pharmacy, vision and behavioral health) or dental insurance or the health care FSA and you notify the EHI Department of such ineligibility within 30 calendar days, a COBRA notice containing enrollment and premium information will be mailed to you and/or your dependents at your address on file in the PeopleSoft system. By enrolling in COBRA and paying the monthly premium and administrative charge, coverage for benefits will continue retroactive to the date of ineligibility without a break in coverage through the period of COBRA eligibility.

WHEN CAN CHANGES BE MADE & WHEN ARE THEY EFFECTIVE?

General

If you have experienced a qualified status change event during the plan year, you may be eligible to add or drop certain benefit elections or add or drop dependents for the remainder of the plan year. The list of events that constitute a Qualified Status Change is provided in the "What Coverage Changes Can I Make During the Plan Year" section.

Qualified status changes must be verified and must be consistent with the event as defined under IRC Section 125. Benefit election changes are consistent with status changes only if the election changes are necessary or appropriate because of the status change.

Requested benefit changes must be submitted on a Group Insurance Change Form within 30 calendar days of the change.

What is a Qualified Status Change?

Examples of qualified status changes, as permitted by IRC Section 125, are listed below:

1. Change in status:
 - a. Events that change an employee's legal marital status, including the following: marriage, death of spouse, divorce, legal separation, or annulment;
 - b. Events that change an employee's number of dependents, including the following: birth, death, adoption, and placement for adoption. In the case of the dependent care spending account, a change in the age of qualifying individuals (e.g. child turns 13).
 - c. Any of the following events that change the employment status of the employee, the employee's spouse or the employee's dependent:
 - termination or commencement of employment;
 - strike or lockout;
 - commencement of or return from an unpaid leave of absence (LOA) including FMLA;
 - change in residence or work site where eligibility no longer exists for the plan originally selected or where the employee or dependent becomes eligible in the new residence or work site;
 - change in the number of regularly scheduled hours to become benefit eligible or ineligible;
 - change in job or employment status that renders the employee benefit eligible or ineligible, such as moving from temporary status (benefit ineligible) to a regular status benefit-eligible position, or changing from a contract position with no benefits to a position with benefits.
2. Dependent satisfies or ceases to satisfy eligibility requirements such as attainment of age or change in student status;
3. Judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody, including a qualified medical child support order requiring accident or health coverage for an employee's child;
4. Significant cost or coverage changes.
5. Entitlement or loss of entitlement of Medicare or Medicaid (the Arizona Health Care Cost Containment System) more commonly referred to by its acronym **AHCCCS**, the Medicaid program in Arizona.

Effective Date of the Change

Below are the qualified family status changes and when the change becomes effective. For short-term disability and life insurance, please review the last two paragraphs of this sub-section.

Adding dependents, electing benefits if previously waived, or waiving benefits due to – birth, adoption, and placement for adoption

To add a new dependent or elect benefits if you previously waived benefits, you must notify the EHI Department on the Group Insurance Qualified Status Change Form within 30 calendar days of the event. If you are currently enrolled for benefits and now wish to waive coverage for yourself and your dependents, you must complete a Group Insurance Qualified Status Change Form within 30 calendar days of the event. In all cases, you are required to provide documentation of the status change within 30 calendar days of the event date. For birth, adoption or placement for adoption or to waive benefits due to these events, the effective date of your coverage change is the event date.

In accordance with ARS 20-1057 B, if your medical coverage is under the CIGNA CMG or OAP plan, coverage of a newborn child, a child placed for adoption or an adopted child will be effective from the date of birth or placement and will continue for the following 30 calendar days if you are the primary insured according to Coordination of Benefits National Association of Insurance Commissioners (NAIC) rules. NAIC rules determine primary responsibility for coverage based on the earliest birthday in the year of the child's parents.

There is no premium associated with coverage for the first 30 days as long as you do not enroll the child for ongoing coverage. In order for medical coverage to continue past the initial 30 days, you will be required to pay a premium retroactively to the date of the event if you are not currently in the appropriate coverage premium level (i.e., if you are paying employee-only or employee-and-spouse premium instead of employee and family or employee and child premium).

In order to properly administer the ongoing enrollment of the newborn in the medical and/or pharmacy plans, you must notify the EHI Department of your qualified family status change and complete the Group Insurance Qualified Status Change form and documentation within 30 calendar days of the event. **If you fail the form and documentation within 30 calendar days of the event, your newborn will not be covered after the initial 30 calendar days and the next opportunity for adding the newborn will be during the next Open Enrollment period.**

Adding dependents, electing benefits if previously waived, or waiving benefits due to– all other family status change events (marriage, dependent attains or loses eligibility, court orders, legal guardianship, etc.)

Employees may add newly acquired or newly eligible dependents, waive if currently covered for benefits, or elect coverage if currently waiving coverage, when a family status change occurs. Changes in medical or pharmacy plans are not allowed. You are required to complete a Group Insurance Qualified Status Change Form within 30 calendar days of the event date. The coverage effective date will not be later than the first calendar day of the month following the date the required documents are received from the employee. The date the request is processed by the EHI Department is deemed the event date and the coverage effective date unless the event is prospective. In this case, the prospective event date is the coverage effective date. The request will be processed only when all required documentation is received by the EHI Department. The EHI Department is responsible for processing requests within 5 calendar days of receipt of all required forms and documents. Premium changes associated with your qualified status change become effective the pay period in which the new coverage is effective. If you fail to submit your form and documentation within 30 calendar days of the event, no changes will be allowed. Retroactive changes will not be allowed unless otherwise required by law.

Losing Eligibility – all family status change events

When a dependent ceases to meet the definition of an eligible dependent, that dependent must be terminated from coverage. It is your responsibility to notify the EHI Department by completing a Group Insurance Qualified Status Change Form within 30 calendar days of the change. The dependent’s coverage will end the last day of the pay period during which he/she lost eligibility.

If you complete the form and submit it to the EHI Department within 30 calendar days of the event date, any premium overpayment will be refunded to you and your department back to the coverage end date.

Short Term Disability (STD)

If you elect STD when you first become benefit eligible or during open enrollment, you may not revise your election until the next regularly scheduled open enrollment even if you have a qualified status change. The only exceptions that may apply are if you are subject to a Reduction in Force (see HR2403) or called to active military duty.

Life insurance

If you elected additional life insurance and/or dependents life insurance, you have special rules that apply. These plans are not subject to I.R.C. Section 125. Please see the special rules that apply to these life insurance plans, in the “Life Insurance Plan” section.

WHAT COVERAGE CHANGES CAN I MAKE DURING THE PLAN YEAR?

Provided below is a list of changes to your medical and dental insurance coverage that you can make in the event you experience a status change. The coverage change must be consistent with the qualified status changes.

1. Marriage
 - Waive, if you elected coverage
 - Add newly acquired dependents to your current plan
 - Elect coverage for yourself and your dependents if you currently waive coverage
2. Divorce
 - Remove former spouse and step-child(ren) from your coverage (required)
 - Remove child(ren) from coverage, only if court order requires other coverage and verification of coverage is received by the EHI Department
 - If waived, elect coverage for yourself, and elect coverage for your dependent child(ren)
 - Waive, if elected coverage
3. Death of Spouse
 - Remove deceased spouse from your coverage (required)
 - Add dependent child(ren) who had been covered by your deceased spouse
4. Birth, Adoption, Placement for Adoption and Legal Guardianship
 - Waive, if you elected coverage
 - Add dependent child(ren) to your current plan
 - Elect coverage if you currently waive coverage

5. Spouse's Eligibility (Employment Changes, etc.)
 - Waive, if you elected coverage
 - All options if you currently waived coverage
 - Drop spouse from coverage
6. Dependent Child's Eligibility (Age, Marriage, Student Status change, etc.)
 - Add or remove dependent child(ren) to your current plan
7. Dependent Child's Eligibility (Court Orders)
 - Add or remove the dependent child to your current plan
8. Going from part-time to full-time benefit status
 - No changes allowed
9. Going from full-time to part-time benefit status
 - Can elect lower cost plan
10. Employee goes on approved LOA
 - Drop some or all benefit elections
11. Employee who drops some or all benefits at commencement of LOA and returns from LOA greater than 30 days
 - Reinstate or change benefits

WHAT DOCUMENTATION IS REQUIRED FOR QUALIFIED STATUS CHANGES?

The EHI Department requires documentation of your qualified status change within 30 calendar days of the event in order to process your Group Insurance Qualified Status Change Form. Notification to the EHI Department of some status changes are allowed via Employee Self Service in PeopleSoft. However, documentation must be received by the EHI Department within 30 calendar days of the change in order for the change to be accepted. Below is a list of acceptable documentation.

1. Divorce, legal separation, annulment or change in legal custody, that include a qualified medical child support order requiring accident or health coverage for an employee's child: Copy of first and last pages and any other pages relating to the order requiring coverage.
2. Change in status:
 - a. Events that change an employee's legal marital status: Marriage or death certificate, divorce or other legal document or decree (first and last pages and any pages identifying the effective date of the event and the date on which the document was finalized);
 - b. Events that change an employee's number of dependents: Birth certificate, court adoption documents (first and last pages and any pages identifying the effective date of the event and the date on which the document was finalized);
 - c. Changes in the employment status of the employee, the employee's spouse or the employee's dependent: Copy of the document from the employer verifying the event or change of address verification such as utility bill or U.S. Postal Service change of address form.
3. Dependent satisfies or ceases to satisfy eligibility requirements: School schedule for the current semester/quarter from the institution verifying full-time student status.
4. Significant cost or coverage changes: Documentation of the before and after coverage and/or costs and the effective date of such change.

Please notify the EHI Department within the 30 calendar day period following the event if documentation is not available due to an extenuating circumstance.

HIPAA PRIVACY NOTICE

In accordance with the privacy standards contained in the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Maricopa County, in its role as the administrator and/or sponsor of the Employee Benefit Plan, or in its role as the health plan makes available a notice setting forth its privacy practices through the EBC/Intranet <http://ebc.maricopa.gov/ehi> home page. This notice describes the potential uses and disclosures of Protected Health Information (PHI), the individual's rights and the plan's legal duties with respect to PHI. The privacy notice may be updated occasionally and such updates will be communicated through [e**Nouncements*](#), accessible through the EBC.

SHARING OF YOUR PROTECTED HEALTH INFORMATION

You and your dependents' protected health information (PHI) will be shared with specific benefit plan representatives and others for the purposes of your health care treatment, payment for that treatment and health care operations (as defined in the HIPAA of 1996, as amended) of Maricopa County and of the benefit plan vendors, as well as for other purposes allowed or required by law. When you submit your enrollment application, are defaulted to a benefit plan because you did not submit your enrollment application timely, make an open enrollment or qualified status change or continue with your current coverage, you are acknowledging and accepting that Maricopa County and your health care providers, which could include CIGNA, CIGNA Dental, Walgreens Health Initiatives (WHI), Magellan Health Services, Delta Dental, EDS, The Standard, Sedgwick CMS, EyeMed Vision Care, Application Software Inc. may share medical and administrative information concerning you and your dependents. By participating in the benefit plans, you are releasing Maricopa County and Maricopa County's plan administrators, benefit managers and vendors from any liability for any good faith release of PHI pursuant to this acknowledgement.

EMPLOYEE CERTIFICATION

By submitting your benefit elections or by allowing your benefits to be defaulted for coverage, you are authorizing Maricopa County to take deductions from your paycheck and from any short-term disability payments you may receive, to pay for benefit costs. Further, you are authorizing Maricopa County to take additional deductions from your paycheck and/or any short-term disability you may receive to reimburse Maricopa County for any benefits you and/or your dependents were unauthorized or ineligible to receive because you provided inaccurate, incorrect and/or incomplete information to Maricopa County. Deductions to reimburse Maricopa County will be in accordance with the law. You are also authorizing the Employee Health Initiatives Department to send necessary personal information to your selected vendors to initiate and support your coverage.

NOTICE REGARDING USE OF YOUR SOCIAL SECURITY NUMBER

Disclosure of your Social Security Number (SSN) for purposes of enrollment and other benefit-related uses is voluntary. Identification (ID) cards from all vendors will carry either a) no ID number, b) an edited ID number (revealing only the last four digits of your SSN), c) your employee ID number, or d) a randomly system-generated number. Your SSN is transmitted to the benefit plan vendors for administrative purposes. Some vendors will use your SSN as your ID number or cross-reference their assigned ID number to your SSN. If you do not want your SSN transmitted to the benefit plan vendors, you may request an alternative ID number. If you are participating in Mariflex, the vendor must have access to your SSN to report your flexible spending account information to the Internal Revenue Service (IRS). If you enroll in the group legal plan, MetLaw, the vendor requires your social security number. If you do not want your social security number sent to MetLaw, you should not enroll in this voluntary benefit.

ALTERNATIVE ID NUMBER

You may request an alternative ID number to be used in lieu of using your SSN at any time by completing the Alternative ID Request form available on the Home page, or by sending your request in writing to the EHI Department. You will be provided with a form to complete before the alternative number will be assigned. This will delay your enrollment (but not your benefit beginning coverage date) in benefits until the alternative number is assigned.

The EHI Department will provide your alternative ID number to you and to your medical, pharmacy, vision, behavioral health and dental vendors. Once the vendor assigns an alternative ID number, you and your dependents will not be identifiable by your SSN.

Assignment of an alternative ID number may become a temporary barrier to receiving medical services or to having your medical claims correctly paid. You are responsible for advising each provider that you have an alternative ID number. If the vendor uses a system-generated ID number, your alternative ID number will be cross-referenced to the system-generated ID number. When you access services, your provider will verify your current eligibility by calling the vendor. The provider must use either your current alternative ID number or your system-generated ID number so that your eligibility can be established, you can access services and your claims can be processed and paid. Additionally, when an alternative ID number is assigned, if you have ever been identified by your SSN, some vendors do not have the technology to cross-reference your records to re-establish prior authorizations or referrals for your care or to process claims submitted under your SSN because the key link between you and their records (your SSN) has been broken. This may cause a temporary delay in receipt of services or result in denied claims until you notify the vendor to correct the records

WELLNESS INITIATIVES AND INCENTIVES

Maricopa County values the health and well being of our employees. That's why we continue to improve our employee worksite wellness program by offering the following health and wellness initiatives and incentives.

We encourage you to participate in the initiatives and incentives for which you qualify in order to learn how you can take more control of your health and well being. If you would like additional information regarding the information below, please call the Employee Health Initiatives Department or go the EHI Home page and click on the Wellness tab. Wellness initiatives are communicated by e*Nouncements via the EBC. Please check with your department for its policy on attending wellness initiatives and programs.

WELLNESS INITIATIVES AND INCENTIVES

<i>Initiative</i>	<i>Description</i>	<i>Who is Eligible?</i>	<i>How to Access Services/Incentives</i>	<i>Cost/Incentive</i>
24/7 Fitness Center	Located in the basement of the County Administration building; locker rooms with showers, weights and cardio equipment	All employees	Complete enrollment form, located on the EHI Home page	No Cost
24-Hour Health Information Line	A telephonic health information library where you can listen to pre-recorded information on over a hundred health topics. Or, speak to a nurse for answers to your questions, suggestions for helpful home care, or assessment of symptoms and direction to the most appropriate care	Employees and their dependents enrolled in a County-sponsored CIGNA medical plan	Call 800-244-6224 and listen for the prompt for the 24-hour Health Information Line or call 800-564-8982 for nurse assistance To access the list of health information topics, go to www.mycigna.com , click on the My Health tab at the top of the page, look at the Health Management Resources heading, then click on print available audio tape topics	No Cost
Adult Immunizations	Shots for: Flu (including Flu Mist) Pneumonia Tdap (Tetanus, Diphtheria & Pertussis)	Employees and their dependents enrolled in a County-sponsored CIGNA medical plan; must meet CDC guidelines for age, frequency and risk factors.	No appointment required for employee only on-site flu shot clinics; service is provided on a first come first served basis. Employees and dependents may access flu shots at CIGNA flu shot clinics; Employees and dependents may receive flu shots at local Walgreens pharmacies. Appointment required for Tdap shots through the Wellness Coordinator, 602-506-3758 or granthaml@mail.maricopa.gov	No Cost
Am I Hungry?	An 8-week workshop that teaches you how to be in charge of your eating instead of feeling out of control; eat the foods you love without overeating and without guilt, and eat healthier foods without depriving or restricting yourself	Employees enrolled in a County-sponsored CIGNA medical plan	Enroll via Pathlore for class LIF160	No Cost
Biometric Screening	Brief personal health history, measurements of height, weight, waist circumference, body fat composition, non-fasting or fasting cholesterol and glucose levels, and blood pressure	Employees enrolled in a County-sponsored CIGNA medical plan	By appointment only through vendor and/or Wellness Coordinator. E*Nouncement provides scheduling details.	No Cost; Save up to \$120 per year (\$5 per pay period) on your County medical insurance premium

Please note, that wellness programs may be discontinued during the benefit plan year based on availability or the program.

