

OPEN ENROLLMENT

FY 2009/2010

What's new?

The seal of Maricopa County, Arizona, is positioned over the letter 'W' of the 'What's new?' text. The seal is circular with a red border and contains the text 'MARICOPA ARIZONA COUNTY' and the year '1891'. It features a central shield with various symbols including a scale of justice, a cactus, and a caduceus.

EMPLOYEE HEALTH INSURANCE PROGRAM

SELECT YOUR CHOICES AT:

STARTS
MAY 4TH



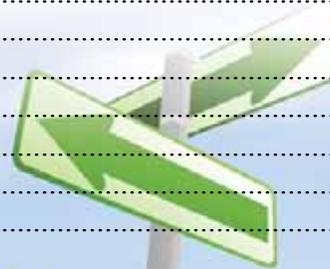
[HTTPS://PORTAL.ADP.COM](https://portal.adp.com)



ENDS
MAY 15TH

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GLOSSARY OF TERMS

Benefit-Eligible: A full- or part-time employee (not a temporary employee) of Maricopa County who is scheduled to work at least 20 hours per week. Contract employees may also be benefit-eligible based on the terms of their contract.

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

Body Mass Index (BMI): A number calculated from a person's weight and height. The formula is defined as $(\text{weight in pounds} \times 703) / (\text{height in inches}^2)$. For example, if your weight is 135 pounds and your height is 61 inches your BMI is approximately 25.50 $(125 \times 703) / (61 \times 61)$.

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): 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: Managed-care plans that require 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 that benefit is 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 health care expenses that are not covered under their health insurance coverage (medical, pharmacy, mental health, dental and vision) and/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 from his/her health plan due to a qualified status change.

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

Health Coaching Program: A program where coaches work one-on-one with employees to help them identify health-related goals, embrace change and work toward meeting their goals.

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 the procedures, providers and benefits.

Health Plan: Include medical, pharmacy, vision, behavioral health and substance abuse, and dental coverage.

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 (aka Member): 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/substance abuse benefits. Employees eligible for the waiver payment may voluntarily request not to receive this payment.

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. A referral is not required to see a specialist. The OAP In-Network also includes the CMG network. Non-network physicians/providers are not covered under this plan.

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 under a specific plan. 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 for a medical plan 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.

Sub-Acute Facilities: A hospital-based facility or a freestanding facility that provides a lower level of care (than acute care) as directed by your physician.

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	FSA: Flexible Spending Account	O
AD&D: Accidental Death & Dismemberment		OAPIN: Open Access Plus In-Network
AHCCCS: Arizona Health Care Cost Containment System	H	OAP: Open Access Plus
ARS: Arizona Revised Statutes	HDL: High-density lipoprotein	OE: Open Enrollment
ASI: Application Software, Inc.	HIPAA: Health Insurance Portability and Accountability Act	P
ASRS: Arizona State Retirement System	HMO: Health Maintenance Organization	PCP: Primary Care Physician
B	HR: Human Resources	PHI: Protected Health Information
BMI: Body Mass Index	HA: Health Assessment	PML: Preferred Medication List
C	HSA: Health Savings Account	PPO: Preferred Provider Organization
CCN: CIGNA Care Network	I	PSPRS: Public Safety Personnel Retirement System
CMG: CIGNA Medical Group	ID: Identification	PST: Pacific Standard Time
COBRA: Consolidated Omnibus Budget Reconciliation Act	IRC: Internal Revenue Code	PTO: Paid Time Off
E	IRS: Internal Revenue Service	R
EAP: Employee Assistance Program	L	RIF: Reduction in Force
EBAC: Employee Benefits Advisory Council	LOA: Leave of Absence	RX: Prescription
EBC: Electronic Business Center (Intranet)	M	S
EDS: Employers Dental Services	MH: Mental Health	SPD: Summary Plan Document
EE: Employee	MST: Mountain Standard Time	SSN: Social Security Number
EHI: Employee Health Initiatives	N	STD: Short-Term Disability
EOI: Evidence of Insurability	NAIC: National Association of Insurance Commissioners	U
F	NEO: New Employee Orientation	UV: Ultraviolet
FMLA: Family Medical Leave Act	NRS: Nationwide Retirement Solutions	W
FML: Family Medical Leave		WHI: Walgreens Health Initiatives

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 <http://ebc.maricopa.gov/ehi>. Refer to the Open Enrollment tab.

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 AM to 5 PM 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 termination or 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 PPO medical plan and/or CIGNA or Delta Dental plans. Plans with out-of-network benefits allow you to see providers who no longer 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 and some medications may require prior authorization or step-therapy. For example, medications may change from preferred brand name level to a generic or non-preferred brand name level, 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, 2010. You may change your Open Enrollment elections online as many times as you want during the Open Enrollment period. Once Open Enrollment ends on May 15, 2009 you will be mailed a confirmation statement to your home address on file in the PeopleSoft system. **Review your confirmation statement immediately.** If the statement differs from your elections you will have an opportunity to change your elections through May 29, 2009 at 5 PM MST. No changes will be allowed after May 29, 2009.

- 1. WHEN MAKING YOUR ELECTIONS IN THE BENEFIT ENROLLMENT SYSTEM, AFTER 15 MINUTES OF INACTIVITY, YOU WILL BE LOGGED OUT, AND YOU WILL SEE A POPUP NOTICE THAT INDICATES THAT DUE TO INACTIVITY, YOUR WEB SESSION HAS TIMED OUT. IF THIS HAPPENS, YOU MAY LOG BACK INTO THE SITE BY 8 PM MST THE SAME DAY, AND YOU WILL BE ABLE TO RESUME YOUR ELECTIONS. IF YOU RETURN AFTER THIS TIME, ANY CHANGES YOU HAVE MADE WILL BE LOST.**
- 2. YOU MUST CLICK THE SUBMIT BUTTON ON THE BENEFIT SUMMARY PAGE TO FINALIZE YOUR ELECTIONS.**
- 3. ONCE THE THANK YOU PAGE APPEARS, YOUR BENEFITS ENROLLMENT IS COMPLETE. PRINT YOUR CONFIRMATION PAGE AS VERIFICATION OF YOUR ELECTIONS. KEEP THIS PAGE TO COMPARE WITH YOUR CONFIRMATION STATEMENT THAT WILL BE MAILED TO YOUR HOME ADDRESS IN THE EVENT OF AN ERROR.**

PCP changes are not available through the Benefit Enrollment System during Open Enrollment. Watch for your new ID card in the mail and upon receipt, be sure to check the PCP. After July 1, 2009, contact your selected medical plan vendor to change your primary care provider (PCP), if applicable. Destroy your old ID card upon receipt of your new card. If additional cards are needed, contact the vendor directly either by phone or through their Web site. See the "Who to Contact" section.

OPEN ENROLLMENT PERIOD

This Open Enrollment period, your benefit elections and premium rates are effective for a 12-month period, beginning July 1, 2009 and ending June 30, 2010. The next time you can change your benefits will be the next Open Enrollment in **May 2010**. All benefit-eligible full- and part-time employees scheduled to work at least 20 hours per week, elected officials, and contract employees with benefits are eligible to complete Open Enrollment.

WHEN?

The Benefit Enrollment System will be available **8 AM, Monday, May 4, 2009 through 5 PM, Friday, May 15, 2009**. It is recommended that you not delay in completing your Open Enrollment elections in the event you encounter system-related problems or problems registering for the portal to the Benefit Enrollment System. Your Open Enrollment information must be entered online in the Benefit Enrollment System no later than 5 PM, May 15, 2009. Late enrollments will not be accepted.

HOW TO GET STARTED

To complete your Open Enrollment elections:

1. You must first register for the ADP Self-Service Portal by typing <https://portal.adp.com> into your browser address bar (for detailed instructions on how to register, go to <http://ebc.maricopa.gov/hr/PRISM/pdf/SelfServiceRegistration.pdf>. The registration pass code for Maricopa County is MCAZ-PRISM09 - this pass code is not case sensitive and contains a zero, not the letter O).
2. Once in the Portal, select the Benefits tab at the top of the page.
3. Click on the Benefit Enrollment System link.
4. For detailed instructions on how to complete your Open Enrollment elections in the Benefit Enrollment System refer to page 43.

If you do not have access to a computer, check with your department HR Liaison for information about computer resources that will be available for your use. Computers are also available at most public libraries.

WHAT DO YOU DO IF YOU DON'T KNOW YOUR USER ID OR PASSWORD?

When you register for the portal at <https://portal.adp.com>, you assign your user name and password. You should write down your user name and password and keep it in a safe place as no one will know this information.

To reset your password:

1. Return to the <https://portal.adp.com>
2. Click on the "Forgot Password" link.
3. Enter your User ID in the box and click the submit button.
4. You will be asked to answer the security questions you selected when registering, your city or town of birth and your birth month and day. After entering that information click on the submit button.
5. You will be asked to change and confirm a new password, which will be sent to the email address you provided when you registered.
6. You will see message confirming your password has been changed
7. You will receive a confirmation email from ADP.

Call your department PC Help Desk or the Customer Support Center at (602) 506-4357 between 6:30 AM-6 PM, Monday-Friday for assistance.

WHERE DO I GET ADDITIONAL INFORMATION NOT CONTAINED IN THIS GUIDE?

While most of the information you need is contained in this guide, other pertinent information is available online at the EHI Home page located at <http://www.maricopa.gov/benefits> (Internet) or <http://ebc.maricopa.gov/ehi> (Intranet). The Benefit vendors are your primary and best source of information regarding the plans they offer. Refer to the "Who to Contact" section for their telephone numbers and Web site addresses.

When will I receive New Insurance ID Cards?

- New CIGNA Medical ID cards will be issued to all enrollees for all medical plans. CIGNA issues an individual ID card for each enrollee.
- New ID cards will be issued to new enrollees in the pharmacy benefit, and EDS or Delta Dental plans. The ID cards from these vendors either 1) contain the names of all covered dependents or 2) contain only the insured's name and can be used for all covered dependents.
- There are no personalized ID cards for Magellan Health Services or CIGNA Dental. These ID cards are available through the Employee Health Initiatives Department.

- New vision benefit ID cards will be issued to all enrollees by EyeMed.
- The Health Care Flexible Spending Account debit card issued in April 2009 for current FSA participants will not be reissued. Each plan year, your debit card will be automatically funded with your FSA annual contribution. Debit cards will only be issued to new health care FSA participants.

WHAT HAPPENS IF I DON'T COMPLETE OPEN ENROLLMENT?

HEALTH & WELLNESS INCENTIVES

If you do not complete Open Enrollment, it will be assumed that you are not voluntarily participating in the Biometric Screening and Health Assessment Initiatives, and therefore, you will not receive the associated financial incentives.

NON-TOBACCO USER INCENTIVE

It is recommended to review the Non-Tobacco User Incentive benefit in the Benefit Enrollment System since the options have changed for the new plan year. The options are listed below:

- I am a user of Tobacco products
- I am not a Tobacco products user but a covered dependent is
- No one (employee & covered dependents(s)) uses Tobacco products

Please note that the incentive is available only when the employee and all covered dependents do not use tobacco products.

Employees who do not provide accurate information and receive the incentive to which they are not eligible for will be subject to disciplinary action up to and including termination. Additionally, misstatement of tobacco use status may result in the life insurance company rescinding coverage.

FLEXIBLE SPENDING ACCOUNT

If you do not complete Open Enrollment, you will not be enrolled in the health care or dependent care flexible spending accounts (FSA). You must re-enroll in the FSA election every Open Enrollment.

ALL MEDICAL PLANS (EXCEPT FOR CHOICE FUND HSA), DENTAL, PHARMACY, VISION, BEHAVIORAL, LEGAL, LIFE & SHORT-TERM DISABILITY

You are encouraged to go online to review your current benefit elections, enrolled dependents and beneficiaries. If you do not complete Open Enrollment, you and your currently enrolled dependents will be enrolled in your current medical, dental, pharmacy, vision, behavioral health, group legal, life insurance and short-term disability benefit plans. In addition, your prior agreement to the Certification Statement provides authorization to continue to process your payroll deductions for the new plan year.