<i>Initiative</i>	<i>Description</i>	<i>Who is Eligible?</i>	<i>How to Access Services/Incentives</i>	<i>Cost/Incentive</i>
Blueprint for Wellness	30+ fasting lab tests, optional PSA for males over 40, optional fecal occult home test kit for employees over 50, mandatory online health risk assessment and a confidential personal wellness report	Employees enrolled in a County-sponsored WHI pharmacy plan who have not participated in a Blueprint event in the last 6 months	By appointment only; scheduled online through Blueprint for Wellness	No Cost
Chronic Disease Self-Management Program	Educational program developed by Stanford University for employees with chronic conditions such as asthma, arthritis, diabetes, high blood pressure, low back pain or heart disease; 6-week course for 2 ½ hours per week	Employees enrolled in a County-sponsored CIGNA medical plan	Enroll through Pathlore on the EBC Intranet Look for class PED136B	No Cost; Receive a workbook, <i>Living a Healthy Life with Chronic Conditions</i> and an audio relaxation tape, <i>Time for Healing</i>
Culprit and the Cure	6-week course focused on achieving and maintaining how to eat right and exercise, and set and achieve attainable goals.	Employees enrolled in a County-sponsored CIGNA medical plan	Enroll via Pathlore on the EBC Intranet	No Cost; receive the <i>Stop and Go</i> book during class and <i>Culprit and Cure</i> book if you attend all 6 classes
Diabetes Management Program	Meet 9 conditions to participate; Click here to review the brochure	Employees and their dependents diagnosed with diabetes who are enrolled in a County-sponsored WHI prescription plan	Enroll via the Wellness Coordinator 602-506-3758 granthaml@mail.maricopa.gov	No Cost; Receive free diabetic medications and supplies for one year; annual recertification required for continued participation.
Ergonomics Classes	Various classes taught by Ergonomic Specialists; Custom classes are available for locations with at least 10 participants	All employees	Enroll via Pathlore on the EBC Internet.	No Cost
Ergonomics consult for seating, lighting, furniture, and equipment	On-site evaluation of facility	All employees	Go to EHI web site and download the ergonomic request service form. Have your supervisor sign the form and fax to 602-506-8974. Some departments have ergonomic facilitators who handle all ergo requests.	No Cost
Ergonomics Evaluation	Evaluation at your individual workstation	All employees	Go to EHI web site and download the ergonomic request service form. Have your supervisor sign the form and fax to 602-506-8974. Some departments have ergonomic facilitators who handle all ergo requests.	No Cost

<i>Initiative</i>	<i>Description</i>	<i>Who is Eligible?</i>	<i>How to Access Services/Incentives</i>	<i>Cost/Incentive</i>
Exercise Physiologist	Small group class with exercise physiologist who instructs and demonstrates on the basics of getting started on an exercise program	Employees enrolled in a County-sponsored CIGNA medical plan	By appointment only through the Wellness Coordinator 602-506-3758 granthaml@mail.maricopa.gov	No Cost
Health Coaching	Voluntary coaching program for employees with certain risks identified through the Biometric Screening Program and/or Health Risk Assessment; help with developing a personal action plan, overcoming personal challenges, and staying motivated with one-on-one support and encouragement	Employees who participated in the Biometric Screening Program and/or Health Risk Assessment who have certain risk factors	Health Coach will contact you directly by phone	No Cost
Health Risk Assessment	Online questionnaire regarding your health and lifestyle. Confidential results alert you to health risks and provide information on how to improve your health score	Employees enrolled in a County-sponsored CIGNA medical plan	Available online at www.mycigna.com ; registration instructions and directions on how to access the health risk assessment tool are available on EHI Home page	No Cost; Save up to \$120 per year (\$5 per pay period) on your County medical insurance premium
Healthy Living Diabetes Care Management Program	Educational program provided by WHI and the Joslin Diabetes Center, the global leader in diabetes research, care and education, dedicated to improving health outcomes for people with diabetes	Employees and their dependents who have met the participation requirements of the Diabetes Management Program	Enroll via the Wellness Coordinator 602-506-3758 granthaml@mail.maricopa.gov	No Cost; Upon program completion, participants will be reimbursed for up to 9 diabetic-related office visit copays per plan year
Healthy Pregnancies, Healthy Babies Program	Comprehensive maternity support program that provides education, assessment and a care plan	Pregnant female employees enrolled in a County-sponsored CIGNA medical plan	Enroll by calling 800-244-6224 and ask to enroll in the Healthy Pregnancies, Healthy Babies Program	No Cost; \$150 incentive available at program completion if enrolled in first trimester or \$75 if enrolled in second trimester

Please note, that wellness programs may be discontinued during the benefit plan year based on availability or the program.

<i>Initiative</i>	<i>Description</i>	<i>Who is Eligible?</i>	<i>How to Access Services/Incentives</i>	<i>Cost/Incentive</i>
Healthy Rewards	A discount program available through CIGNA that offers discounts on weight management and nutrition products and services; fitness equipment, clubs and programs; tobacco cessation program, alternative medicine services; mind/body programs; dental care; vitamins and health and wellness products	Employees and their dependents enrolled in a County-sponsored CIGNA medical plan	Information available via www.cigna.com Type in Healthy Rewards in the search box	Product and service costs and discounts are available on the CIGNA web site
Life Line Screening	Ultrasound screenings for osteoporosis (bone density), carotid artery, abdominal aortic aneurysm, and peripheral arterial disease	All employees	By appointment through Life Line 602-230-2333	Fee for each screening; lower pricing available for 3 or more tests
Lunch N Learns	Monthly classes on various health topics	All employees	Registration requested through the Wellness Coordinator 602-506-3758 granthaml@mail.maricopa.gov Walk-ins are allowed if space permits	No Cost
Mobile On-Site Dentist	Full service general dentistry offering complete examinations, digital x-rays and restorative services including crowns and bridges	Employees enrolled in a County-sponsored CIGNA Dental or Delta Dental plan	Make appointments via www.onsitedental.com or call 888-411-2290	Per service as defined in your dental benefit plan
Mobile On-Site Mammography (MOM)	Mammography screening	Female employees at least 40 years of age enrolled in a County-sponsored CIGNA medical plan; other insurance also accepted	By appointment through MOM 480-967-3767 www.mobileonsitemammography.com	No Cost
Non-Smoker Reward for Additional Life Insurance	Non-smoking employees who have been smoke-free for at least 12 months receive a rate reduction on additional life insurance	All benefit-eligible employees	If you have either never smoked or have not smoked for more than 12 months, you should review your Smoker status in PeopleSoft by going to the Employee Self Service link, clicking on Personal Information Summary, scrolling to the bottom of the page to the “Smoker Status” field.	Rate reduction for non-smokers when additional life insurance is purchased. Refer to life insurance rates in life insurance section.

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<i>Initiative</i>	<i>Description</i>	<i>Who is Eligible?</i>	<i>How to Access Services/Incentives</i>	<i>Cost/Incentive</i>
Non-Tobacco User Medical Insurance Rate Reduction	Non-tobacco using employees and/or their covered dependents who have been tobacco free for at least 6 months receive an incentive	Employees enrolled in a County-sponsored CIGNA medical plan	During benefit election, respond NO to the Tobacco Use question. If you and/or your dependents stopped using tobacco after your benefit election and you and/or your dependents have been tobacco-free for more than 6 months, complete the Tobacco User Status Change Request form located on the EHI Home page, under the Forms link, General forms; submit form to the EHI Department.	Save up to \$390 per year (\$15 per pay period) on your County medical insurance premium
On-Site Screenings	Blood pressure checks; Body composition evaluations; Strength test (dynamometer); Flexibility test (sit & reach); Sub-Max cardio test (3 minute step); Bone density; Sun damage awareness (Dermascan); Diabetic foot screening; and Spirometry	Employees and their dependents enrolled in a County-sponsored CIGNA medical plan	Enroll via the Wellness Coordinator 602-506-3758 granthaml@mail.maricopa.gov	No Cost
Prostate On-Site Project (POP)	Prostate Antigen Specific (PSA) blood test and digital rectal exam	Annually for male employees at least 40 years of age enrolled in a County-sponsored CIGNA medical plan	By appointment through the Wellness Coordinator 602-506-3758 granthaml@mail.maricopa.gov	No Cost
Pure Fitness Discount	Fitness Center with 11 locations	All employees	Contact Pure Fitness 602-577-4109 gina@purefitnessclubs.com	\$19 per month; Cost can change without notice
Work Life Balance	Classes offered through various mediums: On-site instructor, online class or webinar.	All employees (for on-site classes); and employees enrolled in a County-sponsored CIGNA medical plan (for online classes or webinars)	Enroll through Pathlore for on-site classes and webinars. Go to http://ebc.maricopa.gov/training , click on the "On-line Learning Center" link. A new window will pop-up, click on "Schedule of Upcoming Classes", scroll down to "Employee Benefits" and click the "GO!" button.	No Cost
Waisting Away Incentive Program	Program offering a reward for losing weight when attending Weight Watcher (WW) classes	Employees and their dependents age 10 and up enrolled in a County-sponsored CIGNA medical plan	Contact the Wellness Coordinator upon meeting program requirements. Must provide a copy of your paid receipt for the WW 10-week program along with a copy of the WW booklet showing attendance dates, and your beginning and ending weight	Attend 8 of 10 WW classes in a 10-week period and lose 10 pounds to receive \$110 American Express Gift card
Weight-to-Go	8-week, 1½ hour class taught by a Registered Dietician. Includes 6-month follow-up class	Employees enrolled in a County-sponsored CIGNA medical plan	By appointment through the Wellness Coordinator 602-506-3758 granthaml@mail.maricopa.gov	No Cost

Please note, that wellness programs may be discontinued during the benefit plan year based on availability or the program.

<i>Initiative</i>	<i>Description</i>	<i>Who is Eligible?</i>	<i>How to Access Services/Incentives</i>	<i>Cost/Incentive</i>
Weight Watchers at Work	10-week program that focuses on portion control, mindful eating and lifestyle changes	All employees	Enroll through Weight Watchers 602-248-0303	\$120 per each 10-week session. Costs may increase without notice
Well Aware Disease Management Program	A Program that offers telephonic guidance and resources from a registered nurse for diseases and conditions such as asthma, diabetes, COPD, low back pain, weight complications, heart disease, fibromyalgia, acid-related disorders, atrial fibrillation, decubitus ulcer, hepatitis C, inflammatory bowel disease, irritable bowel syndrome, osteoarthritis, osteoporosis, and urinary incontinence	Employees and their dependents enrolled in a County-sponsored CIGNA medical plan with specific diseases or conditions	A Well Aware nurse will contact you directly or you may enroll by calling 866-797-5833	No Cost
Wellness Expo	Visit with health care vendors and receive information on health, benefits and ergonomics; participate in preventive screenings	All employees	None	No Cost

Please note, that wellness programs may be discontinued during the benefit plan year based on availability or the program.



MEDICAL PLANS

Administered by CIGNA

This section provides a brief summary of information on the different medical plans offered, how they operate and the costs of services and premium. For more detailed information, please contact the CIGNA Pre-Enrollment or customer service phone number listed in the “Who to Contact” section. Choices include CMG (CIGNA Medical Group), a managed-care health maintenance organization (HMO) plan, Open Access Plus In-Network (OAPIN), an HMO plan with open access to specialists within the network, Open Access Plus (OAP), an HMO plan with open access to specialists both within the network and outside of the network, and a high deductible health plan, CIGNA Choice Fund, with a Health Savings Account. Some plans have a high and a low option from which to choose. High options have higher premiums but lower copayments for services while low options have lower premiums but higher copayments for services.

If you enroll in a medical plan, you must select “Tobacco User Yes” or “Tobacco User No” when completing your online enrollment through Employee Self Service. If you do not answer this question, it will be assumed that you are a tobacco user and you will be charged a higher premium. “Tobacco User” means the occasional or regular use of a tobacco product including but not limited to cigarettes, cigars, pipes, snuff, chewing tobacco and any other product containing tobacco. **Tobacco user status applies to you and any of your dependents**

that are enrolled in a county medical plan. Additionally, enrollment in a medical plan requires you to respond to questions regarding Biometric Screening and Health Risk Assessment participation. When you participate in either or both initiatives, you save up to \$120 per year per initiative from the cost of your health insurance. If you do not answer the questions associated with these initiatives, it will be assumed that you are not participating and you will be charged a higher premium.

All medical plans include the following, except as noted

Alternative Medicine Benefit: Twenty self-referred alternative medicine visits per plan year are covered. Copayments vary depending upon the medical plan selected. A \$60 credit for herbal/homeopathic or natural supplies dispensed in conjunction with an office visit is also covered. Providers in CIGNA's designated alternative medicine network must be used when accessing this benefit. This benefit is not available out-of-network. Covered services are:

- Physician evaluation and management
- Physical medicine
- Acupuncture/acupressure
- Massage therapy
- Homeopathic consultation
- Biofeedback/guided imagery

Behavioral Health/Substance Abuse Benefit: Provided by Magellan Health Services except for CIGNA Choice Fund for which the benefit is provided by CIGNA Behavioral Health. Refer to the "Behavioral Health and Substance Abuse" section for benefit details.

Vision Benefit: Provided by EyeMed Vision Care. See the "Vision Benefit Plan" section for benefit details.

Pharmacy Benefit: Provided by Walgreens Health Initiatives (except for CIGNA Choice Fund plan for which the benefit is provided by CIGNA). You will select your pharmacy benefit separately from your medical plan, except for the CIGNA Choice Fund plan. Refer to the "Pharmacy Benefit" section for plan choices and benefit details.

24-hour worldwide emergency care.

24-hour Health Information Linesm: Provides access to health information from Registered Nurses at any time. When you are not sure where to go to seek non-emergency care, you can call and speak with a nurse who can respond to your health care questions, direct you to the nearest participating medical facility or provide suggestions for helpful home care that may comfort you until you can see your doctor. Call 800-244-6224 and listen for the prompt for the 24-hour Health Information Line or call 800-564-8982. You also have access to the Health Information Library where you can listen to taped programs on hundreds of topics. Refer to the Wellness Initiatives and Incentives section for information on how to access the list of topics.

Wellness Programs: Well Aware for Better Health is an integrated disease management program helping CIGNA members manage asthma, low back pain, cardiovascular disease, diabetes, chronic obstructive pulmonary disease, weight complications, and targeted conditions such as fibromyalgia, hepatitis C, irritable bowel syndrome, acid-related disorders, atrial fibrillation (irregular or fast heartbeat), decubitus ulcer (pressure or bed sore), inflammatory bowel disease, osteoarthritis, osteoporosis and urinary incontinence. To see if you qualify, call 800-249-6512. Once you are enrolled in a disease management program, you can contact a nurse or dietician for consultation at 877-888-3091. Healthy Pregnancies, Healthy Babies is another wellness program for prenatal guidance, available by calling 800-244-6224. An incentive is available when you complete the program. If you enroll in the first trimester you will receive \$150, or \$75 for second trimester enrollment. Additional wellness programs are available to employees enrolled in County medical plans. Please refer to the "Wellness" section for further information.

Healthy Rewards Program: Discounts on alternative health services and health and wellness products such as fitness club memberships, chiropractic services, therapeutic massage, acupuncture, cosmetic dentistry, laser vision correction, vitamins and herbal supplements, and hearing aids and tests. Call 800-870-3470 to find out more information or go online to www.CIGNA.com/healthyrewards.

myCIGNA.com: Access your benefit and claim information, request an ID card, view your provider directory, change your PCP and more through this secure online Web site.

Guesting Privileges: Provides access to in-network benefits while your dependents are temporarily absent from the service area. Call the CIGNA Customer Service Department to determine whether your dependent qualifies to participate. Certain restrictions apply.

The information on the next four pages are brief summaries of each plan. The detailed Summary Plan Documents are available on the EBC Intranet at ebc.maricopa.gov/ehi.

CIGNA administers the plan. If you have questions regarding covered benefits, claims payment, the appeal process or a provider's participation status, contact CIGNA Customer Service Department, 8 AM - 6 PM MST, Monday - Friday. Additional resources that are available are CIGNA's Web sites www.cigna.com, www.mycigna.com, and www.mycignaplans.com.

Medical claims should be mailed to: CIGNA
P.O. Box 182223
Chattanooga, TN 37422-7223

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	<u>HMO</u>		<u>HMO</u>		<u>HMO</u> 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	
Per Pay Period (24/yr.) Medical Premiums**	Full-time	Part-time	Full-time	Part-time	Full-time	Part-time
Employee	\$5.92	\$85.38	\$4.34	\$60.28	\$11.96	\$86.94
Employee + Spouse	\$22.14	\$95.28	\$17.12	\$71.40	\$55.12	\$96.74
Employee + Child(ren)	\$12.16	\$92.38	\$9.36	\$68.92	\$39.34	\$94.10
Employee + Family	\$38.24	\$99.42	\$29.16	\$73.36	\$81.70	\$100.96

**These premiums are based on all participants being tobacco free and employee voluntarily participating in the biometric screening and Health Risk Assessment initiatives. Medical premiums also include the behavioral health premium. Add \$15 per household for tobacco-users (employees and/or covered dependents). Add \$5 if the employee did not voluntarily participate in the biometric screening initiative. Add \$5 if the employee did not voluntarily participate in the health risk assessment initiative.

Find out how the plans work and compare plans to determine which plan works best for you. Logon to www.mycignaplans.com between April 14, 2008 through June 30, 2009 using **username: Maricopa2008** and **password: cigna**

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.

MEDICAL PLAN SUMMARY CHART

Benefit Provision	Open Access Plus High (OAP High):		Open Access Plus Low (OAP Low):		Choice Fund-HSA ¹ :	
Type of Plan	<u>HMO</u> with Open Access to Specialists		<u>HMO</u> with Open Access to Specialists		<u>High-deductible PPO</u> plan with partially funded Health Savings Account ¹ ; cant' be enrolled in any other type of medical insurance	
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.	
Per Pay Period (24/yr.) Medical Premiums**	Full-time	Part-time	Full-time	Part-time	Full-time	Part-time
Employee	\$14.58	\$104.84	\$4.62	\$67.04	\$0.00	\$90.48
Employee + Spouse	\$64.30	\$117.44	\$17.76	\$74.26	\$0.00	\$105.30
Employee + Child(ren)	\$46.06	\$113.92	\$9.68	\$72.32	\$0.00	\$99.90
Employee + Family	\$95.42	\$123.44	\$30.46	\$76.72	\$0.00	\$114.24

**These premiums are based on all participants being tobacco free and employee voluntarily participating in the biometric screening and Health Risk Assessment initiatives. Medical premiums also include the behavioral health premium. Add \$15 per household for tobacco-users (employees and/or covered dependents). Add \$5 if the employee did not voluntarily participate in the biometric screening initiative. Add \$5 if the employee did not voluntarily participate in the health risk assessment initiative.

¹Maricopa County contributes up to \$500 for employee only or \$1,000 for employee and dependent coverage to your HSA pro-rated by the number of months remaining in the plan year. You can contribute up to \$2,900 (individual) or \$5,800 (family) to your HSA depending on the amount contributed by Maricopa County, plus \$900 catch-up if over 55. Unused balances rollover.

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.

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	Individual	None	None	None
	Family	None	None	None
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		\$15	\$25	\$20
Specialty Care Physician Services		\$25* / \$40	\$45* / \$60	\$30* / \$45
Advanced radiology: 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		\$0	\$0	\$0
Inpatient Facility Charges		\$100/admit	\$500/admit, then 10%	\$200/admit
Inpatient Physician and Surgeon's Services		\$0	\$0	\$0
Outpatient Facility Services		\$0	\$250, then 10%	\$100
Pre- & Postnatal Exams (after pregnancy has been determined)		\$25, waived after 1st visit	\$45, waived after 1st visit	\$30, waived after 1st visit
Delivery		\$100	\$500, then 10%	\$200
Urgent Care		\$35, waived if admitted	\$50, waived if admitted	\$50, waived if admitted
Emergency Room		\$125, waived if admitted	\$125, waived if admitted	\$125, waived if admitted
Ambulance		\$0	\$0	\$0
Durable Medical Equipment No annual limit		\$0	\$0	\$0
External Prosthetics		\$0	\$0	\$0
Chiropractic Services, Pulmonary Rehab, Physical, Speech, Occupational and Cognitive Therapy 120 visits maximum combined/yr.		\$25/provider/day***	\$45/provider/day***	\$30/provider/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	Magellan/WHI	Magellan/WHI

For more detail, review the medical plan summaries on the EHI Home Page or go to 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 year. Other therapies have a combined 60 visit per year.

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.

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
None	\$500	None	\$1,000	\$1,200 (cross accumulated)	\$1,200 (cross accumulated)
None	\$1,000	None	\$2,000	\$2,400 (cross accumulated)	\$2,400 (cross accumulated)
N/A	70% of reasonable and 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
\$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 preventative	30% after deductible
\$250/admit	30% after deductible	\$1,000/admit, then 10%	\$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
\$100	30% after deductible	\$500, then 10%	\$1,000/admit, then 30% after deductible	10% after deductible	30% after deductible
\$35, waived after 1st visit	30% after deductible	\$50, then 10%	30% after deductible	10% after deductible	30% after deductible
\$250	30% after deductible	\$1,000, then 10%	\$2,000, then 30% after deductible	10% after deductible	30% after deductible
\$50, waived if admitted	\$50, waived if admitted	\$75, waived if admitted	\$75, waived if admitted	10% after deductible	10% after deductible
\$125, waived if admitted	\$125, 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
\$0	30% after deductible	10%	30% after deductible	10% after deductible; No limit	30% after deductible; No limit
\$0	30% after deductible	10%	30% after deductible	10%	30% after deductible
\$35/provider/day	30% after deductible/ provider/day	\$50/provider/day	30% after deductible/ provider/day	10% after deductible/ provider/day	30% after deductible/ provider/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	Magellan/WHI	Magellan/WHI	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 to compare plans.

*CIGNA Care Network Specialist

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.



PHARMACY PLANS

Administered by Walgreens Health Initiatives (WHI)

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 cost¹ of the medication) is charged (unless the applicable minimum or maximum copay applies) based on the classification of the medication. 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 drug classes, such as infertility and cosmetic medications, are excluded. You are responsible for paying 100% of the contracted cost 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. 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 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 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	\$30 Maximum ³
Level 3	Non-Preferred Brand with Generic equivalent	\$20 Minimum	50% Co-insurance ¹ +	Difference between brand & generic cost
Level 4	Non-Preferred Brand with No Generic equivalent	\$20 Minimum	50% Co-insurance ¹	
Level 5	Non-Preferred Brand Specialty Drugs	\$50 Copay		

Per Pay Period (24/yr.) Pharmacy Premiums	Full-Time	Part-Time
Employee	\$5.16	\$14.26
Employee+Spouse	\$10.22	\$20.26
Employee+Child(ren)	\$7.68	\$17.48
Employee+Family	\$15.34	\$25.78

¹ 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

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

³ Maximums are reduced when mail service is used.

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Contact Walgreens Health Initiatives for additional information, or view the detailed [Pharmacy Summary Plan](#) document available on the Intranet EHI site at ebc.maricopa.gov/ehi.

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 and no one individual on a Family plan may exceed \$300 of the allocated \$500.
- 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. Individuals insured under a Family plan who reach \$300 of the \$500 deductible are able to move to the Level 3 benefit while the rest of the family must remain at Level 2 until the additional \$200 is met.
- Level 3 is more like your traditional insurance coverage where the County pays 80% of the cost of the medication and you pay 20% of the cost for the remainder of the benefit year.
- Level 4 is limited to specialty medications only and consists of a \$50 copayment. Specialty medication copayments are not charged against any of the first 3 levels.

For further clarification on the Consumer Choice Pharmacy Plan, please refer to the Pharmacy Benefit Plan booklet found on the EHI 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, cosmetics, smoking cessation and non-steroid 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 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. List available on the EHI Home Page.</i>					
Level 1	Pharmacy Account	Individual	\$300 Individual	100% Employer paid ¹	Any unused amount is carried over to next plan year
		Family ²	\$500 Family		
Level 2	Employee Responsibility	Individual	\$300 Individual	100% Employee paid ¹	
		Family ²	\$500 Family		
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 pharmacy account, employee responsibility or insurance levels; Copay applies to out-of-pocket maximum.			

Per Pay Period (24/yr.) Pharmacy Premiums	Full-Time	Part-Time
Employee	\$0.00	\$9.10
Employee+Spouse	\$0.00	\$10.02
Employee+Child(ren)	\$0.00	\$9.80
Employee+Family	\$0.00	\$10.42

¹ 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

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

³ Maximums are reduced when mail service is used.

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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 for a list of pharmacies participating in Advantage90™. Your cost for a three-month supply at an Advantage90™ retail pharmacy is 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 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 EHI Home Page or at www.mywhi.com.

If purchasing medication in a three-month supply is financially problematic, please consider enrolling in either 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, or enrolling in the Health Care FSA (Flex Spending Health Care) and requesting a debit card (requires an additional fee of \$0.75 per pay period). The debit card allows you to pay for your medication in advance up to your annual pre-tax Flexible Spending Account contribution in advance of collecting your full annual contribution. Contact ASI for specific details.

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.

You and/or your covered dependents may voluntarily enroll in the Maricopa County Diabetic Management Program to qualify for free diabetic medications and supplies if you have elected either the Co-insurance or Consumer Choice plan. Once you or your dependents meet the 9 required measures, not only are you able to receive all diabetic medications and supplies free of charge, you also will be eligible to enroll in the Healthy Living Diabetes Care Management Program. Upon completion of this educational program, you will be reimbursed for up to 9 diabetic-related office visit copays per plan year. For information regarding these programs or to request enrollment, please call (602) 506-3758.

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 a three-level co-insurance plan.

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).		

Cost of pharmacy plan included in medical premium for Choice Fund HSA plan
Refer to www.cigna.com for a list of medications by level.

The pharmacy benefit for Choice Fund HSA is administered by:



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COMBINED RATE SHEET

Per Pay Period Total Medical Rates for Non-Tobacco Users and
Employees Participating in the Biometric Screening and Health Risk Assessment
(Includes Medical, pharmacy, behavioral health, vision)

Add \$15 per household for tobacco-users (employees and/or covered dependents)

Add \$5 if the employee did not voluntarily participate in the biometric screening initiative

Add \$5 if the employee did not voluntarily participate in the health risk assessment initiative

CMG High option + Co-insurance Rx	Full-time	Part-time
Employee	\$11.08	\$99.64
Employee + Spouse	\$32.36	\$115.54
Employee + Child(ren)	\$19.84	\$109.86
Employee + Family	\$53.58	\$125.20

CMG High

CMG High option + Consumer Choice Rx	Full-time	Part-time
Employee	\$5.92	\$94.48
Employee + Spouse	\$22.14	\$105.30
Employee + Child(ren)	\$12.16	\$102.18
Employee + Family	\$38.24	\$109.84

CMG Low option + Co-insurance Rx	Full-time	Part-time
Employee	\$9.50	\$74.54
Employee + Spouse	\$27.34	\$91.66
Employee + Child(ren)	\$17.04	\$86.40
Employee + Family	\$44.50	\$99.14

CMG Low

CMG Low option + Consumer Choice Rx	Full-time	Part-time
Employee	\$4.34	\$69.38
Employee + Spouse	\$17.12	\$81.42
Employee + Child(ren)	\$9.36	\$78.72
Employee + Family	\$29.16	\$83.78

OAP In-Network + Co-insurance Rx	Full-time	Part-time
Employee	\$17.12	\$101.20
Employee + Spouse	\$65.34	\$117.00
Employee + Child(ren)	\$47.02	\$111.58
Employee + Family	\$97.04	\$126.74

OAPIN

OAP In-Network + Consumer Choice Rx	Full-time	Part-time
Employee	\$11.96	\$96.04
Employee + Spouse	\$55.12	\$106.76
Employee + Child(ren)	\$39.34	\$103.90
Employee + Family	\$81.70	\$111.38

OAP High option + Co-insurance Rx	Full-time	Part-time
Employee	\$19.74	\$119.10
Employee + Spouse	\$74.52	\$137.70
Employee + Child(ren)	\$53.74	\$131.40
Employee + Family	\$110.76	\$149.22

OAP High

OAP High option + Consumer Choice Rx	Full-time	Part-time
Employee	\$14.58	\$113.94
Employee + Spouse	\$64.30	\$127.46
Employee + Child(ren)	\$46.06	\$123.72
Employee + Family	\$95.42	\$133.86

OAP Low option + Co-insurance Rx	Full-time	Part-time
Employee	\$9.78	\$81.30
Employee + Spouse	\$27.98	\$94.52
Employee + Child(ren)	\$17.36	\$89.80
Employee + Family	\$45.80	\$102.50

OAP Low

OAP Low option + Consumer Choice Rx	Full-time	Part-time
Employee	\$4.62	\$76.14
Employee + Spouse	\$17.76	\$84.28
Employee + Child(ren)	\$9.68	\$82.12
Employee + Family	\$30.46	\$87.14

Choice Fund HSA + CIGNA Rx	Full-time	Part-time
Employee	\$0.00	\$90.48
Employee + Spouse	\$0.00	\$105.30
Employee + Child(ren)	\$0.00	\$99.90
Employee + Family	\$0.00	\$114.24

Choice Fund HSA



DENTAL PLAN SUMMARY CHART

Benefit Provision	EDS		CIGNA Dental*		Delta Dental**	
Type of Plan	<u>DCO</u> (Dental Care Organization)		<u>PPO</u>		<u>PPO</u> (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	<u>www.mydentalplan.net</u>		<u>www.cigna.com</u>		<u>www.deltadentalaz.com</u>	
Per Pay Period (24/yr.) Dental Premiums	Full-time	Part-time	Full-time	Part-time	Full-time	Part-time
	Employee	\$2.16	\$2.16	\$6.98	\$11.58	\$11.18
Employee + Spouse	\$4.10	\$4.10	\$15.38	\$26.44	\$24.66	\$35.72
Employee + Child(ren)	\$5.38	\$5.38	\$16.64	\$27.32	\$26.66	\$37.34
Employee + Family	\$6.18	\$6.18	\$21.36	\$36.10	\$34.24	\$49.00

*Includes the CIGNA Dental Oral Health Integration Program® that addresses risks to pregnancy, diabetes and cardiovascular disease through improved oral health; includes enhanced dental benefits for pregnant members and members enrolled in disease management programs for diabetes and heart disease; also includes coverage for brush biopsy to screen for oral cancer.