CHOICE FUND HSA MEDICAL PLAN

If you are currently enrolled in the Choice Fund HSA plan and have an employee contribution amount going to the HSA, you must complete Open Enrollment to continue your employee contribution.

WAIVER

If you are currently waiving enrollment in a County-sponsored medical plan (for medical, pharmacy, vision, behavioral health and wellness) and you don't complete Open Enrollment, your medical elections will continue to be waived. **Your waiver payment will not continue for the new plan year until you provide verification of current coverage through other group health insurance to the EHI Department.** Verification must be received by June 1, 2009 in order to receive the payment effective July 1, 2009. Verification received by EHI after June 30, 2009 will be processed prospectively with no retroactive payment.

Maricopa County will compensate you \$100 per month if you work at least 30 hours per week or are a contract employee eligible for full-time benefits and waive your medical coverage. To qualify, you must be covered under other group health coverage and provide proof of the group health insurance coverage to EHI on an annual basis. Arizona Health Care Cost Containment System (AHCCCS) coverage does not qualify as group health insurance and does not qualify you to waive your group medical benefits in order to be eligible for the waiver payment. Employees who receive the waiver payment may enroll in the stand-alone vision plan, dental, and/or additional life insurance. **New, effective July 1, 2009, employees may waive enrollment in a County-sponsored medical plan regardless of their coverage in other group health insurance and opt not to receive the \$100 per month waiver payment.**

PRE-ENROLLMENT PRESENTATIONS

To learn more about the benefit offerings, please attend one of the Pre-Enrollment Presentation sessions. Registration is not required. During each session, various benefit vendors will present an overview of their plans.

Date	Location	Address	Time
April 20, 2009	Administration Building	301 W. Jefferson Street, Test Rooms A & B	8 AM - 10 AM
April 21, 2009	Public Works, MCDOT	2901 W. Durango, Apache/Cochise Rooms	8 AM - 10 AM
April 22, 2009	Southeast Facility	1810 S. Lewis, Cactus Room	8 AM - 10 AM
April 23, 2009	Planning & Development	501 N. 44th Street, Gold/Platinum Rooms	10 AM - 12 PM
April 24, 2009	Air Quality/Environmental Services	1001 N. Central Avenue, 5th Flr. Training Room	12 PM - 2 PM
April 27, 2009	Security Building	222 N. Central Avenue, Arizona Conf. Room	10 AM - 12 PM
April 28, 2009	Juvenile Probation (Durango)	3125 W. Durango, Training Rooms 1 & 2	10 AM - 12 PM
April 29, 2009	Change of Venue	101 W. Jefferson Street, Table One Conf. Room	12 PM - 2 PM
April 30, 2009	Probation Service Center (Mesa)	245 N. Centennial Way, Events Room	10 AM - 12 PM
May 1, 2009	Public Health Administration	4041 N. Central Avenue, 14th Flr. Training Room	8 AM - 10 AM

Daily Vendor Order of Presentation	
30 minutes	<i>CIGNA HealthCare (Medical/Dental)</i>
30 minutes	<i>Employers Dental Services (Dental)</i>
30 minutes	<i>Delta Dental (Dental)</i>
30 minutes	<i>Walgreens Health Initiatives (Pharmacy)</i>

QUESTIONS?

Refer to the contact information page provided at the end of this booklet.

Call the Employee Health Initiatives Department at (602) 506-1010 from 8 AM to 5 PM Monday-Friday for benefit questions.

For questions on how to use the Benefit Enrollment System to make your Open Enrollment elections once you are logged on, contact your department's HR Liaison.

WHAT'S NEW?

ALL CHANGES STATED HEREIN ARE EFFECTIVE JULY 1, 2009 THROUGH JUNE 30, 2010

MEDICAL PLAN CHANGES

CMG (CIGNA Medical Group) High Option changes		
Service	Copay	Change from
Convenience Care Clinic Visit *	\$5	New
Durable Medical Equipment	\$75	\$0
Outpatient Facility Services	\$100	\$0
Emergency Room	\$150	\$125
Urgent Care**	\$75	\$35
Deductible***		
Single	\$100	\$0
Family	\$200	\$0

CMG (CIGNA Medical Group) Low Option changes		
Service	Copay	Change from
Convenience Care Clinic Visit *	\$15	New
Durable Medical Equipment	\$75	\$0
Emergency Room	\$150	\$125
Urgent Care**	\$75	\$50
Deductible***		
Single	\$300	\$0
Family	\$600	\$0

OAPIN (Open Access Plus In-Network) Option changes		
Service	Copay	Change from
Convenience Care Clinic Visit *	\$10	New
Durable Medical Equipment	\$75	\$0
Emergency Room	\$150	\$125
Urgent Care**	\$75	\$50
Deductible***		
Single	\$100	\$0
Family	\$200	\$0

OAP (Open Access Plus) High Option changes		
In-Network Service	Copay	Change from
Convenience Care Clinic Visit*	\$15	New
Durable Medical Equipment	\$75	\$0
Emergency Room	\$150	\$125
Urgent Care**	\$75	\$50
Deductible***		
Single	\$100	\$0
Family	\$200	\$0

OAP (Open Access Plus) Low Option changes		
In-Network Service	Copay	Change from
Convenience Care Clinic Visit *	\$25	New
Durable Medical Equipment	\$75	\$0
Emergency Room	\$150	No change
Urgent Care**	\$75	No change
Deductible***		
Single	\$300	\$0
Family	\$600	\$0

Convenience Care Clinics*

When you need treatment for acute ailments, such as strep throat, allergies or ear infections, you can seek medical treatment from certain Convenience Care Clinics at a reduced copay that is \$10 less than your PCP copay (this reduced copay only applies to the Take Care Clinics, including the location inside the County Administration Building, and the CareToday locations). This discount applies to all five medical plans above, but does not apply to the Choice Fund HSA plan. Many of these clinics are located in or near convenient retail and pharmacy locations. Medical treatment is provided by a Convenience Care Clinician (certified nurse practitioner or physician's assistant). Most of these Convenience Care Clinics are open 7 days a week including evenings, weekends and most holidays. These facilities are walk-in clinics so no appointment is necessary. You are seen on a "first come, first served" basis.

Cigna contracts with several different Convenience Care Clinics such as MinuteClinic, RediClinic, Sutter Express Care, The Little Clinic and ValuClinic. When you receive care at these clinics you will pay your primary care office visit copay or for the Choice Fund HSA plan, your primary care office visit co-insurance after your deductible has been met.

Urgent Care**

Urgent care situations require prompt medical attention, but are not emergencies. If you go to urgent care seeking medical treatment and the urgent care provider directly refers you to the emergency room, your urgent care copay will be reimbursed once CIGNA processes the emergency room claim. It may take up to 30 days to receive reimbursement from CIGNA for your urgent care copay. If you have questions regarding your reimbursement please call CIGNA customer service.

Urgent care locations can be viewed at http://ebc.maricopa.gov/ehi/pdf/2009/CIGNA/urgent_care_listing.pdf.

WHAT'S NEW? CONTINUED

ALL CHANGES STATED HEREIN ARE EFFECTIVE JULY 1, 2009 THROUGH JUNE 30, 2010

Deductibles***

An annual in-network deductible has been added to the medical plans listed below.

Medical Plan	Annual In-network Deductible	
	Single	Family
CMG (CIGNA Medical Group) High Option	\$100	\$200
CMG (CIGNA Medical Group) Low Option	\$300	\$600
OAPIN (Open Access Plus In-Network) Option	\$100	\$200
OAP (Open Access Plus) High Option	\$100	\$200
OAP (Open Access Plus) Low Option	\$300	\$600

The in- and out-of-network deductibles for the OAP (Open Access Plus) High Option and for the OAP (Open Access Plus) Low Option accumulate separately. This is different from the CIGNA Choice Fund HSA plan, which cross-accumulates the deductibles.

Deductible Frequently Asked Questions (FAQs) are listed below:

Q1. For each of the Medical Plans listed above, to what services does the deductible apply?

A1. The deductible applies to inpatient and outpatient facility-based services. Examples of these types of services are listed below:

Inpatient Facility	Outpatient Hospital Facility
<ul style="list-style-type: none"> • Hospital • Skilled Nursing • Rehabilitation • Sub-Acute Facilities 	<ul style="list-style-type: none"> • Outpatient hospital surgical center • Advanced Radiological Imaging at an Outpatient Hospital Facility, i.e. MRI, MRA, CAT and PET Scans

Q2. For each of the Medical Plans listed above, please indicate example services where my deductible applies?

A2. Please see the table below:

Description of the Service* In-network only	Does my deductible apply?
Visit my primary care doctor for a routine visit	No
Visit a specialist physician	
Take Care Clinic located in a Walgreens Pharmacy (including the location on the 2nd Floor of the County Administration Building)	
CareToday Clinics	
Urgent Care Clinic	
Emergency Room	
Short-Term Rehabilitative Therapy	
Chiropractic Services	
Advanced Radiological Imaging (i.e. MRI, MRA, CAT Scans, PET Scans) at an Independent Contracted Freestanding (not hospital based) Facility	
Hospital Stay	
Outpatient Surgery Facility Services (i.e. operating rooms, recovery rooms)	
Admission to Skilled Nursing, Rehabilitation, and Sub-Acute Facilities	
Advanced Radiological Imaging (i.e. MRI, MRA, CAT Scans, PET Scans) at an Inpatient/ Outpatient Hospital Facility (Does not apply to free-standing radiology facilities)	

**All providers who perform these services are contracted through CIGNA Health Care*

WHAT'S NEW? CONTINUED

ALL CHANGES STATED HEREIN ARE EFFECTIVE JULY 1, 2009 THROUGH JUNE 30, 2010

Q3. When my claim is paid, what order is the deductible, copay or co-insurance applied?

A3. Your claim is processed in the following order: annual deductible (if applicable to the service and if this has not been met), copay then co-insurance (if applicable).

The following examples are three unique scenarios of how claims are paid for different types of services. Examples apply to employee only coverage and are not related.

Example A: Surgery is performed at an In-network Outpatient Hospital Surgery Center

SERVICE: OUTPATIENT SURGERY					
<i>Medical Plan</i>	<i>CMG High Option</i>	<i>CMG Low Option</i>	<i>OAPIN Option</i>	<i>OAP High Option</i>	<i>OAP Low Option</i>
CIGNA contracted amount owed to the Provider to pay for your service	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500
Your Annual Deductible*	(\$100)	(\$300)	(\$100)	(\$100)	(\$300)
Your Copay for Outpatient Hospital Surgery	(\$100)	(\$250)	(\$100)	(\$100)	(\$500)
Balance Due to the Provider	\$2,300	\$1,950	\$2,300	\$2,300	\$1,700
Your Co-insurance for Outpatient Hospital Surgery		<i>(1,950*10%)</i> (\$195)			<i>(1,700*10%)</i> (\$170)
Balance Due to the Provider	\$2,300	\$1,755	\$2,300	\$2,300	\$1,530
Your TOTAL Responsibility	\$200	\$745	\$200	\$200	\$970

Example B: Surgery performed at an In-network Hospital

SERVICE: INPATIENT HOSPITAL SURGERY					
<i>Medical Plan</i>	<i>CMG High Option</i>	<i>CMG Low Option</i>	<i>OAPIN Option</i>	<i>OAP High Option</i>	<i>OAP Low Option</i>
CIGNA contracted amount owed to the Provider to pay for your service	\$7,500	\$7,500	\$7,500	\$7,500	\$7,500
Your Annual Deductible*	(\$100)	(\$300)	(\$100)	(\$100)	(\$300)
Your Copay for Inpatient Hospital Surgery	(\$100)	(\$500)	(\$200)	(\$250)	(\$1,000)
Balance Due to the Provider	\$7,300	\$6,700	\$7,200	\$7,150	\$6,200
Your Co-insurance for Inpatient Hospital Surgery		<i>(6,700*10%)</i> (\$670)			<i>(6,200*10%)</i> (\$620)
Balance Due to the Provider	\$7,300	\$6,030	\$7,200	\$7,150	\$5,580
Your TOTAL Responsibility	\$200	\$1,470	\$300	\$350	\$1,920

Example C: Advanced Radiological Imaging (MRI, MRA, CAT and PET Scans) performed at an Outpatient Hospital Facility

SERVICE: PERFORMED AT AN OUTPATIENT HOSPITAL FACILITY					
<i>Medical Plan</i>	<i>CMG High Option</i>	<i>CMG Low Option</i>	<i>OAPIN Option</i>	<i>OAP High Option</i>	<i>OAP Low Option</i>
CIGNA contracted amount owed to the Provider to pay for your service	\$1,500	\$1,500	\$1,500	\$1,500	\$1,500
Your Annual Deductible*	(\$100)	(\$300)	(\$100)	(\$100)	(\$300)
Your Outpatient Advanced Radiological Imaging Copay	(\$50)	(\$100)	(\$100)	(\$100)	
Balance Due to the Provider	\$1,350	\$1,100	\$1,300	\$1,300	\$1,200
Your Outpatient Advanced Radiological Imaging Co-insurance		<i>(1,100*10%)</i> (\$110)			<i>(1,200*10%)</i> (\$120)
Balance Due to the Provider	\$1,350	\$990	\$1,300	\$1,300	\$1,080
Your TOTAL Responsibility	\$150	\$510	\$200	\$200	\$420

For each example, your total payment responsibility includes the annual deductible, copay (if applicable) and co-insurance (if applicable). In addition, your annual deductible may be billed at the time services are rendered by your provider.

WHAT'S NEW? CONTINUED

ALL CHANGES STATED HEREIN ARE EFFECTIVE JULY 1, 2009 THROUGH JUNE 30, 2010

Case Management

Case management involves you (or your dependents) with specific complex health care needs, such as oncology, burns, heart disease complications and high-risk pregnancies, for which a treatment plan is formulated and implemented by CIGNA to improve your health status. If you choose to disenroll or not participate in Case Management, you will be charged an additional \$250 for related services.

Onsite Take Care Clinic

The onsite Take Care Clinic is located in the County Administration Building, 2nd floor, next to Suite 200. This clinic is available exclusively for benefit-eligible employees and their benefit-eligible dependents. Except for County holidays, the hours of operation are Monday – Friday 7:00 AM – 4:30 PM. For approximately one hour daily, the health clinic is closed for lunch. No appointment is necessary; simply register using the check-in touch-screen kiosk. The clinic is staffed with board-certified Family Nurse Practitioners who treat acute, non-urgent and non-work related injuries or conditions such as minor cuts, allergies, ear infections or sinusitis. They are also able to provide adult vaccines, like those that help protect against tetanus and prevent shingles, to help you stay healthy. After all, living well is just as important as getting well. Your convenience care clinic visit copayment in the form of cash or debit/credit card is required at the time of service.

For more information, the onsite Take Care Clinic Frequently Asked Questions (FAQs) can be viewed at:

http://ebc.maricopa.gov/ehi/OnsiteRx/Rx_and_TakeCare_FAQs.pdf.

Cranial Banding

Effective July 1, 2009, Cranial Orthotic Devices for Positional or Deformational Plagiocephaly is a covered benefit when medically necessary.

PHARMACY PLAN CHANGES

Erectile dysfunction medication and non-sedating oral antihistamines will be excluded for both the Co-Insurance Pharmacy Plan and the Consumer Choice Pharmacy Plan. Employees and/or dependents impacted by this change will receive a letter by June 1, 2009.

Changes that apply to the Co-insurance Pharmacy Plan

The copay maximum for Preferred Brand Medication is increasing from \$30 to \$40 for up to a 30-day prescription, and from \$90 to \$120 for a 90-day supply at retail pharmacy locations.

The copay minimum for Non-Preferred Brand Medication is increasing from \$20 to \$40 for up to a 30-day prescription, and from \$60 to \$120 for a 90-day supply at mail service and retail pharmacy locations.

Changes that apply to the Consumer Choice Pharmacy Plan

The \$500 pharmacy credit that Maricopa County funds for employees enrolled in the Consumer Choice Pharmacy Plan for family coverage will no longer be limited to \$300 for one individual. Since the limitation has been removed, the \$500 credit can be used by any covered family member or combination of family members.

Healthful Living Diabetes Care Management Program

Diabetic employees and/or dependents will be reimbursed for up to nine diabetic-related office visit copays for the plan year upon completion of the Healthful Living Diabetes Care Management Program. **Participation in the County's Diabetic Management Program is no longer required as a pre-requisite.** This program was developed in collaboration with Joslin Diabetes Center, the global leader in diabetes research, care, and education, dedicated to improving health outcomes for people with diabetes. By participating in the Healthful Living Diabetes Care Management Program, you will receive a binder filled with information designed to help support and encourage you to better manage your condition. Additionally, you (or your dependents) will participate in three to six face-to-face visits with a pharmacist specially trained in diabetes care management. The pharmacist will review your medical history and the medications you take to assess your diabetes control regimen, and recommend ways for you to better manage your condition. To get started, call (602) 506-3758, or visit the onsite Walgreens Pharmacy (located in the County Administration Building, 2nd floor).

Information regarding this program is available on the Benefits/EHI Pharmacy page at <http://ebc.maricopa.gov/ehi/rx.aspx>.

Onsite Walgreens Pharmacy

An onsite Walgreens Pharmacy is available on the 2nd floor of the County Administration Building and is for the exclusive use of benefit-eligible Maricopa County employees and benefit-eligible dependents. Except for County holidays, the hours of operation are Monday through Friday from 7 AM to 5 PM. The pharmacy is staffed by a team of registered pharmacists and pharmacy technicians who are versed and trained on the pharmacy benefits offered by Maricopa County.

Incentives (which began in January 2009) are available at this location only and apply to benefit-eligible Maricopa County employees and their covered dependents who are enrolled in Maricopa County's Co-insurance Pharmacy Plan or Maricopa County's Consumer Choice Plan. Details regarding the incentives are:

WHAT'S NEW? CONTINUED

ALL CHANGES STATED HEREIN ARE EFFECTIVE JULY 1, 2009 THROUGH JUNE 30, 2010

Consumer Choice Pharmacy Plan

Consumer Choice Pharmacy Plan members (or their dependents) will receive a \$25 automatic deposit into their Level 1 pharmacy account when they get their first prescription filled at the onsite Walgreens Pharmacy. This incentive is available once per lifetime and can only be used at the onsite pharmacy for prescriptions.

Co-insurance Pharmacy Plan

Co-insurance Plan members will save an additional 10% on generic medication and an additional 5% on preferred brand medication when filling a 90-day prescription. This savings is realized when compared to the cost at another retail pharmacy but will not be realized if you are already paying the minimum copayment. If you are paying the maximum copay of \$36 for generic or \$90 (increasing to \$120 July 1, 2009) for preferred brand, you will save with the lower maximum of \$28 for generic or \$70 for preferred brand.

For more information, the Onsite Walgreens Pharmacy Frequently Asked Questions (FAQs) can be viewed at:

http://ebc.maricopa.gov/ehi/OnsiteRx/Rx_and_TakeCare_FAQs.pdf.

BEHAVIORAL HEALTH CHANGES

Outpatient Office Visits

The copay for outpatient behavioral health office visits will increase from \$10 to \$20 per visit.

AUTISM COVERAGE

Maricopa County will implement the new state legislation to cover treatment for autism for children.

Autism coverage will have the following limits:

- \$50,000 maximum benefit per plan year up to the age of nine
- \$25,000 maximum benefit per plan year between the ages of nine and 16

VISION CHANGES

Network Change

A new vision network will be implemented through EyeMed.

Vision Benefit Change

The in-network member cost for Standard Contact Lens Fit and Follow-Up has been reduced to no more than \$40 instead of \$55.

Acute Care Benefit

To enable continuity of eye health care services, an Acute/Primary eye care program will be administered by EyeMed Vision Care. The purpose of the program is to provide coverage for acute eye care conditions identified as part of the vision exam as well as those progressive conditions that could result in vision loss. Patients with chronic conditions such as glaucoma or diabetes must receive their vision care (except refraction) through their medical benefit.

ANNUAL HEALTH & WELLNESS INITIATIVES

The biometric screening and health assessment are health and wellness initiatives that require annual participation in order to receive the \$240 savings per year on the County Medical insurance premium. Participation is voluntary; however, in order to receive the savings for the new plan year effective July 1, 2009, you must complete these initiatives before May 14, 2009 and before you complete your online Open Enrollment elections.

Please see participation details below:

- If you participated in the Biometric Screening and Health Assessment initiatives during last year's Open Enrollment, you must participate again in order to qualify for your FY 09/10 incentives which are effective 07/01/09.
- If you participated in one of the ongoing Maricopa County Biometric Screening and Health Assessment events through the end of December 2008, you must participate again in order to qualify for the FY 09/10 incentives which are effective 07/01/09.
- If you participated in one of the ongoing Maricopa County Biometric Screening and Health Assessment events since January 2009, you are receiving your incentive through the remainder of FY 08/09 (06/30/09) AND you are already qualified for FY 09/10 (07/01/09 through 06/30/10), you do not need to participate again to qualify for the FY 09/10 incentives.

Should you decide not to participate by May 14, 2009, these initiatives will be available throughout the year on a limited basis. However, the incentive savings will be processed on a prospective basis.

For more information, the Biometric Screening and Health Assessment Frequently Asked Questions (FAQs) can be viewed at:

http://ebc.maricopa.gov/ehi/pdf/2009/bs-ha_FAQs.pdf

WHAT'S NEW? CONTINUED

ALL CHANGES STATED HEREIN ARE EFFECTIVE JULY 1, 2009 THROUGH JUNE 30, 2010

Confidential Biometric Screening Initiative

Biometric Screening consists of completing a brief personal health history questionnaire as well as having your health screening which consists of blood pressure, body composition measurements (height, weight, waist circumference, percent body fat, and BMI) and a non-fasting blood draw (finger stick) which consists of total cholesterol, HDL, and glucose levels. Your confidential results will be discussed with you by a health educator at the end of the screening process.

Based on the results of your Biometric Screening, a health coach, provided by Magellan Health Services, may call you to work with you one-on-one to help you identify and achieve your health and wellness goals. The Magellan Health Coaching program is a voluntary, confidential program offered at no cost to you.

Screenings will be performed by appointment at several Maricopa County worksite locations and at selected CIGNA Medical Group Health Care Centers. In addition, you can also receive your screening at one of the new CareToday Clinics. The CareToday facilities are walk-in clinics so no appointment is necessary.

A complete schedule of all screening locations is available on the EHI Home Page. If your location requires an appointment, you can either go online at <https://www.cignasc screenings.com/maricopa> or call (800) 694-4982. Phone lines will be in operation Monday – Friday, between the hours of 8 AM – 6 PM MST until May 13, 2009.

Health Assessment Initiative

The new and improved personal health management tool powered by the University of Michigan is available exclusively through myCIGNA.com. The confidential easy-to-use online questionnaire takes just 20 minutes to complete and will calculate a score that will give you a powerful and accurate assessment of your health status. The questionnaire asks you how you feel about your overall health, satisfaction with your life and job, your safety habits (such as using a seat belt), your stress levels, and your family history. It requests biometric screening information such as your weight, blood pressure and cholesterol level.

What's more, the Health Assessment is packed with individualized advice that can help you:

- Identify and monitor your health status;
- Obtain a personal analysis of many preventable and common conditions;
- Review your contributing risk factors in detail; and
- Offer interactive and health improvement programs in the areas of weight management, smoking cessation, stress, and sleep.

The Health Assessment then analyzes your answers through the University of Michigan's Trend Management System and produces a personal health report with details about your most important health issues. The report includes information about wellness and other health programs that may help you improve your health. You'll also get health information for your personal situation. Based upon your responses, you will also receive an invitation to participate in an online coaching program. You can print a summary of your health report to take to your next doctor's visit. Use it to ask your doctor questions to learn more about your health and to make simple changes to improve your health status.