**Includes a third dental cleaning for women in their third trimester of pregnancy or members 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 Exams Evaluations Consultations & X-rays		Copay \$0-\$20	Deductible waived			
			\$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 Fillings		Amalgam \$8-\$21 Resin \$22-\$40	Amalgam 20% Resin 50%	Amalgam 40% Resin 50%	Amalgam 20% Resin 50%	Amalgam 20% 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%
Class III - Major Restorative Services			Amount Paid by the Member			
Prosthodontics Bridges per pontic Partial Dentures Complete Dentures (upper or lower)		\$250 + lab fees \$375 + lab fees \$325 + lab fees	50%		50%	
Restorative Cast Crowns & Jackets Onlays & Inlays		\$250 + lab fees \$135 - \$170	50%		50%	
Class IV - Orthodontic Services			Amount Paid by the Member			
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.

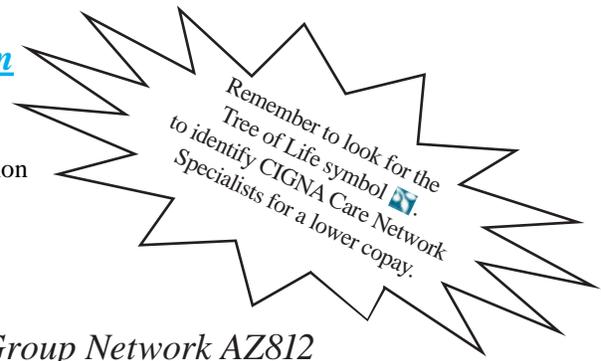
*** Progressive/Regressive Base Plan. If you enroll in this plan, if you receive a preventive service during FY 08-09 plan year you increase your level of coverage for the next plan year.

For more detail, review the dental plan documents on the EHI Home Page.

HOW TO LOOK UP A PHYSICIAN OR DENTIST ONLINE

CIGNA Medical and Dental Plans – Start at www.cigna.com

1. From the home page, select the Provider Directory link (at top of screen)
2. For medical, enter your physician search information
For dental, select the radio button next to Dentist and enter the search information
3. Click on the “Next” button
4. Continue with the applicable instructions below



CMG High and Low Options use the AZ – CIGNA Medical Group Network AZ812

1. On the next page, under “What type of plan you have” section, choose “Network (HMO) Plans or Point of Service (POS) Plans”
2. From the “Network (HMO) Plans or Point of Service (POS) Plans” drop-down list, select AZ-CIGNA Medical Group
3. Under “What you’re looking for” section, select “Primary Care Physician” or “Specialist” and the type from the corresponding drop-down list
4. Click on the “Search” button to view the provider search response

OAP In-Network and OAP High and Low Options use the National Open Access Plus Network AZ300

1. On the next page, under the “What type of plan you have” section, choose “Open Access Plus Only”
2. Under “What you’re looking for” section, select “Primary Care Physician” or “Specialist” and the type from the corresponding drop-down list
3. Click on the “Search” button to view the provider search response

Choice Fund Health Savings Account (HSA) use the National Preferred Provider Network AZ011

1. On the next page, under “What type of plan you have” section, choose “Preferred Provider Organizations (PPO)”
2. Under “What you’re looking for” section, select a physician listed under the “Specialist” area and the type from the corresponding drop-down list
3. Click on the “Search” button to view the provider search response

CIGNA Dental

On the next page, under “Select your dental plan” section, choose CIGNA Dental PPO and select “Core Network” from the drop-down list under “CIGNA Dental EPO (in-network access only). Click on the “Search” button to view the dental search response.

Other Dental Plans

EDS

1. Start at www.mydentalplan.net
2. From the Home page, under the Members Tool section, click on the “Dentist Search” link
3. You can search by city, dentist’s last name or download a provider directory

Delta Dental

1. Start at www.deltadentalaz.com
2. Click on Dentist and then Dentist Search
3. When a new page appears, under “1. Product Selection”, select “Dental Premier” and continue entering the identifying information
4. Or call 602-938-3131 and select 5 and enter the zip code to hear a listing of dentists in your area

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
Exam with Dilation as Necessary	\$10 Copay	\$35
Exam Options: Standard Contact Lens Fit and Follow-Up* Premium Contact Lens Fit and Follow-Up**	Up to \$55 10% off retail price	N/A N/A
Frames: Any available frame at provider location	\$130 allowance, 20% off balance over \$130	\$50
Standard Plastic Lenses: Single Vision Bifocal Trifocal Lenticular	\$10 Copay \$10 Copay \$10 Copay \$10 Copay	\$25 \$40 \$55 \$55
Lens Options: UV Coating Tint (Solid and Gradient) Standard Scratch-Resistance Standard Polycarbonate Standard Anti-Reflective Coating Standard Progressive (Add-on to Bifocal) Other Add-ons and Services	\$15 \$15 \$15 \$0 \$45 \$65 20% off retail price	N/A N/A N/A \$25 N/A N/A N/A
Contact Lenses: (Contact lens allowance covers materials only) Conventional Disposable Medically Necessary	\$0 Copay, \$130 allowance, 15% off balance over \$130 \$0 Copay, \$130 allowance, plus balance over \$130 \$0 Copay, Paid-in-Full	\$130 \$130 \$250
Laser Vision Correction	\$150 allowance; once per lifetime per eye	N/A
Frequency: Examination Frame Lenses or Contact Lenses	Once every 12 months Once every 12 months 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 speciality 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 funded 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. The contact lens benefit allowance is not applicable to this service.

Per Pay Period (24/yr.) Vision Premiums w/Medical Plan	Full-time	Part-time
Employee	\$0.00	\$0.00
Employee + Spouse	\$0.00	\$0.00
Employee + Child	\$0.00	\$0.00
Employee + Family	\$0.00	\$0.00

Per Pay Period (24/yr.) Vision Premiums w/o Medical Plan	Full & Part-time
Employee	\$4.84
Employee + Spouse	\$9.12
Employee + Child	\$9.56
Employee + Family	\$14.04

BEHAVIORAL HEALTH PLAN & EMPLOYEE ASSISTANCE PROGRAM

Administered by Magellan Health Services

Maricopa County offers both an Employee Assistance Program (EAP) and Behavioral Health Benefit administered by the same company, Magellan Health Services (Magellan). All employees (including contract and temporary) and their dependents are eligible for the EAP Program. Dependents under EAP are defined differently than under your health and dental plans. EAP is available for anyone living in your household and for children going to school out of state or who live out-of-state if you are responsible for benefits. However, the Behavioral Health benefit is limited to those employees who have elected CIGNA medical coverage (except for CIGNA Choice Fund Health Savings Account that has coverage through CIGNA Behavioral Health) and to their dependents that are covered under the Medical Plan. For details about the EAP and behavioral health benefit, you may refer to the Magellan brochure and Behavioral Health Summary Plan Document located on the EBC/Intranet at <http://ebc.maricopa.gov/ehi> or on the Internet Web site at www.maricopa.gov/benefits. In addition to EAP and behavioral health services administered by Magellan, Sheriff's Office employees and their dependents may access the Sheriff's Office Behavioral Health Services Unit by calling 602-876-1852.

EAP Program

The Employee Assistance Program (EAP) offered through Magellan is an employer-paid benefit that provides short-term counseling for both personal and work-related issues for you and your dependents. There is no premium charged to you for this benefit and there is no copayment when you use this service.

Sometimes employees face problems that they cannot solve. Concerns can become overwhelming and affect work performance, personal happiness, family relations and health. When this occurs, professional help may be needed to resolve the problem before it becomes a larger issue. You will be assisted by a behavioral health professional who will ensure that your treatment is provided at the most appropriate level for your situation.

Your EAP provides a full range of counseling and referral services for individual, family and marital concerns, stress and job-related matters, child and domestic abuse, chemical and alcohol dependency assessment, and legal or financial issues. Counseling is available by phone or in person, depending on your preference.

Counseling

Your EAP benefit provides up to eight individual counseling sessions for you and your dependents per person, per problem, per year. If sufficient need is shown, upon your approval, your counselor may encourage other member of your family to participate. Magellan provides the strictest confidentiality possible, as set forth in state and federal statutes. Release of information by the EAP concerning an individual can be given only with your written consent, except where required by law (e.g., when child abuse is suspected or when posing a danger to self or others).

Legal Consultation

Your EAP provides legal consultation services. You can call to be referred to an attorney for a prepaid initial in-person consultation or for an immediate telephonic consultation on issues such as estate planning, family and divorce law, civil and criminal matters, and more.

Financial Counseling

Your EAP also includes services to help you reach your financial goals. When you call, you'll be put in touch with a financial expert who can provide information and answer questions on a wide range of topics, including planning for retirement, debt consolidation, and more.

For more information regarding the EAP benefit or to make an appointment, contact Magellan at 888-213-5125, 24 hours a day, seven days a week or online at www.magellanhealth.com.

Behavioral Health Benefit

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

Depression	Legal concerns	Anger management
Severe stress and anxiety	Eating disorders	Financial worries
Alcohol or drug dependency	Grief and loss	Compulsive gambling

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.

The adjacent table is a summary of your benefits. It is important for you to understand that in-network benefits received through a participating provider are payable only if each service is determined to be medically necessary and is approved by Magellan before you start treatment. Higher levels of care for out-of-network providers (such as inpatient, residential, intensive outpatient, and partial hospitalization) also require prior approval by Magellan Health Services. However, out-of-network outpatient individual or group counseling services do not require prior approval.

LIFE INSURANCE PLAN

Fully Insured by The Standard

Your basic and additional life insurance, basic and voluntary accidental death and dismemberment insurance, and dependents life insurance benefits are provided through Standard Insurance Company (“The Standard”). Evidence of insurability may be required when you make your election for additional life insurance depending on the level requested and the total value of your basic and additional life insurance. Evidence of insurability may also be required for late application for additional life insurance. Once you purchase additional life or dependents life insurance, you can reduce it or cancel it at any time.

Basic Term Life with Basic Accidental Death & Dismemberment (AD&D) Insurance

The County provides you with, and pays 100% for, a basic term life insurance benefit equal to your annual salary (excluding overtime, bonus or commissions) rounded up to the next highest \$1,000 to a maximum of \$500,000. Coverage begins on the day after you complete your eligibility waiting period, if a waiting period applies. Life benefits are paid for any cause of death. In addition to the death benefit, AD&D benefits up to the amount of basic life coverage may be payable if an accident is the cause of death or if a dismemberment occurs. Evidence of insurability is not required for basic life and basic AD&D coverage.

Additional Life Insurance

If you want to add to your basic level of coverage, you can apply for additional life insurance. You pay all of the premium for additional life insurance. Evidence of insurability is required for additional life when the coverage requested is greater than the guarantee issue amount of \$500,000.

The amount of your life insurance coverage may not exceed \$1 million of basic life and additional life combined. The amount of your AD&D insurance coverage may not exceed \$500,000 of basic AD&D and \$500,000 of voluntary AD&D.

If you purchase additional life insurance at the time you are a new hire, you can elect coverage in amounts of 1, 2, 3, 4 or 5 times your annual salary rounded up to the next \$1,000. Evidence of insurability will be required for an amount greater than \$500,000. If you elect more than \$500,000, you will be enrolled for coverage up to \$500,000 until your evidence of insurability application for the amount in excess of \$500,000 has been approved.

If you didn’t enroll in additional life insurance as a new hire, you may apply for any level of coverage (1, 2, 3, 4 or 5 times your annual salary) at any time with satisfactory evidence of insurability.

If you experience a qualified status change, you can, within 30 calendar days of that change, add or increase additional life coverage (1, 2, 3, 4 or 5 times your annual salary) without completing an evidence of insurability form, unless the requested amount is greater than \$500,000. If you apply for any amount of life insurance over \$500,000 and you complete an evidence of insurability form, if you are not approved for the increase in coverage, you will remain at the same level you had prior to applying for the increase. However, if your current level is less than \$500,000, your coverage will be increased to the next level as long as that level does not exceed \$500,000. To learn what constitutes a qualified status change, refer to “What is a Qualified Status Change?” section.

During an annual enrollment period, you can increase your additional life coverage by one level without completing an Evidence of Insurability application, provided the increased amount does not exceed \$500,000. If you wish to increase your coverage by more than one level or if the increased amount is over \$500,000, you must complete an Evidence of Insurability application. If you do not complete the Evidence of Insurability application or if you are not approved for the increase in your coverage, you will remain at the same level you had prior to applying for the increase. However, if your current level is below the guarantee issue amount of \$500,000, your coverage will be increased to the next level.

Evidence of Insurability

Evidence of insurability is required for a member or dependent when:

- electing an amount in excess of the guaranteed issue limit; and
- increasing coverage beyond the amount allowed during open enrollment and qualified status change
- benefits are reinstated
- applying more than 30 calendar days after you become eligible (late entrant)
- increasing dependents life insurance

Evidence of insurability is not required for voluntary AD&D insurance. The Evidence of Insurability (Medical History Statement) application is available at www.standard.com/mybenefits/maricopa.

For all employees who are required to complete an Evidence of Insurability (Medical History Statement) application, The Standard will review the information and make a determination whether to approve or deny your request for additional coverage. The Standard may request further information, including, but not limited to, medical records, when making a determination. Coverage and the associated premium do not become effective until The Standard approves your request. For new hires, the effective date of coverage

is the first day of the pay period next following the date your application is approved. Approved increases are effective the first day of the calendar month next following the date your application is approved, or the following July 1 if you apply during an annual enrollment period.

Life Features

- Repatriation
 - Available when death occurs more than 75 miles from insured’s primary residence
 - Reimburses the lesser of 2% of life benefit (Basic and Additional) or \$2,500, for transportation of an insured’s remains to a mortuary near the primary residence
- Accelerated Benefit
 - Applies to insured who is terminally ill with 12 or less months to live
 - Limited to 50% of Basic and Additional life
- Assignment
 - Benefits are not assignable

Medex® Travel Assist Benefit - Group# 7088

Medex® is a comprehensive program of information, referral, assistance, transportation and evacuation services when eligible members are traveling more than 100 miles from home or in a foreign country. The Medex brochure, which contains the ID card, is posted on the EHI Web site and on the Standard’s Web site.

- Services
 - Pre-Trip assistance
 - Medical assistance
 - Emergency transportation services
 - Travel assistance
 - Personal security
 - Medical supplies
- Eligibility
 - Any Maricopa County employee covered by The Standard’s Group Life insurance plan and his/her eligible dependents (spouse and/or unmarried dependent children under age 19 or through age 24 if a full-time student)

Special Rate for Non-Tobacco Users

As part of the County’s commitment to good health, a reward is offered for leading a healthier lifestyle. If you are not a tobacco user, your life insurance premiums are lower than those of an employee who uses tobacco.

Note: Misstatement of tobacco use status may result in the life insurance company rescinding coverage

5 Year Age Categories (Age on last January 1)	Employee Cost Monthly per \$1,000 of Coverage (Non-Tobacco Multiplier)	Employee Cost Monthly per \$1,000 of Coverage (Tobacco Multiplier)
Under 25	\$0.040	\$0.065
25-29	\$0.047	\$0.070
30-34	\$0.062	\$0.080
35-39	\$0.070	\$0.136
40-44	\$0.092	\$0.194
45-49	\$0.150	\$0.385
50-54	\$0.230	\$0.709
55-59	\$0.390	\$0.722
60-64	\$0.660	\$1.120
65-69	\$0.950	\$1.370
70 and older	\$1.760	\$2.250

Additional Life Insurance Premium Calculator Example

If you are enrolling online through Employee Self Service, the system calculates your premium automatically.

Take your annual base salary - example: \$24,500					
Round up to the nearest \$1,000	\$25,000	\$25,000	\$25,000	\$25,000	\$25,000
Multiply	1x Salary	2x Salary	3x Salary	4x Salary	5x Salary
Salary amount	\$25,000	\$50,000	\$75,000	\$100,000	\$125,000
÷ divided by \$1,000	25	50	75	100	125

Refer to the Additional Life Insurance table above to find your age category and multiplier

Multiply the divided result from the last calculation in the table above by the multiplier and divide by 2 to calculate the per pay period premium (24/yr.)