Instructions on how to access the Health Assessment can be found at: http://ebc.maricopa.gov/ehi/pdf/2009/CIGNA/HA_instructions.pdf

PREMIUM RATE CHANGES

- The premium incentive has been increased from \$15 to \$20 per pay period for non-tobacco using households (employees and their dependents). Participants must be tobacco-free for the past six consecutive months to qualify. Households, where either the employee and/or a covered dependent use tobacco-products, do not qualify for the incentive.
- Employees voluntarily participating in the annual biometric screening and health assessment initiatives will save \$240 per year (\$5 per initiative, 24 pay-periods per year) on their medical insurance premiums. Employees who do not participate in these initiatives do not qualify for these incentives.
- Premium rates have changed. Additionally, the rates are displayed differently. You will notice that the full benefit premium rate is displayed for the medical benefit. As you qualify for incentives, the amount of the incentive will reduce the cost of the premium. Review each benefit and the corresponding rate. There is also a rate schedule that shows the combined rates for medical, behavioral health, pharmacy and vision.
- Contract employees may be offered health insurance benefits at the option of the appointing authority as long as the employee meets the same eligibility requirements of classified and unclassified employees. Contract employees scheduled to work less than 20 hours per week will not qualify for benefits except if the following applies:
 - Employees who retire from the ASRS are statutorily limited to the number of hours they may work for the first year following their retirement date.
 - If one of these employees returns to work within that time period, he/she may be offered only part-time benefits, regardless of the number of hours he/she is scheduled to work, at the option of the appointing authority while the employee

WHAT'S NEW? continued

ALL CHANGES STATED HEREIN ARE EFFECTIVE JULY 1, 2009 THROUGH JUNE 30, 2010

waits for the one year limitation on hours worked to expire. At that time the employee shall revert to meeting the requirements of all other contract employees.

- Employees who are on a special work assignment and enrolled in additional life insurance and/or short-term disability benefits will notice a decrease in premium and coverage. This is due to the premium being calculated on the base salary instead of the special work assignment salary.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

Automatic Data Processing, Inc. (ADP) began performing the health care flexible spending account administration for Maricopa County April 1, 2009. As a payment convenience each employee received the FSA Card that can be used to pay for medical, pharmacy, dental, vision and FSA-approved over-the-counter health items at participating providers. This card pays the provider for the care or item and your available FSA balance is reduced by the purchase amount. Follow-up claim documentation will be required for some charges so be sure to keep your receipts.

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 which does not require you to purchase maintenance medication in three-month quantities, or enrolling in the Health Care FSA (Flexible Spending Health Care) plan which provides a debit card. The debit card allows you to purchase your medication in advance of your full contribution.

Terminated employees must file claims within 60 calendar days of their termination date to avoid forfeiture.

Information regarding this program is available on the EHI Home Page: <http://ebc.maricopa.gov/ehi/flexdirect.aspx>.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

Automatic Data Processing, Inc. (ADP) began performing the dependent care flexible spending account administration for Maricopa County effective April 1, 2009.

Information regarding this program is available on the EHI Home Page: <http://ebc.maricopa.gov/ehi/flexdirect.aspx>.

DEDUCTIONS

- Benefit-related payroll deductions will be processed at the end of each pay period instead of on the pay date. This means the two pay periods where benefit premiums are not deducted is changing from the third paycheck date in a month to the third pay period end date in a month: i.e. Instead of the free benefit-related payroll deductions occurring on the July 31st paycheck, it will now occur on the June 5th paycheck.
- Liberty Mutual deductions will occur every pay period. This change will take effect on pay period beginning May 18, 2009.
- The rates in the Benefit Enrollment System and in this booklet have been reconfigured for the new plan year. For each incentive that you receive, the savings amount will be deducted. Below are some examples:

Example A: Full-time employee only coverage.

<i>Benefit Type</i>	<i>Elected Plan</i>	<i>Per Pay Period Cost</i>
Medical	CMG High	\$36.68
Pharmacy	Co-insurance	\$5.35
Vision	Included with medical	\$0.00
Behavioral Health		\$0.00
Total Combined Per Pay Period Rate Before Incentives:		\$42.03
Total Combined Annual Rate Before Incentives:		\$1,008.72
<i>Incentives</i>		<i>Savings</i>
Tobacco-free Household		(\$20.00)
Biometric Screening Participation		(\$5.00)
Health Assessment Participation		(\$5.00)
Per Pay Period Cost After Incentives:	\$12.03	\$30.00 per pay period savings
Annual Cost After Incentives:	\$288.72	\$720.00 annual savings (\$1,008.72-\$288.72)

Example B: Full-time employee only coverage.

<i>Benefit Type</i>	<i>Elected Plan</i>	<i>Per Pay Period Cost</i>
Medical	CMG High	\$36.68
Pharmacy	Consumer Choice	\$0.00
Vision	Included with medical	\$0.00
Behavioral Health		\$0.00
Total Combined Per Pay Period Rate Before Incentives:		\$36.68
Total Combined Annual Rate Before Incentives:		\$880.32
<i>Incentives</i>		<i>Savings</i>
Tobacco User Household		(\$0.00)
No Biometric Screening Participation		(\$0.00)
Health Assessment Participation		(\$5.00)
Per Pay Period Rate After Incentives:	\$31.68	\$5.00 per pay period savings
Annual Rate After Incentives:	\$760.32	\$120.00 annual savings (\$880.32-\$760.32)

Example C: Full-time employee & family coverage.

<i>Benefit Type</i>	<i>Elected Plan</i>	<i>Per Pay Period Cost</i>
Medical	Choice Fund HSA	\$30.00
Pharmacy	Included with medical	\$0.00
Vision		\$0.00
Behavioral Health		\$0.00
Total Combined Per Pay Period Rate Before Incentives:		\$30.00
Total Combined Annual Rate Before Incentives:		\$720.00
<i>Incentives</i>		<i>Savings</i>
Tobacco-free Household		(\$20.00)
Biometric Screening Participation		(\$5.00)
Health Assessment Participation		(\$5.00)
Per Pay Period Cost After Incentives:	\$0.00	\$30.00 per pay period savings
Annual Cost After Incentives:	\$0.00	\$720.00 annual savings (\$720.00-\$0.00)

LIFE INSURANCE

When selecting spouse life during Open Enrollment, the cost is based on the employee's age until the spouse information is systematically processed and the benefits are calculated. This means when you print your Confirmation Page from the Benefit Enrollment System, the cost of spouse life could be incorrect. Once your information is systematically processed after the Open Enrollment period closes, the cost of spouse life will be correct on the Confirmation Statement mailed to your home.

ELIGIBILITY

When changing your status from benefit-ineligible to benefit-eligible, such as temporary status to regular status, the effective date cannot be sooner than a new hire effective date. This means that instead of being effective immediately, the change will be effective the first of the following month.

CHOOSING THE PLAN THAT SUITS YOU

Maricopa County is committed to promoting better health for its employees and their families by continually evaluating our employee health benefits. Furthermore, Maricopa County continually looks for innovative solutions that will help all of us effectively control short and long-term health care costs without sacrificing the quality of health care you and your family deserve. We believe that by providing a wide selection of medical insurance benefit options every employee has the opportunity to choose the “right plan” for their family.

To help you decide what medical plan is “right for you”, please consider the following questions in the tables below. Table A is specific to the High Deductible Health Plan (HDHP) with the Health Savings Account, and Table B applies to all other medical options. Please take the time to review both tables and the plans for which you are interested.

TABLE A - IS THE CHOICE FUND HEALTH SAVINGS ACCOUNT BENEFIT OPTION RIGHT FOR YOU?	
Do you consider yourself to be healthy?	Yes / No
Do you enjoy managing and investing your money in programs like Deferred Compensation or other investments vehicles and watching the balance grow over the years?	Yes / No
Are you interested in having funding available to help save for future medical and retiree health expenses on a tax-free basis?	Yes / No

If you answered Yes more than twice, please turn to the Medical Plan Summary Chart for more information on the CIGNA Choice Fund HSA plan benefit option.

TABLE B - FIND THE MEDICAL PLAN THAT’S BEST FOR YOU!	
Will you and/or your covered dependents live outside of Maricopa County during the plan year?	Plans
The OAP High and Low options as well as Choice Fund HSA offer out-of-network benefits and national networks of providers. The OAP In-Network option uses a national network of providers.	OAPIN OAP High OAP Low Choice Fund HSA
Do you like to use the CIGNA Medical Centers exclusively for your primary care needs?	
If you enjoy the convenience of receiving your primary medical care through a CIGNA Medical Center (owned and operated by CIGNA), you may want to consider the CMG High or Low benefit options.	CMG High CMG Low
Do you prefer lower out-of-pocket costs (copays and co-insurance) when deciding which medical benefit option to choose?	
Lower out-of-pocket costs, such as copays, mean that your per paycheck deduction will be higher. CMG High and OAP In-network benefit options offer lower copays.	CMG High OAPIN
Are your doctors and hospitals covered under the medical benefit option you choose?	
For all benefit options, CIGNA contracts with a variety of medical providers for different services that includes doctors, hospitals, laboratories, etc. Some benefit options offer larger networks that includes private practice primary care physicians and national networks to cover out-of-area services. The OAP In-network, OAP Low, OAP High and CIGNA Choice Fund HSA benefit options offer large provider networks.	OAP Low OAP High OAPIN Choice Fund HSA
Do you like having the flexibility of seeing providers who are outside of the plan’s network?	
The OAP Low, OAP High and Choice Fund HSA benefit options offer coverage of providers who are not in the plan’s network.	OAP High OAP Low Choice Fund HSA
Is having direct access to network providers without a referral important to you?	
For the OAP In-Network, OAP Low, OAP High and Choice Fund HSA benefit options, NO referrals to network specialists or PCP designation is necessary.	OAPIN OAP High OAP Low Choice Fund HSA

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

QUESTIONS?

Refer to the contact information page provided at the end of this booklet.

Call the Employee Health Initiatives Department at (602) 506-1010 from 8 AM to 5 PM Monday-Friday for benefit questions.

For questions on how to use the Benefit Enrollment System to make your Open Enrollment elections once you are logged on, contact your department’s HR Liaison.

MEDICAL PLAN SUMMARY CHART

Benefit Provision	CIGNA Medical Group High (CMG High):		CIGNA Medical Group Low (CMG Low):		Open Access Plus In-Network (OAPIN):	
Type of Plan	<i>HMO</i>		<i>HMO</i>		<i>HMO</i> with Open Access to Specialists	
Service Area Where Care Must be Received	Maricopa County only, except for emergency care		Maricopa County only, except for emergency care		Nationally	
Residency Requirement	Must work or reside in Maricopa County		Must work or reside in Maricopa County		None	
Primary Care Physician (PCP) Required	Yes; May only use PCP's who practice in CIGNA Medical Group Centers		Yes; May only use PCP's who practice in CIGNA Medical Group Centers		No	
Referral Required	Yes, except to obstetrician/gynecologist, urgent care, emergency care, chiropractic care, & alternative medicine		Yes, except to obstetrician/gynecologist, urgent care, emergency care, chiropractic care, & alternative medicine		No	
Out-of-Network Coverage	No		No		No	
Network	AZ-CIGNA Medical Group Network AZ812		AZ-CIGNA Medical Group Network AZ812		National Open Access Plus AZ300	
Prior Authorization	Provider's responsibility		Provider's responsibility		Provider's responsibility	
Per Pay Period (24/yr.) Medical Premiums**	Full-time	Part-time	Full-time	Part-time	Full-time	Part-time
Employee	\$36.68	\$125.49	\$34.34	\$89.68	\$45.79	\$143.37
Employee + Spouse	\$55.03	\$136.65	\$47.12	\$100.70	\$102.93	\$156.39
Employee + Child(ren)	\$43.74	\$133.39	\$39.36	\$98.24	\$82.03	\$152.89
Employee + Family	\$73.24	\$141.31	\$59.16	\$102.63	\$138.16	\$161.97

**The premium will be reduced by \$20 if the entire household (employee and all covered dependents) is tobacco-free for the past six consecutive months; and/or by \$5 for voluntarily participating in the biometric screening initiative; and/or by \$5 for voluntarily participating in the health assessment initiative.

Find out how the plans work and compare plans to determine which plan works best for you. Log on to www.mycignaplans.com between May 4, 2009 through June 30, 2010 using **Open Enrollment ID:** *Maricopa2009* and **Open Enrollment 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	<i>HMO</i> with Open Access to Specialists		<i>HMO</i> with Open Access to Specialists		<i>High-deductible PPO</i> plan with partially funded Health Savings Account ¹	
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	\$46.73	\$148.76	\$34.62	\$95.13	\$30.00	\$131.47
Employee + Spouse	\$103.87	\$163.12	\$47.76	\$102.12	\$30.00	\$147.23
Employee + Child(ren)	\$82.90	\$159.12	\$39.68	\$100.24	\$30.00	\$141.39
Employee + Family	\$139.65	\$169.95	\$60.46	\$104.50	\$30.00	\$156.95

**The premium will be reduced by \$20 if the entire household (employee and all covered dependents) is tobacco-free for the past six consecutive months; and/or by \$5 for voluntarily participating in the biometric screening initiative; and/or by \$5 for voluntarily participating in the health assessment initiative.

¹ Employee and covered dependents cannot be enrolled in any other type of medical insurance to qualify. Maricopa County contributes \$500 for employee only coverage 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 \$3,000 (individual) or \$5,950 (family) to your HSA, plus \$1,000 catch-up if over 55. Unused balances roll over. If you previously enrolled in the Consumer Choice Pharmacy plan, you may request that the balance in your Level 1 pharmacy account be rolled over to your HSA. Please contact the EHI Dept.

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

For more detail, review the medical plan summaries on the EHI Home Page or go to www.mycignaplans.com to compare plans.

*CIGNA Care Network Specialist, for more information see the Glossary of Terms on page 3.

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

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

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

MEDICAL COPAY/CO-INSURANCE COMPARISON CHART

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

For more detail, review the medical plan summaries on the EHI Home Page or go to www.mycignaplans.com to compare plans.

*CIGNA Care Network Specialist, for more information see the Glossary of Terms on page 3.

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



PHARMACY PLANS

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

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

Co-insurance Benefit Plan

The Co-insurance benefit is a five-level plan in which a co-insurance amount (percentage of the cost¹ of the medication) is charged (unless the applicable minimum or maximum copay applies) based on the classification of the medication per the Preferred Medication List. The list is available on the EHI Home page. This plan covers generic, preferred brand-name, non-preferred brand-name and specialty medication. Some medications require prior authorization or must be used in a certain order (step therapy). Quantity limits apply for certain medications. Some drugs, such as infertility, oral non-sedating antihistamines, erectile dysfunction, non-steroidal anti-inflammatory and cosmetic medications, are excluded. You are responsible for paying 100% of the contracted cost¹ 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 cost¹. If you choose a non-preferred brand-name medication when a generic equivalent is available, you will also pay the difference in the cost¹ 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	\$40 Maximum ³
Level 3	Non-Preferred Brand with Generic equivalent	\$40 Minimum	50% Co-insurance ¹ +	Difference between brand & generic cost
Level 4	Non-Preferred Brand with No Generic equivalent	\$40 Minimum	50% Co-insurance ¹	
Level 5	Non-Preferred Brand Specialty Drugs	\$50 Copay		

Per Pay Period (24/yr.) Pharmacy Premiums	Full-Time	Part-Time
Employee	\$5.35	\$14.36
Employee+Spouse	\$10.59	\$20.40
Employee+Child(ren)	\$7.96	\$17.61
Employee+Family	\$15.89	\$25.96

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 for a 90-day supply. See information on mail service on page 24.

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.

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.
- Level 2 consists of the Employee deductible portion and begins when the \$300 Individual or \$500 Family amount in Level 1 is exhausted. Employees must then meet their deductible of \$300 for an Individual or \$500 for a Family before moving to the next level.
- Level 3 is traditional insurance coverage where the County pays 80% of the cost¹ of the medication and you pay 20% of the cost¹ for the remainder of the plan year.
- Level 4 is limited to specialty medications only and consists of a \$50 copayment. Specialty medication copayments are not charged or credited against any of the first 3 levels.

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

The amounts you pay toward any covered medication will apply to your plan year out-of-pocket maximum. The out-of-pocket maximum is \$1,500 for individual coverage or \$3,000 for family² coverage. Once the out-of-pocket maximum is met, covered prescriptions are paid 100% by the plan for the remainder of the plan year.

Annual Out-of-Pocket Maximum \$1,500 Single / \$3,000 Family ²					
<i>Certain generic preventive medications are provided at no cost and are not charged or credited against any levels. 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	\$9.17
Employee+Spouse	\$0.00	\$10.10
Employee+Child(ren)	\$0.00	\$9.88
Employee+Family	\$0.00	\$10.50

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.

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.

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.



Did you know?
 Diabetic medications & supplies can be free and some office visit copays can be reimbursed with either WHI plan. Call 602-506-3758 to enroll in the Diabetic Programs.

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 co-insurance cost for a three-month supply at an Advantage90™ retail pharmacy may be slightly less than three times the one-month supply copay or co-insurance.

THREE-MONTH SUPPLY THROUGH THE MAIL SERVICE PHARMACY Prescriptions for maintenance medications or long-term health conditions can be ordered through the Walgreens Mail Service pharmacy. Besides being convenient, you could save more money! Maximum copayments and co-insurance percentages for the Co-insurance plan are reduced when mail service is used. Level One (generic) has 15% co-insurance with a maximum of \$28, and Level Two (preferred brand) has 25% co-insurance with a maximum of \$70. For the Consumer Choice Plan, you may save money as many of the medications, especially generics, have a higher discounted contracted cost than medications filled at a retail or Advantage90™ pharmacy. You must use a specific order form when placing your first order so as to provide Walgreens Mail Service with important health, allergy and plan information. This form is called the Tempe Registration and Order Form and is available online at the [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 (Flexible Spending Account) which provides a debit card. The debit card allows you to pay for your medication in advance up to your annual pre-tax Flexible Spending Account contribution before collecting your full annual contribution. Contact ADP at (800) 654-6695 between 8 AM - 8 PM EST 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 have meet the 9 required measures, you are able to receive all of your diabetic medications and supplies free of charge. You and/or your covered dependents may also voluntarily enroll in the Healthful Living Diabetes Care Management Program. Upon completion of this educational program, you will be reimbursed for up to 9 diabetic-related office visits copays per plan year. For information regarding these programs or to request enrollment, please call (602) 506-3758.

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

CIGNA Pharmacy Plan for Choice Fund HSA Plan

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

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).

The pharmacy benefit for Choice Fund HSA is administered by:

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.

BEHAVIORAL HEALTH & SUBSTANCE ABUSE BENEFIT

Behavioral Health & Substance Abuse Benefit Administered by Magellan Health Services

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

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

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

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

Behavioral Health Summary

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

For details about the Magellan behavioral health and substance abuse benefit, you may refer to the Behavioral Health Benefits Summary on the Intranet EHI site at ebc.maricopa.gov/ehi.

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

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

Behavioral Health Benefits for CIGNA Choice Fund HSA Plan

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

Behavioral Health & Substance Abuse Premium

Per Pay Period (24/yr.) Premiums w/Medical Plans	Magellan Health Services		CIGNA Choice Fund HSA	
	Full-Time	Part-Time	Full-Time	Part-Time
Employee	\$0.00	\$0.00	\$0.00	\$0.00
Employee+Spouse	\$0.00	\$0.00	\$0.00	\$0.00
Employee+Child(ren)	\$0.00	\$0.00	\$0.00	\$0.00
Employee+Family	\$0.00	\$0.00	\$0.00	\$0.00



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 \$40 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 specialty fittings other than Standard Contact Lenses (Examples include toric, multifocal, etc.)

Additional Discounts:

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

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

After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com. 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	\$5.08
Employee + Spouse	\$9.58
Employee + Child	\$10.04
Employee - Family	\$14.74

COMBINED RATE SHEET

Per Pay Period Total Medical Rates 24 times/plan year
(Includes Medical, pharmacy, behavioral health, vision)

Reduce \$20 per tobacco free household (employees and covered dependents)

Reduce \$5 if the employee voluntarily participates in the biometric screening initiative

Reduce \$5 if the employee voluntarily participates in the health assessment initiative

CMG High option + Co-insurance Rx	Full-time	Part-time
Employee	\$42.03	\$139.85
Employee + Spouse	\$65.62	\$157.05
Employee + Child(ren)	\$51.70	\$151.00
Employee + Family	\$89.13	\$167.27

CMG High

CMG High option + Consumer Choice Rx	Full-time	Part-time
Employee	\$36.68	\$134.66
Employee + Spouse	\$55.03	\$146.75
Employee + Child(ren)	\$43.74	\$143.27
Employee + Family	\$73.24	\$151.81

CMG Low option + Co-insurance Rx	Full-time	Part-time
Employee	\$39.69	\$104.04
Employee + Spouse	\$57.71	\$121.11
Employee + Child(ren)	\$47.32	\$115.85
Employee + Family	\$75.05	\$128.59

CMG Low

CMG Low option + Consumer Choice Rx	Full-time	Part-time
Employee	\$34.34	\$98.85
Employee + Spouse	\$47.12	\$110.80
Employee + Child(ren)	\$39.36	\$108.12
Employee + Family	\$59.16	\$113.13

OAP In-Network + Co-insurance Rx	Full-time	Part-time
Employee	\$51.14	\$157.73
Employee + Spouse	\$113.52	\$176.79
Employee + Child(ren)	\$89.99	\$170.50
Employee + Family	\$154.05	\$187.93

OAPIN

OAP In-Network + Consumer Choice Rx	Full-time	Part-time
Employee	\$45.79	\$152.54
Employee + Spouse	\$102.93	\$166.49
Employee + Child(ren)	\$82.03	\$162.77
Employee + Family	\$138.16	\$172.47

OAP High option + Co-insurance Rx	Full-time	Part-time
Employee	\$52.08	\$163.12
Employee + Spouse	\$114.46	\$183.52
Employee + Child(ren)	\$90.86	\$176.73
Employee + Family	\$155.55	\$195.91

OAP High

OAP High option + Consumer Choice Rx	Full-time	Part-time
Employee	\$46.73	\$157.93
Employee + Spouse	\$103.87	\$173.22
Employee + Child(ren)	\$82.90	\$169.00
Employee + Family	\$139.65	\$180.45

OAP Low option + Co-insurance Rx	Full-time	Part-time
Employee	\$39.97	\$109.49
Employee + Spouse	\$58.35	\$122.52
Employee + Child(ren)	\$47.64	\$117.85
Employee + Family	\$76.35	\$130.46

OAP Low

OAP Low option + Consumer Choice Rx	Full-time	Part-time
Employee	\$34.62	\$104.30
Employee + Spouse	\$47.76	\$112.22
Employee + Child(ren)	\$39.68	\$110.12
Employee + Family	\$60.46	\$115.00

Choice Fund HSA + CIGNA Rx	Full-time	Part-time
Employee	\$30.00	\$131.47
Employee + Spouse	\$30.00	\$147.23
Employee + Child(ren)	\$30.00	\$141.39
Employee + Family	\$30.00	\$156.95

Choice Fund HSA



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DENTAL PLAN SUMMARY CHART

Benefit Provision	EDS		CIGNA Dental*		Delta Dental**	
Type of Plan	<i>DCO</i> (Dental Care Organization)		<i>PPO</i>		<i>PPO</i> (but does not use PPO network; see network below.)	
Service Area Where Care Must be Received	Maricopa County		Nationally		Nationally	
Residency Requirement	No		No		No	
Primary Care Dentist Required	Yes, all family members must choose the same dentist		No		No	
Referral Required	No		No		No	
Out-of-Network Coverage	No		Yes		Yes	
Network	EDS Provider Network		CIGNA Dental Network		Delta Premier Network	
Prior Authorization	No		No, predetermination recommended for services over \$250		No, predetermination recommended for services over \$250	
Location of Provider Directory	www.mydentalplan.net		www.cigna.com		www.deltadentalaz.com	
Per Pay Period (24/yr.) Dental Premiums	Full-time	Part-time	Full-time	Part-time	Full-time	Part-time
Employee	\$2.16	\$2.16	\$7.23	\$12.02	\$11.92	\$16.74
Employee + Spouse	\$4.10	\$4.10	\$15.95	\$27.45	\$26.31	\$37.81
Employee + Child(ren)	\$5.38	\$5.38	\$17.25	\$28.37	\$28.44	\$39.56
Employee + Family	\$6.18	\$6.18	\$22.18	\$37.48	\$36.57	\$51.87

*Includes the CIGNA Dental Oral Health Integration Program®.