Example: Age 37	Multiplier for Non-Tobacco User \$0.070	Multiplier for Tobacco User \$0.136	Coverage Amount
1 x Salary	$\$0.070 \times 25 = \$1.75/2 = \mathbf{\$0.88}$	$\$0.136 \times 25 = \$3.40/2 = \mathbf{\$1.70}$	\$25,000
2 x Salary	$\$0.070 \times 50 = \$3.50/2 = \mathbf{\$1.75}$	$\$0.136 \times 50 = \$6.80/2 = \mathbf{\$3.40}$	\$50,000
3 x Salary	$\$0.070 \times 75 = \$5.25/2 = \mathbf{\$2.63}$	$\$0.136 \times 75 = \$10.20/2 = \mathbf{\$5.10}$	\$75,000
4 x Salary	$\$0.070 \times 100 = \$7.00/2 = \mathbf{\$3.50}$	$\$0.136 \times 100 = \$13.60/2 = \mathbf{\$6.80}$	\$100,000
5 x Salary	$\$0.070 \times 125 = \$8.75/2 = \mathbf{\$4.38}$	$\$0.136 \times 125 = \$17.00/2 = \mathbf{\$8.50}$	\$125,000

Voluntary AD&D Benefits

This plan also includes voluntary AD&D insurance from The Standard. With voluntary AD&D insurance, you or your beneficiaries may be eligible to receive an additional amount in the event of death or dismemberment as a result of an accident.

Eligible employees may choose voluntary AD&D coverage of 1, 2, 3, 4 or 5 times their annual salary, rounded to the next \$1,000. The maximum amount is \$500,000.

You may elect voluntary AD&D coverage for yourself, or you may elect family coverage for you and your spouse and child(ren). If you elect family coverage, the amount of AD&D coverage for your spouse and child(ren) will equal a percentage of your voluntary AD&D insurance as follows:

- Spouse only: 60%
- Child(ren) only: 10% for each child, not to exceed \$25,000
- Spouse and child(ren): 50% for your spouse; 5% for each child

You are not required to elect additional life coverage in order to elect voluntary AD&D.

Voluntary Accidental Death & Dismemberment Family Monthly Cost
\$0.035 per \$1,000
Employee Only Cost
\$0.02 per \$1,000

Other voluntary AD&D benefit features are listed below:

- Seat Belt
 - Lesser of \$25,000 or 10% of AD&D benefit payable for loss of life
 - Applies to insured passenger or driver as evidenced by police report
- Airbag
 - Lesser of \$15,000 or 5% of the AD&D benefit payable for loss of life
 - Applies if seat belt benefit is payable for a passenger or driver in position to be protected by airbag as evidenced by police report
- Career Adjustment
 - Lesser of \$10,000 or 25% of AD&D benefit; \$5,000 per year maximum
 - Payable to surviving spouse
 - Pays tuition expense up to three years after death
- Child Care
 - 3% of the amount of the AD&D benefit; \$2,000 per year maximum
 - Payable to surviving spouse for eligible child(ren)
 - Pays child care expenses (for a licensed provider) up to three years after death

- Higher Education
 - Lesser of \$40,000 or 25% of AD&D benefit; \$10,000 per year maximum
 - Available to surviving child(ren) at or near high school/college age
 - Pays tuition expense up to four years after member’s death
- Line of Duty
 - Lesser of \$50,000 or 100% of the amount of AD&D benefits payable for the loss of insured public safety officer (does not include corrections, probation, parole or judicial officers)
- Occupational Assault
 - Lesser of \$25,000 or 100% of the amount of AD&D benefit payable for the loss if assaulted while actively at work as evidenced by police report
- Public Transportation
 - Lesser of \$200,000 or 100% AD&D benefit payable for loss by a fare paying passenger on public transportation

AD&D Exclusions

AD&D benefits are not payable for death or dismemberment caused by or contributed by:

- War or acts of war
- Suicide or other intentionally self-inflicted injury
- Injuries sustained while committing or attempting to commit a felony
- Any drug not used in accordance to the directions of a physician
- Sickness, pregnancy, heart attack or stroke
- Medical or surgical treatment for any of the above

Dependents Child and Spouse Life Coverage

In addition to basic and additional life insurance for yourself, you may choose dependents life insurance for your eligible dependents.

Note: You may not cover your spouse as a dependent if he or she is enrolled for basic life coverage as a Maricopa County employee.

Child Life

Child Life coverage may be purchased for the employee’s dependent child(ren) from live birth to age 19, or to age 25 if a full-time student. Coverage may also be purchased for a continuously disabled child(ren). You must provide proof of disability to The Standard within 30 days after a) the date insurance would otherwise end because of the child’s age or b) the effective date of Maricopa County’s coverage under Standard’s policy, if you child is disabled on that date. Contact the EHI Department to obtain the appropriate form to complete for a disabled child.

Coverage is available initially in increments of \$5,000, from \$5,000 to a maximum of \$20,000. The child coverage amount may not exceed the total amount of the employee’s life insurance (Basic and Additional combined). Evidence of insurability is required for child coverage amounts greater than \$10,000. Once insured, all increases require evidence of insurability.

Please note that a dependent child may only be insured by one employee.

Children (live birth to 25 years if full-time student)	
Monthly Cost	Coverage Amount
\$0.50	\$5,000
\$1.00	\$10,000
\$1.50	\$15,000
\$2.00	\$20,000

Spouse Life

Spouse Life coverage may be purchased for the employee’s legal spouse initially in increments of \$10,000, from \$10,000 to a maximum of \$100,000. The spouse coverage amount may not exceed the total amount of the employee’s life insurance (Basic and Additional combined). Evidence of insurability is required for spouse coverage amounts greater than \$50,000. Once insured, all increases require evidence of insurability.

The premium for Spouse Life Insurance coverage is based on the age of the spouse as of January 1 of the current year. In order for the premium to calculate accurately you must ensure that your spouse’s age is included on the dependent record.

Spouse Life - Monthly Cost	
Age on last January 1	Spouse
Under 25	\$0.06/\$1,000
25-29	\$0.07/\$1,000
30-34	\$0.08/\$1,000
35-39	\$0.10/\$1,000
40-44	\$0.12/\$1,000
45-49	\$0.20/\$1,000
50-54	\$0.34/\$1,000
55-59	\$0.54/\$1,000
60-64	\$0.90/\$1,000
65-69	\$1.28/\$1,000
70 and older	\$2.08/\$1,000

Claims Process

Claims must be filed no later than one year from the date of loss. A certified death certificate is required when filing a claim. Please contact the EHI Department in the event of a loss of life or an accidental dismemberment. The Benefits Specialist will assist with providing the Beneficiary Statement Form to the beneficiary and completing the Proof of Death Form.

Summary of Coverage

Coverage	Who is Covered?	Minimum	Maximum	Evidence of Insurability	Who pays premium?	Monthly Premium
Basic Life	Employee Only	1 x salary	\$500,000	None	Maricopa County	.10/1,000
Basic AD&D	Employee Only	1 x salary	\$500,000 (matches Basic Life amount)	None	Maricopa County	.02/1,000
Additional Life ²	Employee Only	1 x salary	5 x salary to a combined total of \$1M (Basic + Additional) at new hire or status change. May only increase 1 level during OE.	>\$500,000	Employee	Based on smoker status & age
Spouse Dependent Life	Legal Spouse of Employee	\$10,000	\$100,000 but not more than EE's combined Basic + Additional. Once insured, all increases require EOI.	>\$50,000 for initial enrollment. Once insured, all increases require EOI, even at OE.	Employee	Based on age
Child(ren) Dependent Life	Child(ren)	\$5,000	\$20,000 per child, but not more than EE's combined Basic + Additional per child. Once insured, all increases will require EOI.	>\$10,000 for initial enrollment. Once insured, all increases require EOI, even at OE.	Employee	.10/1,000
Employee Only Voluntary AD&D ¹	Employee Only	1 x salary	5 x salary to a maximum of \$500,000	Does not apply to AD&D	Employee	.02/1,000
Family Voluntary AD&D ³	Employee, Spouse and Child(ren)	1 x salary	5 x salary to a maximum of \$500,000	Does not apply to AD&D	Employee	.035/1,000

¹Evidence of Insurability is always required for a late entrant (other than a status change or eligible Open enrollment election)

²Employee does not have to enroll in Additional Life in order to purchase Voluntary AD&D

³Family coverage includes employee and/or legal Spouse and/or Child(ren). Employee may not be insured for Employee Only Voluntary AD&D coverage and Family Voluntary AD&D coverage. Family coverage amounts are a) 60% of employee's voluntary AD&D amount when only a Spouse is covered; b) 10% of employee's voluntary AD&D amount up to \$25,000 maximum when only a Child(ren) is covered; and c) 50% of employee's voluntary AD&D amount for a Spouse and 5% for each Child when both Spouse and Child(ren) are covered.

Portability

If your group coverage ends due to employment termination, retirement or reduction in hours, you may be eligible for portable group basic, additional, AD&D and dependent coverages. The portable insurance is available for up to your current coverage amount up to \$1,000,000 or you may decrease the amount of your coverage.

To apply, you must complete the Group Life Insurance Portability form and send it to The Standard along with premium payment within 45 calendar days after your group insurance coverage ends. You and the EHI Department must complete portions of this form. The form is available on The Standard's Web site.

If you die or become divorced, your dependents may be eligible for portable group insurance coverage. The maximum amount of dependents life insurance that may be continued is the lesser of the amount in effect on the day before the insurance would otherwise end or \$100,000 for your spouse and \$10,000 for your child. Your spouse must continue insurance in order to continue insurance for a child.

If you are not eligible to apply for portable coverage or your portable coverage ends, you or your dependents may qualify for conversion coverage.

Conversion

When your group life insurance terminates due to termination of benefits while on a leave of absence (see bullets below), you can convert your basic and additional life coverage (not AD&D) to an individual whole life policy or you may purchase one year term insurance. If you purchase the term insurance, your policy will automatically be renewed at your attained age as a whole life policy at the end of the year, provided the premium is paid on the anniversary. Conversion applies at the end of the following periods.

- If you are not working due to injury or sickness, you can continue to be covered through the end of the pay period following 180 days from the date your approved, unpaid leave status began.
- If you are on a military leave of absence, you will be covered through the end of the pay period following 90 days from the date your military leave of absence began.
- If you are on an approved personal leave of absence, you will be covered through the end of the pay period following 90 days from the date your leave of absence began.

To apply for conversion, you must complete the Application for Conversion of Group Insurance and send it along with premium payment to The Standard within 45 calendar days after your group insurance coverage ends. You and the EHI Department must complete portions of the form. The form is available on the Standard's Web site.

Beneficiaries

You should name a beneficiary for your basic and additional life insurance benefits when you become insured. You may name primary and secondary beneficiaries, and you may name more than one beneficiary as primary and more than one beneficiary as secondary. You may allocate benefits by percentage or amount.

The Beneficiary Designation form is located on the EBC Intranet <http://ebc.maricopa.gov/ehi/> under the Forms link.

If you allocate your benefit as a percentage, you must use a whole percentage. Primary beneficiary designations must equal 100%. Secondary beneficiary designations also must equal 100%.

If you allocate your benefits as an amount, you also must use whole numbers and you must designate a beneficiary to receive any remaining amount.

You may change your beneficiary at any time. The new beneficiary designation will be effective as of the date you submit an electronic designation during annual enrollment or make a beneficiary change online through Employee Self Service.

This is a brief summary of the life and accidental death and dismemberment insurance coverages. For further details of the coverages, you may refer to Maricopa County's Group Life Insurance Certificate on The Standard's Web site.

For more information regarding the life insurance policy or claims payment, contact The Standard Insurance Company at 888-414-0396 or online at www.standard.com/mybenefits/maricopa.

<p>This information is only a brief description of the group Basic Life/AD&D, Additional Life/AD&D insurance policy. For more complete details of coverage, go to The Standard's Web site or contact The Standard.</p>
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SHORT-TERM DISABILITY PLAN

Administered by Sedgwick CMS

Short-term disability (STD) is a plan that replaces a portion of your monthly salary while you are disabled. There is a 3-week waiting period from the onset of your disability during which time you are required to use FML/sick. If you do not have enough of this time, you must use PTO/vacation time. If you have more than 3 weeks FML/sick leave, it all must be exhausted before benefits begin. The maximum payment period is 23 weeks. Any FML/sick leave that continues past the 3-week waiting period reduces the 23-week payment period.

What benefit coverage amount can you elect?

You elect the benefit coverage amount when you enroll for STD coverage. You may elect 40%, 50%, 60% or 70% of your monthly salary. The maximum benefit is \$1,000 per week.

Note: If your weekly disability payment will be at the \$1,000 per week maximum, you may be enrolling in a coverage level with a higher multiplier than necessary. Refer to the STD calculator on the Benefits home page to determine the most cost-effective coverage level.

You may only increase or decrease your coverage during Open Enrollment. No changes will be allowed during the plan year (July 1 through June 30) except when ineligible for benefits (i.e., during leave of absence following a reduction in force after the Career Center or when called to active military duty).

This plan contains a pre-existing condition if you have a condition related to your disability for which you received treatment 90 days before your coverage became effective. In this case, benefits will not be payable for that condition until you have been treatment free for 3 months or covered by the plan for 12 months.

Changes resulting in an increase in benefits are subject to the pre-existing condition. Example: If you previously elected a 50% benefit and during an Open Enrollment period changed your election to a 70% benefit, the difference between the 50% and the 70% benefit is subject to pre-existing condition payment criteria.

If your claim is related to a mental health diagnosis, Sedgwick CMS will work with Magellan Health Services to ensure that you receive a disability assessment and care by a licensed mental health professional and that you are assigned a care coordinator who will regularly work with you, Sedgwick CMS and your mental health provider on your treatment plan and your return-to-work goals. The STD benefit includes a return-to-work incentive designed to lessen the financial hardship that your disability caused by allowing you to return to work on a part-time basis within your restrictions and limitations. Your STD benefit continues to be paid, within certain limits, in addition to your part-time earnings. Refer to the STD Summary Plan Document for an example of this calculation.

How is your benefit payment calculated?

To calculate the amount of your weekly benefit, multiply your weekly earnings by the percentage of the benefit coverage amount you elected and deduct any other income you are receiving that offsets your benefit.

Benefits payable for less than one weekly period will be paid to you at the rate of one-seventh of the STD benefit amount for each day of disability. Other income may offset your disability payment.

Short-Term Disability Rate Calculation Example

Coverage	Multiplier	Monthly Salary: \$2,083.33	40% Option	50% Option	60% Option	70% Option
40%	0.38%	Monthly Premium = Monthly Salary (up to Maximum Monthly Salary) multiplied by Rate Multiplier	\$2,083.33	\$2,083.33	\$2,083.33	\$2,083.33
50%	0.55%		x	x	x	x
60%	0.85%		0.0038	0.0055	0.0085	0.0132
70%	1.32%					
Annual Salary:	\$25,000	Monthly Premium	\$7.92	\$11.46	\$17.71	\$27.50
Annual Salary divided by 12 months = Monthly Salary	\$25,000 ÷ 12 = \$2,083.33	Pay Period Premium = Monthly Premium divided by 2	\$3.96	\$5.73	\$8.86	\$13.75

Refer to the Short-Term Disability Summary Plan Document on the EHI Web site for further details.

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.

MARIFLEX FLEXIBLE SPENDING ACCOUNTS

Administered by ASI

Maricopa County offers two flexible spending accounts (FSA) that allow you to pay for health care and/or day care expenses for your dependents with tax-free money. Once you enroll in an FSA, you must re-enroll during each Open Enrollment to renew your spending account(s).