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

For more information about these dental wellness programs, refer to the Wellness Initiatives and Incentives section in this booklet.

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.

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 Routine Cleanings Sealants Space Maintainers		\$0 \$12/tooth \$20 + lab fees	In-Network	Out-of-Network**	In-Network	Out-of-Network**
			Deductible waived			
			\$0	20%	\$0	\$0
Diagnostic Exams Evaluations Consultations & X-rays		Copay \$0-\$20	Deductible waived			
			\$0	20%	\$0	\$0
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%	Amalgam 40%	Amalgam 20%	Amalgam 20%
			Resin 50%	Resin 50%	Resin 50%	Resin 50%
Oral Surgery Extractions		From \$35	20%	40%	20%	20%
Endodontics Root Canal Treatment Pulpotomy		Copay \$170-\$265	20%	40%	20%	20%
Periodontics Treatment of gum disease Periodontal Maintenance		Debridement: \$80 Root Planing: \$90	20%	40%	20%	20%
Bridge & Denture Repair		\$10 + lab fees	20%	40%	20%	20%
Class III - Major Restorative Services			Amount Paid by the Member			
Prostodontics Bridges per pontic Partial Dentures Complete Dentures (upper or lower)		\$250 + lab fees	50%		50%	
		\$375 + lab fees				
		\$325 + lab fees				
Restorative Cast Crowns & Jackets Onlays & Inlays		\$250 + lab fees	50%		50%	
		\$135 - \$170				
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.

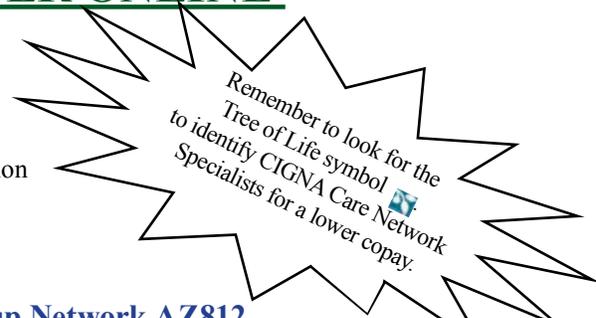
***Progressive/Regressive Base Plan. If you enroll in this plan, if you received a preventive service during FY 08-09 plan year you increase your level of coverage by 5% for Class II and Class III services for the next plan year.

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

HOW TO LOOK UP A PROVIDER 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 “What type of plan you have” section, choose “CIGNA Dental PPO or CIGNA Dental EPO” and select “Core Network” from the drop-down list. 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

EyeMed Vision Care

1. Start at www.eyemedvisioncare.com
2. From the Home page, in the left menu section, click on the drop-down box labeled “Select Your Network” and choose the “Select” option.
3. Enter your zip code where indicated and click the “Submit” button
4. A new window will open and ask you to enter text in the box, click the “Submit” button after entering the text



LIFE INSURANCE PLAN

*Fully Insured by The Standard
Policy Number: 645547*

Basic Life and Basic AD&D - Employee Only Coverage

Maricopa County provides all benefit-eligible employees with the following benefits paid in full by Maricopa County:

- Basic term life insurance coverage equal to their annual base salary to a maximum of \$500,000
- Accidental Death coverage equal to their basic term life insurance coverage, if an accident is the cause of death
- Accidental Dismemberment coverage as a percentage of the basic term life insurance coverage

Additional Life Insurance - Employee Only Coverage

Additional life coverage amounts are available in 1, 2, 3, 4, or 5 times the employee's annual base salary. The total amount of Basic Life and Additional Life may not exceed \$1,000,000. During Open Enrollment the Additional Life coverage may be increased by one level without providing evidence of insurability up to the guarantee issue limit of \$500,000. Evidence of insurability (EOI) is required for coverage amounts greater than \$500,000.

The premium for Additional Life coverage is based on your smoker status and your age as of January 1 of the current year.

Spouse Life Insurance Coverage

Spouse Life coverage may be purchased for the employee's legal spouse 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 if elected when initially eligible. Otherwise EOI is required for any amount elected or any increase.

The premium for Spouse Life Insurance coverage is based on the age of the spouse as of January 1 of the current year.

Child Life Insurance Coverage

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 31 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 your child is disabled on that date.

Coverage is available 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 if elected when initially eligible. Otherwise EOI is required for any amount elected or any increase.

Additional AD&D Insurance - Employee Only Coverage

Additional AD&D coverage is available in increments of 1, 2, 3, 4, or 5 times the employee's annual base salary, to a maximum of \$500,000. This coverage may be purchased separately from or in addition to Additional Life Insurance. This coverage may not be purchased in combination with Family Additional AD&D Insurance.

Additional AD&D - Family Coverage

Additional AD&D coverage is available for the employee, and his or her legal spouse and dependent child(ren).

This coverage is available in increments of 1, 2, 3, 4, or 5 times the employee's annual base salary to a maximum of \$500,000 for the employee.

For other dependents, the coverage amount is a) 60% of employee's additional AD&D coverage when only a spouse is covered; b) 10% of employee's additional AD&D coverage when only a child(ren) is covered up to \$25,000 maximum; and c) 50% of employee's additional AD&D coverage for a spouse and 5% for each child when both spouse and child(ren) are covered.

This coverage may not be purchased in combination with Employee Only Additional AD&D insurance.

How to complete your Evidence of Insurability

Evidence of insurability (Medical History Statement) 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. Should you need to fill out a Medical History Statement, you must complete and submit your benefit elections first. Then submit your Medical History Statement, either online via The Standard's Web site, or directly to the Employee Health Initiatives Department. The Medical History Statement form is available at www.standard.com/mybenefits/maricopa or http://ebc.maricopa.gov/ehi/pdf/2009/Standard/medical_history_statement.pdf.

LIFE INSURANCE PREMIUMS

Additional Life and/or Accidental Death and Dismemberment (AD&D)
1 to 5 times Base Salary - 100% Paid by Employee

This rate and calculation sheet is provided for your information. The Benefit Enrollment System will calculate your premiums for you.

Additional Life Insurance Table - Employee Only

5 Year Age Categories (Age on last January 1)	Employee Cost Monthly per \$1,000 of Coverage (Non-Smoker Multiplier)	Employee Cost Monthly per \$1,000 of Coverage (Smoker Multiplier)	<i>Smoker rates are controlled by your response to tobacco-use questions on the Additional Life Plan page in the Benefit Enrollment System. Misstate- ment of your tobacco use status may result in the life insurance company rescinding coverage.</i>
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

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 ÷ divided by \$1,000	\$25,000	\$50,000	\$75,000	\$100,000	\$125,000
	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

Example: Age 37	Multiplier for Non-Smoking (\$0.070) <i>Annual Adjusted Rate = (\$0.07 x 12)</i>	Multiplier for Smoking (\$0.136) <i>Annual Adjusted Rate = (\$0.136 x 12)</i>	Coverage Amount
1 x Salary	$0.84 \times 25 = \$21.00/24 = \mathbf{\$0.88}$	$1.63 \times 25 = \$40.75/24 = \mathbf{\$1.70}$	\$25,000
2 x Salary	$0.84 \times 50 = \$42.00/24 = \mathbf{\$1.75}$	$1.63 \times 50 = \$81.50/24 = \mathbf{\$3.40}$	\$50,000
3 x Salary	$0.84 \times 75 = \$63.00/24 = \mathbf{\$2.63}$	$1.63 \times 75 = \$122.25/24 = \mathbf{\$5.09}$	\$75,000
4 x Salary	$0.84 \times 100 = \$84.00/24 = \mathbf{\$3.50}$	$1.63 \times 100 = \$163.00/24 = \mathbf{\$6.80}$	\$100,000
5 x Salary	$0.84 \times 125 = \$105.00/24 = \mathbf{\$4.38}$	$1.63 \times 125 = \$203.75/24 = \mathbf{\$8.49}$	\$125,000

Dependent Life and Additional AD&D Insurance Tables

100% paid by Employee

Age on last January 1	Monthly for 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

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

Monthly for Family AD&D
\$0.035 per \$1,000
Employee Only AD&D
\$0.02 per \$1,000

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, contact The Standard.

FLEXIBLE SPENDING ACCOUNTS



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. You must enroll during each Open Enrollment to renew your spending account(s). This Open Enrollment you are enrolling in flexible spending account(s) effective for expenses incurred from July 1, 2009 through June 30, 2010 or in the 2 ½ month grace period (applicable to the health care FSA only) July 1 - Sept. 15. Money that is put in an FSA will be forfeited if claims are not incurred within this 14½ month period or if claims are not filed by November 30, 2010 for health care FSAs and August 31, 2010 for dependent care FSAs. Terminated employees must file claims within 60 calendar days of their termination date to avoid forfeiture.

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. Since your benefit plan year is based on the fiscal year you will be responsible for controlling your IRS mandated calendar year maximum (\$5,200 for health care FSA, \$5,000 for dependent care FSA).

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 (Flexible Spending Account) which provides a debit card. The debit card allows you to pay for your medication in advance up to your annual pre-tax Flexible Spending Account contribution before collecting your full annual contribution. Contact ADP at (800) 654-6695 between 8 AM - 8 PM EST for specific details.

Health Care FSA

You can enroll in the health care FSA (unless you enrolled in the Choice Fund HSA medical plan or are covered by another 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 but are not limited to 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 maximum contribution. Deductions are taken 26 times per plan year. A minimum plan annual contribution of \$26 is required.

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 entire plan year contribution is available as of July 1.

Limited Use FSA

If you enrolled in the CIGNA Choice Fund HSA medical plan, you can still take advantage of the FSA. However, you and your covered dependents can only participate in the Limited Use plan. This plan allows you to be reimbursed for dental and vision care services (as defined by the IRS) but not medical expenses.

You can set aside up to \$5,200 as your plan year maximum contribution. Deductions are taken 26 times per plan year. A minimum plan annual contribution of \$26 is required.

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 plan year contribution. Deductions are taken 26 times per plan year. A minimum plan annual contribution of \$26 is required.

To find out more about the FSAs including what items are eligible for reimbursement, contact ADP, the Flexible Spending Account Administrator by phone at (800) 654-6695 between 8 AM - 8 PM EST or via email through the flexdirect.adp.com Web site.

SHORT-TERM DISABILITY PLAN

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 and all FML/sick leave 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 base earnings. Base earnings do not include special work assignment pay. 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 EHI home page to determine your 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 if the employee is activated for military duty in which case benefits will be terminated.

This plan contains a pre-existing condition clause that applies 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 50% benefit would be paid for a pre-existing condition unless you had been treatment free for three months or covered at the new-higher level for 12 months.

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.

Short-Term Disability Rates

Coverage	Multiplier
40%	0.38%
50%	0.55%
60%	0.85%
70%	1.32%

Calculation Example

Annual Base Salary: \$25,000	40% Option	50% Option	60% Option	70% Option
Multiplier	0.0038	0.0055	0.0085	0.0132
Per Pay Period Multiplier (Multiplier x (26/24))	0.0041	0.006	0.0092	0.0143
Per Pay Period Salary (Annual Salary / 26)	\$961.54	\$961.54	\$961.54	\$961.54
Per Pay Period Premium (Per Pay Period Salary x Per Pay Period Multiplier)	\$3.94	\$5.77	\$8.85	\$13.75



Sedgwick CMS

Refer to the [*Short-Term Disability Summary Plan Document*](#) on the [*EHI Home Page*](#) 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.