When you elect to participate in an FSA, your gross income is reduced because your FSA contributions are not subject to Medicare, OASDI, federal or state income taxes. The amount of your contribution is called your annual pledge which is divided by the number of pay periods remaining in the plan year. Eligible health care expenses must be incurred during the plan year (July 1 through June 30) or the following 2½ month grace period (the following July 1 through September 15). Money that is put into an FSA will be forfeited if not used. Claims for reimbursement for the health care and/or the dependent care FSAs must be submitted by the following November 30. To file a claim, complete the claim form located on the EHI Web site under the “Other” tab or the ASI Web site.

Health Care FSA

You can enroll in the health care FSA (unless you enroll in the Choice Fund HSA medical plan or are covered by an HSA) to pay for eligible health care expenses that are not covered by your insurance such as office visit or prescription copays. Certain over-the-counter products purchased to treat an existing or imminent medical condition may qualify as a covered medical expense. These over-the-counter items include allergy medications, smoking cessation products, aspirin, and cold medications. Eligible expenses are defined by the Internal Revenue Service and can be found in IRS Publication 502.

You can set aside up to \$5,200 as your plan year contribution.

An optional debit card is available for a small monthly fee via payroll deduction. The debit card will allow you to process your claim at the time you receive your service. You may be required to submit receipt for services, as determined by ASI.

Because the Walgreens Health Initiatives pharmacy plans require you to purchase maintenance medication in 90-day quantities, it can be very beneficial for you to consider opening an FSA since your full plan year contribution is available as soon as your enrollment is effective.

Limited Use FSA

If you enroll in the CIGNA Choice Fund HSA medical plan, you can still take advantage of the Mariflex plan. However, you and your covered dependents can only participate in the Limited Use plan. You can set aside up to \$5,200 as your plan year contribution. This plan allows you to be reimbursed for dental and vision care services (as defined by the IRS) that are not covered by your insurance.

Dependent Day Care FSA

Dependent care Flexible spending accounts allow you to use pre-tax money to pay for dependent daycare for your dependents under 13 or your spouse or dependent who is physically or mentally incapable of self-care which gives you and your spouse the ability to work. Refer to IRS publication 503 for more information.

You can set aside up to \$5,000 as your calendar year maximum contribution.

To find out more about the Mariflex FSAs including what items are eligible for reimbursement, contact ASI, the Mariflex Flexible Spending Account Administrator by phone or via email with your specific questions.



Don't let him take YOUR MONEY!

DEFERRED COMPENSATION

Administered by Nationwide Retirement Solutions

To enhance your future, Maricopa County, in partnership with Nationwide Retirement Solutions (NRS), offers you a deferred compensation plan.

Your pension plan through ASRS or PSPRS was not designed to provide your entire retirement income, which is why participating in a deferred compensation program is an essential step to achieving financial independence upon retirement. A deferred compensation program allows you to contribute money, before it is taxed, to an account. When you withdraw the monies from your deferred compensation account, typically during retirement, you will have to pay the applicable taxes. However, tax is paid only on the amounts you withdraw in a given year. Meanwhile, the rest of your investment has the opportunity to continue to grow tax deferred.

Once you enroll, contributions are deducted from your paycheck. You can make changes to the amount of your contribution at any time as your personal situation and needs change. The minimum contribution is \$10 per pay period. The maximum contribution is 100% of includible compensation, up to \$15,500 for 2008 if you are under age 50. If you are 50 or older, the catch-up provision allows you to contribute a maximum of \$20,500 in 2008. If you are within three years of retirement, you may qualify to contribute more if you have past dollars to “catch up”. For this pre-retirement window only, the maximum amount deferrable is the lesser of twice the normal deferral limit (\$31,000) or 100% of includible compensation.

You have more than 35 investment choices as well as a Personal Choice Retirement Account through Schwab if you have at least \$5,000 on account. As an added bonus, your money is available to you upon separation from County service with no early withdrawal penalty. Funds are also available for withdrawal for a financial hardship as defined by the IRS or through the loan provision where you can borrow up to 50% of the value of your account with a minimum of \$1,000.

To request a consultation with a retirement specialist, contact NRS at 602-266-2733. For general information, call customer service at 800-598-4457, visit their Web site at www.maricopadc.com or stop by the NRS office located at 4747 N 7th Street, #418, Phoenix, AZ 85014.

METLAW® GROUP LEGAL SERVICES

Administered by MetLife through Hyatt Legal Plans

Finding an affordably priced lawyer to represent you when you have trouble with creditors, buy or sell your home, or even prepare your will can be a challenge. Now there's a simple, affordable solution. MetLaw is a legal services plan that provides legal representation for you, your spouse and dependents at an affordable price.

Now you have a resource at your fingertips for important, everyday legal services. What's more, you'll also have someone to turn to for unexpected legal matters. With MetLaw, you can receive legal advice and fully covered legal service for a wide range of personal legal matters, including:

- Court Appearances
- Document Review and Preparation
- Debt Collection Defense
- Wills
- Family Matters
- Real Estate Matters
- Traffic Ticket Defense (except DUI/DWI)



This is just a partial list of services. For more information contact Hyatt Legal Plans at 800-821-6400 or online at www.legalplans.com (password 1500518).

Services are provided from a network of experienced attorneys either on the phone or in person. When you use a Plan Attorney, there are no deductibles, copays, waiting periods, claim forms or limits on usage. You also have the flexibility to use a non-Plan Attorney and get reimbursed for covered services according to a set fee schedule.

The premium for this plan is \$7.87 per pay period, 24 pay periods per year.

AUTO, HOME AND RENTERS INSURANCE

Fully Insured by Liberty Mutual

As a Maricopa County employee, you qualify for a special group discount* on your auto, home and renters insurance through Group Savings Plus® from Liberty Mutual. With Group Savings Plus, you can enjoy the ease and convenience of paying your premiums through payroll or checking account deductions, with no down payment or finance charges. You also will enjoy fast, easy, round-the-clock claims service and a variety of discounts for multi-car, multi-policy, safe-driver, passive restraints and anti-theft devices.*

See for yourself how much money you could save with Liberty Mutual compared to your current insurance carrier. For a free, no-obligation quote, call 800-524-9400 or visit www.libertymutual.com/lm/maricopacountyemployees.

*Discounts and credits are available where state laws and regulations allow and may vary by state. Certain discounts apply to specific coverage only. To the extent permitted by law, applicants are individually underwritten; not all applicants may qualify. Coverage is provided and underwritten by Liberty Mutual Insurance Company and its affiliates, 175 Berkeley Street, Boston, MA.

Enrollment Worksheet

This worksheet will assist you while you are enrolling for your benefits online at my.maricopa.gov.

Complete this worksheet before you go online and use it to enter your enrollment elections.

Remember to

- turn off your Caps Lock on your keyboard as passwords are case-sensitive
- make sure you did not enter any extra spaces in the password field
- submit your enrollment elections within 30 calendar days of your date of hire or change of appointment or status change.

If you have questions, contact your department
PC Help Desk or the Customer Support Center at
(602) 506-4357 between 6:30 AM - 6 PM, Monday-Friday,
excluding holidays, to reset your password.

The use of this system is restricted to authorized individuals.

M E D I C A L	Coverage	CIGNA Plan	Cost
M E D I C A L	<input type="checkbox"/> Employee only	<input type="checkbox"/> CMG High option	
		<input type="checkbox"/> CMG Low option	
	<input type="checkbox"/> Employee+spouse	<input type="checkbox"/> OAP In-Network only	
		<input type="checkbox"/> OAP High option	
	<input type="checkbox"/> Employee+children	<input type="checkbox"/> OAP Low option	
	<input type="checkbox"/> Employee+family	<input type="checkbox"/> Choice Fund Health Savings Account	
	<input type="checkbox"/> Waive Medical coverage for yourself and dependents (use only if covered under other group health insurance, proof required by May 30, 2008) <i>If you waive your medical coverage, you automatically waive behavioral health/substance abuse and pharmacy benefits.</i>		

D E N T A L	Coverage	Plan	Cost
D E N T A L	<input type="checkbox"/> Employee only	<input type="checkbox"/> Employers Dental Services	
	<input type="checkbox"/> Employee+spouse	<input type="checkbox"/> CIGNA Dental	
	<input type="checkbox"/> Employee+children	<input type="checkbox"/> Delta Dental	
	<input type="checkbox"/> Employee+family		
	<input type="checkbox"/> Waive Dental coverage for yourself and dependents		

V I S I O N	Coverage	Plan	Cost
V I S I O N	<input type="checkbox"/> Employee only	<input type="checkbox"/> Vision for medical plans*	\$0.00
	<input type="checkbox"/> Employee+spouse		
	<input type="checkbox"/> Employee+children	<input type="checkbox"/> Vision for medical waive**	
	<input type="checkbox"/> Employee+family		
	<input type="checkbox"/> Waive Vision coverage for yourself and dependents <i>*If you chose a medical plan, you must enroll in Vision for medical plans</i> <i>**If you waived a medical plan, you may only enroll in Vision for medical waive or Waive Vision coverage</i>		

H E A L T H R I S K A S S E S S M E N T					
H E A L T H R I S K A S S E S S M E N T	<input type="checkbox"/> Not taken	\$5.00	B I O M E T R I C S C R E E N I N G	<input type="checkbox"/> Not taken	\$5.00
	<input type="checkbox"/> Taken	\$0.00		<input type="checkbox"/> Taken	\$0.00
	<input type="checkbox"/> Waive H.R.A.			<input type="checkbox"/> Waive Biometric Screening	
	<i>If you waived a medical plan, you must choose Waive H.R.A. If you chose a medical plan, you may not waive H.R.A.</i>			<i>If you waived a medical plan, you must choose Waive Biometric Screening. If you chose a medical plan, you may not waive Biometric Screening.</i>	

P H A R M A C Y	Coverage	Plan	Cost
P H A R M A C Y	<input type="checkbox"/> Employee only	<input type="checkbox"/> Co-insurance	
	<input type="checkbox"/> Employee+spouse		
	<input type="checkbox"/> Employee+children	<input type="checkbox"/> Consumer Choice	
	<input type="checkbox"/> Employee+family		
	<input type="checkbox"/> Waive Pharmacy coverage for yourself and dependents <i>If you chose a medical plan, you must enroll in a pharmacy plan unless you chose Choice Fund HSA. If you waived a medical plan or enrolled in Choice Fund HSA, you must waive pharmacy.</i>		

T O B A C C O U S E	Coverage	Surcharge	Cost
T O B A C C O U S E	<input type="checkbox"/> Employee and / or family members	<input type="checkbox"/> Tobacco Use - Yes	\$15.00
		<input type="checkbox"/> Tobacco Use - No	\$0.00
	<input type="checkbox"/> Waive Tobacco Use for yourself and dependents <i>If you or a covered dependent uses or have used a tobacco product in the last 6 consecutive months, you must respond as a Tobacco User. If you waived medical coverage, you must waive tobacco use.</i>		

GROUP LEGAL SERVICES	Cost
<input type="checkbox"/> Group Legal Services	\$7.87
<input type="checkbox"/> Waive Legal Services	\$0.00

BASIC LIFE & BASIC AD & D
No changes can be made. This an employer-paid benefit for 1X your annual salary

ADDITIONAL LIFE - EMPLOYEE ONLY					
Employee:	Annual Salary				
	<input type="checkbox"/> 1x	<input type="checkbox"/> 2x	<input type="checkbox"/> 3x	<input type="checkbox"/> 4x	<input type="checkbox"/> 5x
<input type="checkbox"/> Waive additional Life Insurance for yourself.					
<i>*You may only increase one level without evidence of insurability*</i>					

ADDITIONAL ACCIDENTAL DEATH & DISMEMBERMENT (AD & D)					
Employee:	Annual Salary				
	<input type="checkbox"/> 1x	<input type="checkbox"/> 2x	<input type="checkbox"/> 3x	<input type="checkbox"/> 4x	<input type="checkbox"/> 5x
Employee & Family:	Annual Salary				
	<input type="checkbox"/> 1x	<input type="checkbox"/> 2x	<input type="checkbox"/> 3x	<input type="checkbox"/> 4x	<input type="checkbox"/> 5x

D E P E N D E N T C H I L D L I F E				
D E P E N D E N T C H I L D L I F E	<input type="checkbox"/> \$5,000	S P O U S E L I F E	<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$20,000 ²
	<input type="checkbox"/> \$10,000 ²		<input type="checkbox"/> \$30,000 ²	<input type="checkbox"/> \$40,000 ²
	<input type="checkbox"/> \$15,000 ^{1,2}		<input type="checkbox"/> \$50,000 ²	<input type="checkbox"/> \$60,000 ^{1,2}
	<input type="checkbox"/> \$20,000 ^{1,2}		<input type="checkbox"/> \$70,000 ^{1,2}	<input type="checkbox"/> \$80,000 ^{1,2}
	<input type="checkbox"/> Waive Dependent Child Life		<input type="checkbox"/> \$90,000 ^{1,2}	<input type="checkbox"/> \$100,000 ^{1,2}
¹ Evidence of insurability required for initial election; ² Evidence of insurability also required for any increase in coverage after initial election.		¹ Evidence of insurability required for initial election; ² Evidence of insurability also required for any increase in coverage after initial election.		

SHORT - TERM DISABILITY				
<input type="checkbox"/> 40%	<input type="checkbox"/> 50%	<input type="checkbox"/> 60%	<input type="checkbox"/> 70%	<input type="checkbox"/> Waive

FLEX SPENDING HEALTH CARE \$5,200 plan year limit	
<input type="checkbox"/> FSA (Flexible Spending Account) Health Care	\$ _____
<input type="checkbox"/> Limited Use FSA for Choice Fund Health Savings Account	\$ _____
<input type="checkbox"/> Waive Flex Spending Health Care	
<i>Please Note: Do not enroll if you are wanting to make a contribution to a health savings account. This can't be done in the system. Call (602) 506-1010 for more information.</i>	

FLEX SPENDING DEPENDENT DAY CARE \$5,000 calendar year limit	
<input type="checkbox"/> Dependent Day Care FSA - Yes	\$ _____
<input type="checkbox"/> Dependent Day Care FSA - No	

SUBMIT
You must click on the "Submit" button to **finalize** your benefit elections.

Remember to Print
Go back to your submitted Enrollment event and print the "**Enrollment Summary**" page. Keep it to compare with your confirmation statement.

ONLINE EMPLOYEE SELF SERVICE INSTRUCTIONS

1. Start your browser by double clicking the  on your desktop.

2. In the address line in the browser, type my.maricopa.gov and press “Enter” on the keyboard

-or

from work, access the Intranet click on the My.Maricopa.Gov button at the top of the EBC home page (<http://ebc.maricopa.gov>)



3. At the initial PeopleSoft login screen, enter your user ID and password and click the “Sign In” button or hit “Enter” on the keyboard.

User ID:

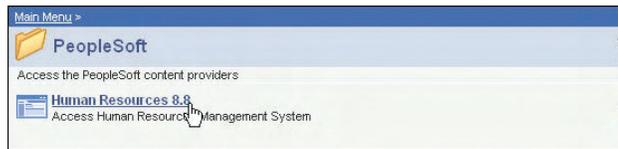
Password:

(if you do not know your ID or Password, call your department PC Help Desk or the Customer Support Center at 602-506-4357)

4. After successfully logging in, click on “PeopleSoft” located in the menu on the left of the page.

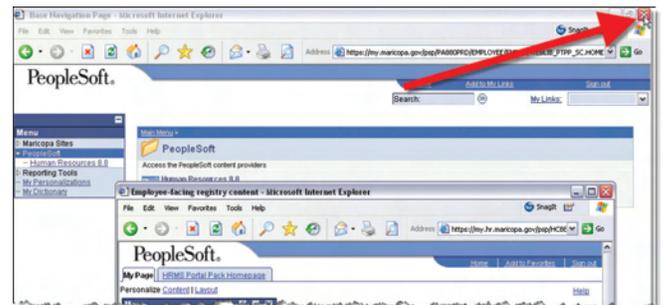


5. Click on “Human Resources 8.8”



6. A new PeopleSoft page will open. Close the first window.

If you do not close the initial PeopleSoft page, you will be timed out after 20 minutes and may lose your selections.