OTHER BENEFITS OFFERED

Auto, Home and Renters Insurance

You qualify for a special Maricopa County group discount on your auto, home and renters insurance through Group Savings Plus from Liberty Mutual. Payroll deduction is available. Contact Liberty Mutual directly to enroll.



Deferred Compensation

Your deferred compensation program is administered by Nationwide Retirement Solutions. This program allows you to defer a portion of your earnings each pay period through payroll deduction into an account for your retirement. When you contribute a portion of your income, you reduce the amount that is taxable. You're not only saving for tomorrow, you're postponing federal and state income taxes today.

The maximum amount you can defer is \$16,500 for 2009 if you're under the age of 50. If you are age 50 or over, your maximum is \$22,000 in 2009 or 100% of includible compensation, whichever is less. If you are within 3 years of retirement, you may qualify to contribute more if you have past dollars to "catch up". The minimum amount of deferral is \$10 per pay period. You have 29 investment choices as well as contribution to a Personal Choice Retirement Account through Schwab that allows you to do other investing if you choose. You may also change your contribution amount to your program at any time. And, as an added bonus, your money is available to you upon separation from County service with no early withdrawal penalty. For more information or to enroll, call Margaret Volpe-Rodgers or Linda Pond at Nationwide at 602-266-2733 or visit our Web site at www.maricopadc.com.



Employee Assistance Plan (EAP)

Your Employee Assistance Plan benefit is offered by Magellan Health Services. All active employees are automatically enrolled in this benefit that provides short-term counseling for both personal and work-related issues. Services are provided at no cost to the employee and his/her dependents. The EAP benefit also provides limited legal consultation and financial counseling.



MetLaw® Group Legal Services

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®, administered by Hyatt Legal Plans. 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 a complete list contact Hyatt Legal Plans at (800) 821-6400 or online at: www.info.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 plan year.



OPEN ENROLLMENT CHECKLIST

1. Complete your Worksheet that was mailed to your home address to assist in making the enrollment elections quickly.
2. After 15 minutes of inactivity, you will be logged out. Your changes will be saved as long as you go back and finish your elections by 8 PM MST.
3. Register for the portal.
4. Log on to the portal.
5. Click on the Benefits tab.
6. Click on the Benefit Enrollment System link.
7. Read the Welcome page and press Continue.
8. Read the instructions for completing each page, located in the left-hand column.
9. At the Main Menu, click on the Open Enrollment link.
10. Review your Personal Information. If incorrect, contact Employee Records at: (602) 506-3519
11. Review your dependents. Dependents must be listed in order to be enrolled in a benefit or for spouse or child life insurance coverage.
12. Review and update your benefit elections.
13. Update your beneficiary information.
14. Review and update your Annual Account elections (for flexible spending accounts and health savings account contributions).
15. Click on the submit button on the 2009-2010 Benefit Summary page.
16. Enter your email address if you would like an email acknowledgement or click Cancel.
17. Print your 2009-2010 Confirmation page.
18. A Confirmation Statement will be mailed to your home address the week of May 18th.
19. Compare the Confirmation page with the Confirmation Statement.
20. If the information on the Confirmation Statement does not match your printed Confirmation page, log on to the portal and make your changes in the Benefit Enrollment System.
21. Another Confirmation Statement will be mailed to you, if you have made changes between May 18th and May 29th, during the week of June 1st.



ENROLLMENT WORKSHEET EXAMPLE

The Open Enrollment Worksheet will be mailed to your home address on April 30, 2009.

Maricopa County Employee Health Initiatives
301 S 4th Ave, Suite B100
Phoenix, AZ 85003



2009/2010 Benefits Enrollment Worksheet

ENROLLMENT DEADLINE

05/15/2009



John Doe
123 N. Central Avenue
Phoenix, AZ 85003

MCYWTST
T4ZV 0001

Enrollment Instructions:

1. Review this Worksheet. You will be enrolled in the benefit coverage marked with a check (✓) unless you make a change.
2. Complete this Worksheet before you go online to make benefit changes.
3. Use the boxes on the left-hand side of the Worksheet to indicate the option code and cost for each benefit you select.
4. Enroll online at <http://portal.adp.com> by the enrollment deadline shown above.
5. If you do not have access to a computer, check with your department HR Liaison for computer resources that will be available for your use.
6. Paper enrollment or late enrollment will not be accepted. Contact 602-506-1010 if you have enrollment questions.
7. You must register at <http://portal.adp.com>. Your registration pass code is MCAZ-PRISM09
8. For information regarding the benefits offered, please visit www.maricopa.gov/benefits or the internal Intranet at <http://ebc.maricopa.gov/ehi>.
9. Review the *Know Your Benefits* booklet for the current plan year or the *What's New* booklet during the annual open enrollment period.
10. This worksheet represents all of your available options. Based on your event you may not be able to make changes to all options.

Printed: 05/04/2009
Event: Open Enrollment
Employee ID: 811123321

Dependent Information

You are responsible for adding only eligible dependents and updating any incorrect or incomplete dependent information. The following list displays all individuals who are currently enrolled in benefits as your dependent.

No.	Name	Relationship*	Birth Date	Sex	Student	Disabled	Medical	Dental	Vision
0	JOHN DOE	EE		M			✓	✓	✓

*Relationship codes are:

EE = Employee, SP = Spouse, CH = Child, SC = Step-Child, LG = Legal Guardian, CO = Court-order, BN = Beneficiary

Medical

Coverage Category/Cost Per Pay Period

Your Choice Option Code	Option Code	Option Name	Employee Only	Employee plus Spouse	Employee plus Child(ren)	Employee plus Family
<input type="text"/>	001	CIGNA Medical Group High *	\$36.68	\$55.03	\$43.74	\$73.24
<input type="text"/>	002	CIGNA Medical Group Low *	\$34.34	\$47.12	\$39.36	\$59.16
<input type="text"/>	003	Open Access Plus In-Network	\$45.79	\$102.93	\$82.03	\$138.16
<input type="text"/>	004	Open Access Plus High	\$46.73	\$103.87	\$82.90	\$139.65
<input type="text"/>	005	Open Access Plus Low	\$34.62	\$47.76	\$39.68	\$60.46
<input checked="" type="checkbox"/>	006	Choice Fund - HSA	\$30.00	\$30.00	\$30.00	\$30.00
<input type="text"/>	000	Waived Medical Benefit Plan				

* You are required to provide the code for the Primary Care Provider at the time you enroll. Contact the plan to obtain the PCP code.

Biometric Screening Incentive

Coverage Category/Cost Per Pay Period

Employees (not including dependents) enrolled in a County-sponsored medical plan who participate in the annual Biometric Screening will save up to \$120 per plan year on their medical insurance premium. The biometric screening provided by CIGNA Onsite Health consists of completing a brief personal health history as well as having your measurements taken for height, weight, blood pressure, waist circumference, body fat composition, cholesterol, and glucose levels.

Enroll online at <http://portal.adp.com> by 05/15/2009

T4ZV 0001 0104



2009/2010 Benefits Enrollment Worksheet

Health Assessment Incentive

Coverage Category/Cost Per Pay Period

Employees (not including dependents) enrolled in a County-sponsored medical plan who participate in the annual Health Assessment will save up to \$120 per plan year on their medical insurance premium. The Health Assessment is available online through www.mycigna.com and consists of a series of questions about your health and lifestyle. Your confidential responses are then assessed by the online tool to determine your health risks.

Non-Tobacco User Incentive

Coverage Category/Cost Per Pay Period

When employees and all of their dependents enrolled in a County-sponsored medical plan do not use tobacco products (occasionally or regularly), they will save up to \$480 per plan year on their medical insurance premium. Tobacco use includes cigarettes, cigars, pipes, snuff, chewing tobacco and any other product containing tobacco during the last six consecutive months.

Health Savings Account

When you enroll in the Choice Fund Health Savings Account medical plan, you may contribute to your Health Savings Account on an annual basis. You can contribute up to \$2,900 (individual) or \$5,800 (family) to your account depending on the amount contributed by Maricopa County. Unused balances in your account rollover each plan year.

Pharmacy

Coverage Category/Cost Per Pay Period

Your Choice

Option Code

Cost

Option Code	Option Name	Employee Only	Employee plus Spouse	Employee plus Child(ren)	Employee plus Family
001	Co-insurance Prescription Benefit Plan	\$5.35	\$10.59	\$7.96	\$15.89
002	Consumer Choice Prescription Benefit Plan	\$0.00	\$0.00	\$0.00	\$0.00
<input checked="" type="checkbox"/> 003	Choice Fund HSA Prescription Plan	\$0.00	\$0.00	\$0.00	\$0.00
000	Waived Prescription				

Vision

Coverage Category/Cost Per Pay Period

Your Choice

Option Code

Cost

If you enroll in any County-sponsored medical plan, you must enroll in the vision plan (EyeMed with Med election). 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 (EyeMed no Med election). However, you may not enroll your dependents in a vision plan if they are not enrolled in your medical plan.

Option Code	Option Name	Employee Only	Employee plus Spouse	Employee plus Child(ren)	Employee plus Family
<input checked="" type="checkbox"/> 001	EyeMed (with Med election)	\$0.00	\$0.00	\$0.00	\$0.00
002	EyeMed (no Med election)	\$5.08	\$9.58	\$10.04	\$14.74
000	Waived Vision				

Behavioral Health Coverage

The behavioral health coverage is provided as part of your enrollment in a County-sponsored medical plan and is provided to you at minimal cost. Enrollment is mandatory.



2009/2010 Benefits Enrollment Worksheet

Dental Coverage Category/Cost Per Pay Period

Your Choice Option Code	Option Code	Option Name	Employee Only	Employee plus Spouse	Employee plus Child(ren)	Employee plus Family
<input type="text"/>	001	Employers Dental Services *	\$2.16	\$4.10	\$5.38	\$6.18
Cost <input type="text"/>	002	CIGNA Dental	\$7.23	\$15.95	\$17.25	\$22.18
	003	Delta Dental	\$11.92	\$26.31	\$28.44	\$36.57
	✓000	Waived Dental				

* You are required to provide the code for the Primary Care Provider at the time you enroll. Contact the plan to obtain the PCP code.

Additional Life Insurance

Your Choice Option Code	Option Code	Coverage Level	Non Tobacco User	Tobacco User
<input type="text"/>	001	1X Annual Base Salary		
Cost <input type="text"/>	002	2X Annual Base Salary		
	003	3X Annual Base Salary		
	004	4X Annual Base Salary		
	005	5X Annual Base Salary		
	✓000	Waived Additional Life		

Your rates which are based on your base salary and your smoker status will display on your individualized worksheet.

Additional Accidental Death and Dismemberment

Your Choice Option Code	Option Code	Coverage Level	Employee Only	Employee Plus Family
<input type="text"/>	001	1X Annual Base Salary		
Cost <input type="text"/>	002	2X Annual Base Salary		
	003	3X Annual Base Salary		
	004	4X Annual Base Salary		
	005	5X Annual Base Salary		
	✓000	Waived Additional AD&D		

Your rates which are based on your base salary will display on your individualized worksheet.