7. You now have one PeopleSoft page open with a Menu similar to the one displayed. You may need to enlarge the page to fully view the menu and options (Press F11 on your keyboard to view the page full screen).

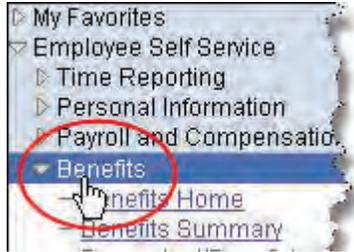


8. At the Menu...

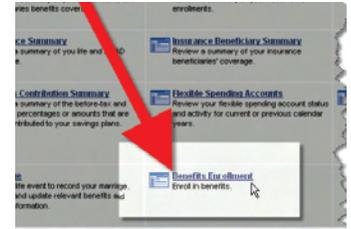
Click on "Employee Self Service"



Click on 'Benefits'



Click on "Benefits Enrollment"



9. You may now begin the Enrollment process.

To begin, click on the "Select" button.



Once you click Select, it will take a few seconds for your benefits enrollment information to load.

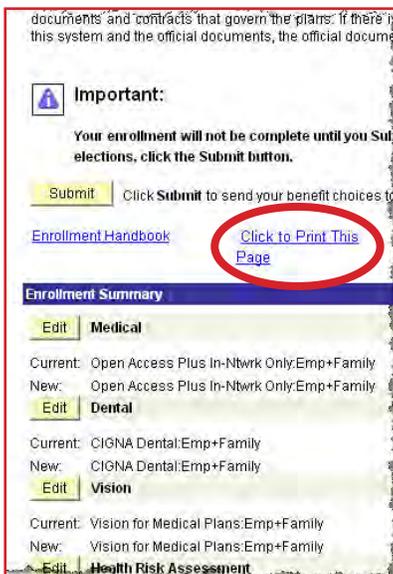
10. Go through each option listed in the Enrollment Summary in the order they are listed. To view your medical and other benefit options, click the "Edit" button to the left of each option.

Enrollment Summary			
		Before Tax	After Tax
Edit	Medical		
Current:	Choice Fund HSA:Emp+Spous		
New:	Choice Fund HSA:Emp+Spous	0.00	
Edit	Dental		
Current:	Delta Dental:Emp+Family		
New:	Delta Dental:Emp+Family	34.24	
Edit	Vision		
Current:	Vision for Medical Plans:Emp+Spous		
New:	Vision for Medical Plans:Emp+Spous	0.00	
Edit	Health Risk Assessment		
Current:	HRA:NOT TAKEN	5.00	
Edit	Biometric Screening		
Current:	Biometric Screening:NOT TAKEN	5.00	
Edit	Pharmacy		
Current:	Waive		
New:	Waive	0.00	
Edit	Tobacco Use		
Current:	Tobacco User- No:NO		
New:	Tobacco Use:NO	0.00	
Edit	Group Legal Services		
Current:	Waive		
New:	Waive	0.00	
Edit	Basic Life and AD&D		
Current:	Basic Life: 1 * Salary		
New:	Basic Life: 1 * Salary: \$60,000	0.00	
Edit	Additional Life		
Current:	Add LF 5x: 5 * Salary		
New:	Add LF 5x: 5 * Salary: \$300,000	10.50	
Edit	Additional AD&D		
Current:	FM ADD 5x: 5 * Salary		
New:	FM ADD 5x: 5 * Salary: \$300,000	5.25	
Edit	Dependent Child Life		
Current:	Dependent Children Life \$ 10K		
New:	Dependent Children Life \$ 10K	0.50	
Edit	Spouse Life		
Current:	Spouse Life \$50K: \$50,000		
New:	Spouse Life \$50K: \$50,000	2.50	
Edit	Short-Term Disability		
Current:	Short Term Disability 70%: 70% of Salary		
New:	Short Term Disability 70%: 70% of Salary	32.61	
Edit	Flex Spending Health Care		
Current:	Limited use FSA for CFHSA: \$1,625.00		
New:	Limited use FSA for CFHSA: \$1,625.00	67.71	
Edit	Flex Spending Dependent Care		
Current:	Waive		
New:	Waive		

11. Make sure to review the "TOBACCO USE", "HEALTH RISK ASSESSMENT", and "BIOMETRIC SCREENING" elections and answer the questions accurately. This is the area where you indicate your eligibility for the wellness incentives.

12. You must click on **two "SUBMIT" buttons** to complete your enrollment. After making all benefit elections, click on the "Submit" button at the bottom of the page. On the next page, click on the "Submit" button at the bottom of the page to send your final choices to the EHI Department.

EXAMPLE



This table summarizes estimated costs for your new benefit choices.

	Before Tax	After Tax	Total
Your Costs	111.95	51.36	163.31

These costs do not include certain choices that are based on variable earnings.

[Submit](#) Click **Submit** to send your benefit choices to the Benefits Office.

13. Once you have submitted your final benefit elections, go back into your New Hire event and "print" the benefit enrollment summary page so you will have verification of your benefit elections. Use the printed summary page to compare to the confirmation statement you will receive from your department's HR Liaison. In case of an error, you can use the printed enrollment summary page to have your benefits corrected.

NOTIFICATIONS

HIPAA

Maricopa County's Group Health Plan - Notice of Privacy Practices



Maricopa County's Group Health Plan Notice of Privacy Practices

The Health Insurance Portability and Accountability Act, otherwise known as HIPAA, requires Maricopa County to protect the privacy of your personal health information, and to provide you with this notice. HIPAA is a federal law that was effective April 14, 2003. The reason the law requires Maricopa County to provide you with this notice is because certain benefit programs administered through the Employee Health Initiatives Department are considered to be a Group Health Plan that is regulated by this law. This notice explains how your personal health information may be used, and what kind of rights you have under this law.

THIS INFORMATION DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Maricopa County offers a Group Health Plan (the "Plan"), which is a type of Health Plan, for eligible regular employees, certain contract employees, employees of affiliated organizations, retirees, and COBRA participants.

The Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

- the Plan's uses and disclosures of your Protected Health Information (PHI)
- your rights with respect to your PHI;
- the Plan's duties with respect to your PHI;
- your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services;
- and
- the person or office to contact for further information about the Plan's privacy practices

The term "Protected Health Information" ("PHI") includes all individually identifiable health information transmitted or maintained by the Plan whether oral, written, or electronic.

SECTION 1. NOTICE OF PHI USES AND DISCLOSURES

Upon your request, the Plan is required to give you access to certain PHI in order to inspect and copy it.

Use and disclosure of your PHI may be required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

Uses and Disclosures to Carry Out Treatment, Payment, and Health Care Operations

The entities that provide coverage under your medical, prescription, behavioral health and substance abuse, dental, vision, flexible spending accounts, and COBRA, may share your PHI for treatment purposes, to get paid for treatment, or to conduct health care operations. Many of these entities may provide you with their own Notice of Privacy Practices. Refer to Table A for a list of the current entities that provide the above coverages.

The Plan and/or its business associates may use your PHI, without your consent, authorization, or opportunity to agree or object, to carry out treatment, payment, and health care operations. For each business associate, the Plan has a written contract that contains terms to protect the privacy of your PHI.

The Plan may also share your information or allow the sharing of your PHI with Maricopa County as the Plan Sponsor for plan administration functions. The Plan Sponsor has amended its plan documents to protect your PHI as required by federal law.

Treatment is defined as the provision, coordination, or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. In addition, providers may share information with each other. The Plan does not use PHI for treatment purposes.

Maricopa County's Group Health Plan - Notice of Privacy Practices

Payment includes, but is not limited to, actions to make coverage determinations and payment (including billing, premium payment, claims management, subrogation, coordination of benefits, reviews for medical necessity and appropriateness of care and utilization review and pre-authorizations). For example, the Plan may tell a doctor (provider) whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include, but are not limited to, quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating, and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. For example, the Plan may use information about your claims to determine compliance with physician-issued prescriptions, refer you to a disease or case management program, project future benefit costs or audit the accuracy of its claims processing functions.

Uses and Disclosures That Require Your Written Authorization

Your written authorization will be obtained before the Plan will use or disclose PHI for employer-related activities that include, but are not limited to, ombudsman activities which includes resolving your claims issue, fitness for duty examinations, short term disability claims, return to work program, employee assistance plan, ergonomics evaluations, wellness programs, workers' compensations claims, and care received at an on-site medical clinic. You may revoke your authorization in writing, at anytime, to stop any future uses or disclosures.

Certain types of PHI, including PHI regarding communicable disease and HIV/AIDS, drug and alcohol abuse treatment, and evaluation and treatment for serious mental illness, may have additional protection under state or federal law. Your written authorization is required in order to release this type of information.

Uses and Disclosures That Require You Be Given an Opportunity to Agree or Disagree Prior To the Use or Release

Disclosure of your PHI to family members, other relatives, and your close friends is allowed if:

- the information is directly relevant to the family or friend's involvement with your care or payment for that care, and
- you either have agreed to the disclosure or have been given an opportunity to object and have not objected.

Uses and Disclosures for Which Consent, Authorization, or Opportunity to Object Is Not Required

Use and disclosure of your PHI is allowed without your consent, authorization, or request under the following circumstances:

1. When required by law.
2. When authorized by law regarding when you have been exposed to a communicable disease or are at risk of spreading a disease or condition.
3. When authorized by law to report information about abuse, neglect, or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice could cause a risk or serious harm. For purposes of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.
4. The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations, inspections, and licensure or for disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate health care fraud).
5. The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.
6. When required for law enforcement purposes (for example, to report certain types of wounds).
7. For law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.
8. When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
9. The Plan may use or disclose PHI for research, subject to conditions.

Maricopa County's Group Health Plan - Notice of Privacy Practices

10. When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
11. When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization.

SECTION 2. RIGHTS OF INDIVIDUALS

Right to Request Restrictions on PHI Uses and Disclosures

You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your request. The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Such requests should be made in writing to the **Employee Health Initiatives Manager, at 301 W. Jefferson St., Suite 201, Phoenix, AZ 85003.**

Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI. "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form. "Designated Record Set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made in writing to the **Employee Health Initiatives Manager, 301 W. Jefferson St., Suite 201, Phoenix, AZ 85003.** If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

Right to Amend PHI

If you believe your PHI is erroneous or incomplete, you have the right to request the Plan to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set. You must make this request in writing and provide a reason to support your request. The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI. Requests for amendment of PHI in a designated record set should be made in writing to the **Employee Health Initiatives Manager, 301 W. Jefferson St., Suite 201, Phoenix, AZ 85003.** You or your personal representative will be required to complete a form to request amendment of the PHI in your designated record set.

The Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request, but not before April 14, 2003. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) prior to the compliance date; or (4) based on your written authorization. If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

The Right to Receive a Paper copy of This Notice upon Request

To obtain a paper copy of this Notice, contact the **Employee Health Initiatives Manager in writing at 301 W. Jefferson St., Suite 201, Phoenix, AZ 85003.**

SECTION 3. THE PLAN'S DUTIES

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of its legal duties and privacy practices. This is effective beginning April 14, 2003 and the Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this notice will be provided to all participants for whom the Plan still maintains PHI. The notice will be distributed electronically via the Electronic Business Center (EBC) Intranet Benefit Home page. Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individuals rights, the duties of the Plan or other privacy practices stated in this notice.

Maricopa County's Group Health Plan - Notice of Privacy Practices

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts no to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. However, the minimum necessary standard will not apply in the following situations:

- disclosures to or requests by a health care provider for treatment;
- uses or disclosures made to the individual;
- disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- uses or disclosures that are required by law; and
- uses or disclosures that are required for the Plan's compliance with legal regulations.

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify and individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual is not individually identifiable health information.

In addition, the Plan may use or disclose "summary health information" to the plan sponsor or business associates for obtaining premium bids or modifying, amending or terminating the group health plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and from which identifying information has been deleted in accordance with HIPAA.

SECTION 4. YOUR RIGHT TO FILE A COMPLAINT WITH THE PLAN OR DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE FOR CIVIL RIGHTS

If you believe that your privacy rights have been violated, you may complain to the Plan by writing to the Employee Health Initiatives Manager, 301 W. Jefferson St., Suite 201, Phoenix, AZ 85003. You may file a written complaint, either on paper or electronically, by mail, fax, or e-mail with the Secretary of the Department of Health and Human Services. To obtain a copy of the complaint form or for more information about the Privacy Rule or how to file a complaint with Office for Civil Rights, contact any OCR office or go to www.hhs.gov/ocr/hipaa. Mailing address: Office for Civil Rights, U.S. Department of Health & Human Services, 50 United Nations Plaza – Room 322, San Francisco, CA 94102, Telephone (415) 437-8310, Fax (415) 437-8329, TDD (415) 437-8311. Visit the HHS OCR website at www.os.dhhs.gov/ocr/hipaa for more information. The Plan will not retaliate against you for filing a complaint.

SECTION 5. WHOM TO CONTACT AT THE PLAN FOR MORE INFORMATION

If you have any questions regarding this notice or the subjects addressed in it, you may contact the following individual: Employee Health Initiatives Manager, 301 W. Jefferson St., Suite 201, Phoenix, AZ 85003, telephone number (602) 506-1010, electronic mail BenefitsService@mail.maricopa.gov.

SECTION 6. CONCLUSION

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at *45 Code of Federal Regulations Parts 160 and 164*. This notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this notice and the regulations.

TABLE A

Entity	Description of Coverage	Entity	Description of Coverage
CIGNA HealthCare of AZ	Medical	Magellan Health Services	Behavioral Health & Substance Abuse
Walgreens Health Initiatives (WHI)	Pharmacy	EyeMed Vision Care	Vision
CIGNA Dental	Dental	Application Software Inc. (ASI)	Flexible Spending Accounts
Delta Dental	Dental	CompuSys	COBRA
Employers Dental Services (EDS)	Dental		

EMPLOYEE ACKNOWLEDGEMENT

I hereby acknowledge receipt of this **Notice of Privacy Practices** and understand that it is my responsibility to read the information contained herein.

Employee Name (printed)

Employee Signature

Date

Return your signed copy of this form to your Department HR Liaison

COBRA INITIAL NOTIFICATION

This notice on possible future group health insurance continuation coverage rights applies individually to the following plan participants: **Employee, Spouse, and each covered dependent.**

It is being provided to you at this time because you have recently become, or are about to become, covered under a Maricopa County sponsored Health plan. It is important that all covered individuals take the time to read this notice carefully and be familiar with its contents. Should you add additional dependents in the future, notice to the covered employee and spouse at this time will be deemed notification to the newly covered dependent.

Plan Administrator:

Maricopa County Employee Health Initiatives Department
301 S. 4th Ave., Suite B100
Phoenix, Arizona 85003
Telephone number 602-506-1010
Fax number: 602-506-2354
Email: BenefitsService@mail.maricopa.gov

COBRA continuation coverage
for the Plan is managed by:

CompusSys/Erisa Group, Inc.
12325 Hymeadow Dr.
Bldg. #4
Austin, TX 78750
Telephone number 1-800-933-7472
Fax number: (512) 250-2937

Under federal COBRA law, should you lose your group health insurance because of one of the below listed qualifying events, covered employees and covered family members (called qualified beneficiaries) will be offered the opportunity for a temporary extension of health coverage (called Continuation Coverage) at group rates which you will be required to pay. This notice is intended to inform all plan participants, in a summary fashion of your potential future options and obligations under the continuation coverage provisions of federal law. Should an actual qualifying event occur in the future, the plan administrator will send you additional information and the appropriate election notice at that time. **Please take special note, however, of your notification obligations and procedures which are highlighted in this notification!**

Qualifying Events For Covered Employee * - If you are the covered employee, you will become a qualified beneficiary and have the right to elect this health plan continuation coverage **if** you lose your group health coverage because of a termination of your employment (for reasons other than gross misconduct on your part) or a reduction in your hours of employment.

Qualifying Events For Covered Spouse * - If you are the covered spouse of an employee, you will become a qualified beneficiary and have the right to elect this health plan continuation coverage for yourself **if** you lose group health coverage because of any of the following reasons:

1. A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;
2. The death of your spouse;
3. Divorce or, if applicable, a legal separation from your spouse; or
4. Your spouse becomes enrolled in Medicare (Part A, Part B, or both).

Qualifying Events For Covered Dependent Children * - If you are the covered dependent child of an employee, you will become a qualified beneficiary and have the right to elect continuation coverage for yourself **if** you lose group health coverage because of any of the following reasons:

1. A termination of the parent-employee's employment (for reasons other than gross misconduct) or reduction in the parent-employee's hours of employment;
2. The death of the parent-employee;
3. Parent's divorce or, if applicable, a legal separation;
4. The parent-employee becomes enrolled in Medicare (Part A, Part B, or both); or
5. You cease to be eligible for coverage as a "dependent child" under the terms of the health plan.

*Rights similar to those described above may apply to covered retirees, and their covered spouses, and dependents if Maricopa County commences a bankruptcy proceeding under title 11 of the United States code and these individuals lose coverage within one year of or one year after the bankruptcy filing.

Employee/Qualified Beneficiary 60 Day Notification Requirement

Under group health plan rules and COBRA law, the employee, spouse, or other covered family members have the responsibility to notify the Plan Administrator of a divorce, legal separation, or a child losing dependent status under the plan. Please read your summary plan description for specific information on when a dependent ceases to be a dependent under the terms of the plan. To protect your continuation coverage rights in these two situations, this notification must be made within 60 days from whichever date is later, the date of the event or the date on which health plan coverage would be lost under the terms of the insurance contract because of the event. Procedures for making proper and timely notice are listed below.

1. Complete a Group Insurance Status Change form.
2. Make a copy of the form for your records.
3. Attach the required documentation depending upon the qualifying event.
4. Mail the notification form to the Plan Administrator and document your mailing.
5. Call the Plan Administrator within 10 calendar days to insure the notification form has been received.

If this notification is not completed according to the outlined procedures and within the required 60 day notification period, then rights to continuation coverage will be forfeited. In addition, keeping an individual covered by the health plan beyond what is allowed by the plan will be considered insurance fraud on the part of the employee.

If the qualifying event is a termination of employment, reduction in hours, death, enrollment in Medicare (Part A, Part B, or both), or for retiree coverage, a commencement of a bankruptcy proceeding, the employer will notify the Plan Administrator within 30 calendar days of the qualifying event.

Election Period And Coverage - Once the Plan Administrator learns a qualifying event has occurred, the Plan Administrator will notify qualified beneficiaries of their rights to elect continuation coverage. Each qualified beneficiary has independent election rights and will have 60 calendar days to elect continuation coverage. The 60 calendar day election window is measured from the later of the date health plan coverage is lost due to the event or from the date of notification. This is the maximum period allowed to elect continuation coverage as the plan does not provide an extension of the election period beyond what is required by law. For each qualified beneficiary who elects group health insurance continuation coverage, coverage will begin on the date that coverage under the plan would be lost because of the event. If a qualified beneficiary does not elect continuation coverage within this election period, then rights to continue health insurance will end and he/she ceases to be a qualified beneficiary.

If a qualified beneficiary elects continuation coverage, he/she will be required to pay the entire cost for the health insurance, plus a 2% administration fee. Maricopa County is required to provide the qualified beneficiary with coverage that is identical to the coverage provided under the plan to similarly situated non-COBRA participants and/or covered dependents. Should coverage change or be modified for non-COBRA participants, then the change and/or modification will be made to your coverage as well.

Length Of Continuation Coverage - 18 Months. If the event causing the loss of coverage is a termination of employment (other than for reasons of gross misconduct) or a reduction in work hours, then each qualified beneficiary will have the opportunity to continue coverage for 18 months from the date of the qualifying event. Exception: If you are participating in a health flexible spending account at the time of the qualifying event, you will only be allowed to continue the health flexible spending account until the end of the current plan year in which the qualifying event occurs.

Social Security Disability Extension - The 18 months of continuation coverage can be extended for an additional 11 months of coverage, to a maximum of 29 months, for all qualified beneficiaries if the Social Security Administration determines a qualified beneficiary was disabled according to Title II or XVI of the Social Security Act on the date of the qualifying event or at any time during the first 60 calendar days of continuation coverage. In the case of a newborn or adopted child that is added to a covered employee's continuation coverage, the first 60 calendar days of continuation coverage for the newborn or adopted child is measured from the date of the birth or the date of the adoption. It is the qualified beneficiaries responsibility to obtain this disability determination from the Social Security Administration and provide a copy of the determination to the Plan Administrator according to the below listed notification procedures within 60 calendar days after the date of determination and before the original 18 months expire. In general, if coverage is extended due to a Social Security Disability, premium rates may be raised to 150% of the applicable rate

Secondary Event Extension - Another extension of the 18 or above mentioned 29 month continuation period can occur, if during the 18 or 29 months of continuation coverage, a second qualifying event takes place such as a divorce, legal separation, death, Medicare entitlement, or a dependent child ceasing to be a dependent. If a second event occurs, during the original 18 or 29 months of continuation coverage, coverage will be extended to 36 months from the date of the original qualifying event date for eligible dependent qualified beneficiaries. It is the qualified beneficiaries responsibility to notify Maricopa County according

to the below listed notification procedures within 60 calendar days of the second event and within the original 18 or 29 month continuation timeline. In no event, however, will continuation coverage last beyond three years from the date of the event that originally made the qualified beneficiary eligible for continuation coverage. A reduction in hours followed by a termination of employment is not a second event.

Social Security Disability/Second Qualifying Event Notification Procedures

1. Complete the COBRA Qualifying event notification form.
2. Make a copy of the form for your records.
3. Attach the required documentation depending upon the qualifying event.
4. Mail the notification form to the address listed on the form and document your mailing.
5. Call within 10 calendar days to insure the notification form has been received.

Length Of Continuation Coverage - 36 Months. If the original event causing the loss of coverage was the death of the employee, divorce, legal separation, Medicare entitlement, or a dependent child ceasing to be a dependent child under the Maricopa County Employee Health Insurance Program, then each dependent qualified beneficiary will have the opportunity to continue coverage for 36 months from the date of the qualifying event.

Eligibility, Premiums, And Potential Conversion Rights - A qualified beneficiary does not have to show they are insurable to elect continuation coverage, however, they must have been covered by the plan on the day before the event to be eligible for continuation coverage. An exception to this rule is if while on continuation coverage a baby is born to or adopted by a covered employee qualified beneficiary. If this occurs, the newborn or adopted child can be added to the plan and will gain the rights of all other qualified beneficiaries. The COBRA timeline for the newborn or adopted child is measured from the date of the original qualifying event. Procedures and timelines for adding these individuals can be found in your Know Your Benefits booklet and must be followed. The Plan Administrator reserves the right to verify continuation eligibility status and terminate continuation coverage retroactively if a qualified beneficiary is determined to be ineligible or if there has been a material misrepresentation of the facts.

A qualified beneficiary will have to pay all of the applicable premium plus a 2% administration charge for continuation coverage. These premiums will be adjusted during the continuation period if the applicable premium amount changes. In addition, if continuation coverage is extended from 18 months to 29 months due to a Social Security disability, Maricopa County can charge up to 150% of the applicable premium during the extended coverage period. Qualified beneficiaries will be allowed to pay on a monthly basis. In addition there will be a maximum grace period of 60 calendar days for the regularly scheduled monthly premiums. At the end of the 18, 29, or 36 months of continuation coverage, a qualified beneficiary will be allowed to enroll in an individual conversion health plan provided under your health plan if an individual conversion plan is available at that time.

Cancellation Of Continuation Coverage - The law provides that if elected and paid for, your continuation coverage will end prior to the maximum continuation period for any of the following reasons:

1. Maricopa County ceases to provide any group health plan to any of its employees;
2. Any required premium for continuation coverage is not paid in a timely manner;
3. A qualified beneficiary first becomes, after the date of COBRA election, covered under another group health plan that does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary other than such an exclusion or limitation which does not apply to or is satisfied by such beneficiary by reason of the Health Insurance Portability and Accountability Act;
4. A qualified beneficiary first becomes, after the date of COBRA election, entitled to Medicare;
5. A qualified beneficiary extended continuation coverage to 29 months due to a Social Security disability and a final determination has been made that the qualified beneficiary is no longer disabled;
6. A qualified beneficiary notifies the Plan Administrator he/she wishes to cancel continuation coverage.
7. For cause, on the same basis that the plan terminates the coverage of similarly situated non COBRA participants.

Should continuation coverage be terminated for one of the above reasons, a notice will be sent to you at that time outlining any available health coverage options that may be available to you.

Notification Of Address Change - In order to protect your group health insurance continuation coverage rights and to insure all covered individuals receive information properly and efficiently, you are required to notify the Plan Administrator of any address change as soon as possible. Failure on your part to do so will result in delayed notifications or a loss of continuation coverage options.

Any Questions? - Remember, this notice is simply a summary of your potential future continuation coverage options and not a description of your actual health benefits under the plan. For questions regarding your health benefits, you should either review the Plan's Summary Plan Description or get a copy of the Plan Document from the Plan Administrator. Should an actual qualifying event occur and it is determined that you are eligible for continuation, you will be notified of all your actual rights at that time. Should you have any questions regarding the information contained in this notice, you should contact the Maricopa County Employee Health Initiatives Department, or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's web site at www.dol.gov/ebsa.

Women's Health and Cancer Rights Act (WHCRA)

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call CIGNA Customer Service for more information.

Obtaining a Certificate of Creditable Coverage Under This Plan

Upon loss of coverage under this Plan, a Certificate of Creditable Coverage will be mailed to each terminating individual at the last address on file. You or your dependent may also request a Certificate of Creditable Coverage, without charge, at any time while enrolled in the Plan and for 24 months following termination of coverage. You may need this document as evidence of your prior coverage to reduce any pre-existing condition limitation period under another plan, to help you get special enrollment in another plan, or to obtain certain types of individual health coverage even if you have health problems. To obtain a Certificate of Creditable Coverage, contact CIGNA Customer Service.

General Notice of the Plan's Pre-existing Condition Exclusion

The Open Access Plus In-Network plan, the Open Access Plus High and Low plans, and the Choice Fund Health Savings Account plan imposes a pre-existing condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within 60 days prior to your effective date of coverage. The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months from your first day of coverage. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage."

- Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days.
- To reduce the 12-month exclusion period by your creditable coverage, you should give CIGNA a copy of any certificates of creditable coverage you have.
- If you do not have a certificate, but you do have prior health coverage, you should contact your prior plan and ask them for a certificate of creditable coverage. Please contact the EHI Dept. at (602) 506-1010 if you need help demonstrating creditable coverage.

Notice of Special Enrollment Rights

In general, IRS restrictions prevent you from making changes to your coverage elections during the year. This means that once you make your health plan elections at Open Enrollment, you may not drop dependents or change your coverage until the next Open Enrollment period. You may be able to add or drop dependents during the year if you experience and report a life event, also known as a status change. These changes include the following:

- You get married or divorced.
- You acquire a dependent child through birth, adoption or placement for adoption.
- Your spouse or dependent dies.
- Your dependent no longer meets the plan's eligibility requirements.
- Your spouse terminates employment or begins new employment.
- You or your spouse change from part-time work to full-time work (or vice-versa).
- You or your spouse have a significant change in health care coverage.
- You are required to provide dependent medical coverage as a result of a valid court decree that meets the requirements of a Qualified Medical Child Support Order (QMCSO).

Any benefit enrollment change you make must be consistent with your qualified status change. To change your coverage, you must call the EHI Department at (602) 506-1010, complete the status change form and provide documentation of the change within 30 calendar days of the date you experience the status change. Your new elections will be effective on either the date of your status change or the date your status change was processed, and retroactive payroll deductions may be withheld. If you do not call within the 30 calendar day period, you must wait until the next Open Enrollment period to change your benefits.

**FY 2008-2009 PAYROLL SCHEDULE
USED FOR BENEFIT PREMIUM CALCULATIONS,
COVERAGE EFFECTIVE DATES & COVERAGE END DATES**

	Beginning	Ending	Pay Day
1	June 16, 2008	June 29, 2008	July 3, 2008
2	June 30, 2008	July 13, 2008	July 18, 2008
3	July 14, 2008	July 27, 2008	August 1, 2008
4	July 28, 2008	August 10, 2008	August 15, 2008
5	August 11, 2008	August 24, 2008	August 29, 2008
6	August 25, 2008	September 7, 2008	September 12, 2008
7	September 8, 2008	September 21, 2008	September 26, 2008
8	September 22, 2008	October 5, 2008	October 10, 2008
9	October 6, 2008	October 19, 2008	October 24, 2008
10	October 20, 2008	November 2, 2008	November 7, 2008
11	November 3, 2008	November 16, 2008	November 21, 2008
12	November 17, 2008	November 30, 2008	December 5, 2008
13	December 1, 2008	December 14, 2008	December 19, 2008
14	December 15, 2008	December 28, 2008	January 2, 2009
15	December 29, 2008	January 11, 2009	January 16, 2009
16	January 12, 2009	January 25, 2009	January 30, 2009
17	January 26, 2009	February 8, 2009	February 13, 2009
18	February 9, 2009	February 22, 2009	February 27, 2009
19	February 23, 2009	March 8, 2009	March 13, 2009
20	March 9, 2009	March 22, 2009	March 27, 2009
21	March 23, 2009	April 5, 2009	April 10, 2009
22	April 6, 2009	April 19, 2009	April 24, 2009
23	April 20, 2009	May 3, 2009	May 8, 2009
24	May 4, 2009	May 17, 2009	May 22, 2009
25	May 18, 2009	May 31, 2009	June 5, 2009
26	June 1, 2009	June 14, 2009	June 19, 2009

HOLIDAY SCHEDULE

	2008	2009
New Year's Day	Tuesday, January 1	Thursday, January 1
Martin Luther King Jr./Civil Rights Day	Monday, January 21	Monday, January 15
President's Day	Monday, February 18	Monday, February 16
Memorial Day	Monday, May 26	Monday, May 25
Independence Day	Friday, July 4	Friday, July 4
Labor Day	Monday, September 1	Monday, September 7
Columbus Day	Monday, October 13	Monday, October 12
Veteran's Day	Tuesday, November 11	Wednesday, November 11
Thanksgiving Day	Thursday, November 27	Thursday, November 26
Christmas Day	Thursday, December 25	Friday, December 25

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WHO TO CONTACT

Maricopa County Employee Health Initiatives Department

(Benefits Office)

Maricopa County Administration 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
Pages { <http://ebc.maricopa.gov/ehi>
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
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
(username: Maricopa2008 / 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) 337-3416
Medication Therapy Management - (866) 352-5310
www.mywhi.com

Behavioral Health / EAP*

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

Vision

EyeMed Vision Care - Group #9690793
Customer Service - (866) 724-0782
Pre-Enrollment Questions - (866) 723-0596
LASIK - (877) 552-7376
www.eyemedvisioncare.com
emvision@eyemed.sento.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



Life Insurance

The Standard - Policy #645547
(888) 414-0396

www.standard.com/mybenefits/maricopa

Short-Term and Long-Term Disability

Sedgwick CMS - Group# 435000
Short Term Disability - (800) 599-7797
Long Term Disability - (800) 495-9301
www.sedgwickcms.com/calabasas

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

ASI - Group #455
Mariflex (Flexible Spending Accounts)
(800) 659-3035
www.asiflex.com
asi@asiflex.com

Liberty Mutual: - Group #8871
Auto, Home and Renters Insurance
(800) 221-8135
www.libertymutual.com

MetLaw® - Plan 150 / Group #0518
(800) 821-6400
www.legalplans.com (password - 1500518)

Compusys
COBRA Administrator
(602)-234-0497
(800) 933-7472
mccobra@cserisa.com



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