Spouse Life Insurance

Your Choice Option Code	Option Code	Coverage Level	Cost Per Pay Period	Option Code	Coverage Level	Cost Per Pay Period
<input type="text"/>	001	\$10,000	<i>Rates which are based on your spouse's age at the beginning of the calendar year will display on your individualized worksheet if the spouse's information is on file.</i>	007	\$70,000	<i>Rates which are based on your spouse's age at the beginning of the calendar year will display on your individualized worksheet if the spouse's information is on file.</i>
Cost <input type="text"/>	002	\$20,000		008	\$80,000	
	003	\$30,000		009	\$90,000	
	004	\$40,000		010	\$100,000	
	005	\$50,000		✓000	Waived Spouse Life	
	006	\$60,000				



2009/2010 Benefits Enrollment Worksheet

Child Life Insurance

Your Choice Option Code	Option Code	Coverage Option	Cost Per Pay Period
<input type="text"/>	001	\$5,000	\$0.25
Cost	002	\$10,000	\$0.50
<input type="text"/>	003	\$15,000	\$0.75
	004	\$20,000	\$1.00
	✓ 000	Waived Child Life	

Short Term Disability

Your Choice Option Code	Option Code	Coverage Level	Cost Per Pay Period	Option Code	Coverage Level	Cost Per Pay Period
<input type="text"/>	001	40% STD Coverage	<i>Your rates which are calculated on your base salary will display on your individualized worksheet.</i>	004	70% STD Coverage	<i>Your rates which are calculated on your base salary will display on your individualized worksheet.</i>
Cost	002	50% STD Coverage		✓ 000	Waived STD Coverage	
<input type="text"/>	003	60% STD Coverage				

Health Care Flexible Spending Account

Annual Goal

(Pre-Tax Contribution)

When you enroll in the Health Care Spending Account, you may contribute from \$26.00 to \$5,200.00 for the plan year. The amount you elect will be divided by the number of pay periods in the plan year and taken from each paycheck.

You will default to no contribution if you do not make an election.

Dependent Care Flexible Spending Account

Annual Goal

(Pre-Tax Contribution)

When you enroll in the Dependent Care Spending Account, you may contribute from \$26.00 to \$5,000.00 for the plan year. The amount you elect will be divided by the number of pay periods in the plan year and taken from each paycheck.

You will default to no contribution if you do not make an election.

Employee Assistance Program

The Employee Assistance Program is provided to you at no cost.

Group Legal Services

Your Choice Option Code	Option Code	Coverage Option	Cost Per Pay Period
<input type="text"/>	001	METLAW Group Legal Services	\$7.87
Cost	✓ 000	Waived Group Legal	
<input type="text"/>			

ONLINE BENEFIT ENROLLMENT SYSTEM INSTRUCTIONS

1. Start your browser and type <https://portal.adp.com> in your address bar. Click on the “Go” button or press enter on your keyboard.



2. At the initial ADP login screen, click on the “User Login” button as illustrated. A dialog box will prompt you to enter your User name that you received via email from ADP_netsecure@adp.com, and your Password you selected when you registered.



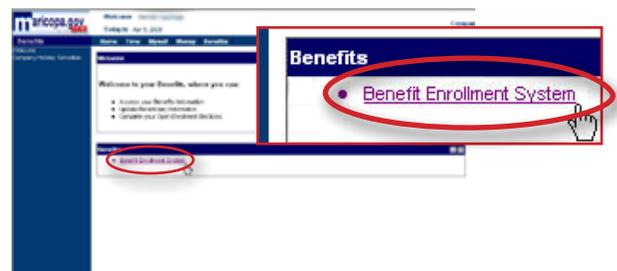
If not registered, go to PRISM Registration Instructions at: <http://ebc.maricopa.gov/hr/PRISM/pdf/SelfServiceRegistration.pdf> or click on “First Time Users Register Here” link. The registration pass code is MCAZ-PRISM09 (the last two digits are numbers zero and nine).

If you forgot your User name and/or Password, click the link that reads “Forgot your User Id” or “Forgot your Password”.

3. Once you are logged in, click on the “Benefits” tab as indicated in the image here.



On this next page, click on the “Benefit Enrollment System” link as shown.



4. At the welcome page, click the “Continue” button to get to the “Main Menu” page.



The next screenshot shows the “Main Menu” page with the Instructions section and Open Enrollment link outlined. The instructions will guide you throughout the entire process. To proceed, click on the “Open Enrollment” link.



ONLINE BENEFIT ENROLLMENT SYSTEM INSTRUCTIONS

- After clicking on the “Open Enrollment” link, your 2009-2010 Benefit Summary will display.

After 15 minutes of inactivity, you will be logged out. Your changes will be saved as long as you go back and finish your elections by 8 PM MST the same day.

- The “Personal Information” section will display your general information such as your full name, address, birthday, etc.
- The “Dependents” section will show any current dependents that are linked to your profile. You can click on the dependent’s name to display more information about him/her. You can also add a dependent by clicking on the “Add Dependent” button.
- The “Benefit Elections” section will be pre-populated with your current elections (with the exception of the Biometric Screening Incentive and Health Risk Assessment Incentive). To change any of your plan elections, click on the benefit link.

Note: Make sure to put a check mark next to the dependents that you would like to cover for each benefit. If you de-select a dependent from medical coverage, that dependent will not be eligible for pharmacy, vision, or behavioral health coverage.
- The “Annual Account Elections” section will display the benefit options according to your medical plan election.

All elections are defaulted to waived unless you change your Annual Contribution Amount in each benefit. To change any of your plan elections, click on the benefit link.

- The “Beneficiary Designations” section will display the designated beneficiary’s name, relationship and percentage of designation for each benefit elected.

- Once you are finished with this section, review all your elections to ensure everything you have chosen reflects on the summary page and click on the “Submit” button to save your elections.

- When you click on the “Submit” button, a pop-up window will appear asking for your email address to send you an email acknowledgement. If you do not want the email acknowledgement, click on the “Cancel” button. Otherwise, enter your email address and click “OK”.



2009 - 2010 Benefit Summary

Personal Information

Name:	John Doe	Address:	123 Main St
Birth Date:	01/01/1980	City:	Denver
Base Salary:	\$50,000.00	State:	CO
		Country:	USA

Dependents

Name	Relationship	Birth Date
John Doe	Spouse	01/01/1980

Benefit Elections

Benefit	Plan Election	Coverage	Employee Cost Per Pay Period	Employer Cost Per Pay Period
Medical	Waived Medical Benefit Plan	No Coverage	\$0.00	\$0.00
Medical Waiver Credit Summary	Medical Waiver Credit Not Elected		\$0.00	\$0.00
Biometric Screening Incentive	Biometric incentive does not apply		\$0.00	\$0.00
Health Risk Assessment Incentive	Health Risk Assessment Incentive does not apply		\$0.00	\$0.00
Non-Tobacco User Incentive	Non-Tobacco user Incentive does not apply		\$0.00	\$0.00
Pharmacy	Waived Pharmacy Benefit Plan	No Coverage	\$0.00	\$0.00
Vision	Waived Vision Benefit Plan	No Coverage	\$0.00	\$0.00
Active Behavioral Health	Waived Behavioral Health Benefit Plan	No Coverage	\$0.00	\$0.00
Dental	Delta Dental Benefit Plan	Employee Only	\$11.92	\$9.59
Basic Life Insurance	1 times Annual Base Salary		Company Paid	\$3.00
Basic Accidental Death & Dismemberment	1 times Annual Base Salary		Company Paid	\$0.60
Additional Life Insurance	2 times Annual Base Salary	Non Tobacco User	\$4.20	\$0.00
Additional Accidental Death & Dismemberment	4 times Annual Base Salary	Employee Only	\$2.40	\$0.00
Second Life Insurance	\$100,000 <i>Your coverage will remain at a fixed amount until EOL is achieved</i>		\$5.00	\$0.00
Child Life Insurance	\$20,000 <i>Your coverage will remain at a fixed amount until EOL is achieved</i>		\$1.00	\$0.00
Short-Term Disability	Waived Short-Term Disability Coverage		\$0.00	\$0.00
Employee Assistance Program	Employee Assistance Plan		Company Paid	\$0.00
Group Legal Services	Waived Group Legal Services		\$0.00	\$0.00

Total Employee Cost Per Pay Period: \$24.52
Total Employer Cost Per Pay Period: \$13.19

Annual Account Elections

Benefit	Plan Election	Before-Tax Contribution
Health Care Flexible Spending Account	Waive Participation	\$0.00
Dependent Care Flexible Spending Account	Contribute	\$5,000.00

Beneficiary Designations

Benefit	Name	Relationship	Percent	Designation
Basic Life Insurance	John Doe	Spouse	90%	Primary
	John Doe	Beneficiary	5%	Primary
	John Doe	Beneficiary	5%	Primary
Basic Accidental Death & Dismemberment	John Doe	Spouse	90%	Primary
	John Doe	Beneficiary	3%	Primary
	John Doe	Beneficiary	5%	Primary
Additional Life Insurance	John Doe	Spouse	100%	Primary
	John Doe	Beneficiary	50%	Contingent
	John Doe	Beneficiary	50%	Contingent
Additional Accidental Death & Dismemberment	John Doe	Spouse	100%	Primary
	John Doe	Beneficiary	100%	Contingent

ONLINE BENEFIT ENROLLMENT SYSTEM INSTRUCTIONS

2009 - 2010 Confirmation

You have successfully completed your enrollment.
Your Confirmation Number is 85841722.



Personal Information		
Name:	VICTOR MARINO	Address: 2943 S EXTENSOOR
Birth Date:	10/04/1971	MESA
Base Salary:	\$58,280.00	AZ 85210 USA

Dependents		
Name	Relationship	Birth Date
Jennifer J Marino	Spouse	06/22/1971

Benefit Elections				
Benefit	Plan Election	Coverage	Employee Cost Per Pay Period	Employer Cost Per Pay Period
Medical	Choice Fund-Health Savings Account Benefits Plan	Employee plus Spouse <i>Jennifer</i>	\$30.00	\$424.01
Medical Waiver Credit Summary	Medical Waiver Credit Not Declined		\$0.00	\$0.00
Biometric Screening Incentive	I have completed Biometric Screening		-\$5.00	\$0.00
Health Risk Assessment Incentive	I have completed the Health Risk Assessment		-\$5.00	\$0.00
Non-Tobacco User Incentive	No one (emp & covered dependent(s)) uses Tobacco products		-\$20.00	\$0.00
Pharmacy	Choice Fund HSA Pharmacy Benefit Plan	Employee plus Spouse <i>Jennifer</i>	\$0.00	\$0.00
Vision	Vision Benefit Plan	Employee plus Spouse <i>Jennifer</i>	\$0.00	\$4.95
Active Behavioral Health	Behavioral Health Benefit Plan	Employee plus Spouse <i>Jennifer</i>	\$0.00	\$0.00
Dental	Delta Dental Benefit Plan	Employee plus Spouse <i>Jennifer</i>	\$26.31	\$21.14
Basic Life Insurance	1 times Annual Base Salary		Company Paid	\$3.00
Basic Accidental Death & Dismemberment	1 times Annual Base Salary		Company Paid	\$0.00
Additional Life Insurance	5 times Annual Base Salary	Non Tobacco User	\$10.50	\$0.00
Additional Accidental Death & Dismemberment	5 times Annual Base Salary	Employee plus Family	\$5.31	\$0.00
Spouse Life Insurance	\$50,000		\$2.50	\$0.00
Child Life Insurance	Waived Child Life		\$0.00	\$0.00
Short Term Disability	60% Short-Term Disability Coverage		\$20.98	\$0.00
Employee Assistance Program	Employee Assistance Plan		Company Paid	\$0.00
Group Legal Services	Waived Group Legal Services		\$0.00	\$0.00

Total Employee Cost Per Pay Period: \$65.68
Total Employer Cost Per Pay Period: \$453.70

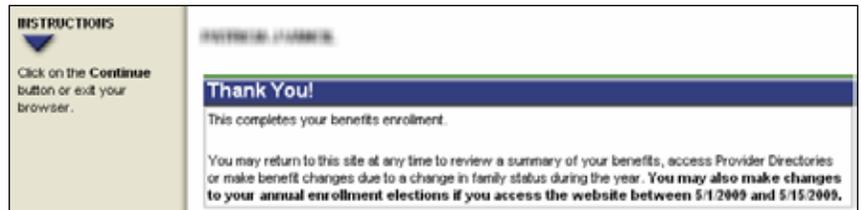
Annual Account Elections		
Benefit	Plan Election	Before-Tax Contribution
Dependent Care Flexible Spending Account	Waive Participation	\$0.00
Health Savings Account	Waived Contribution to Health Savings Account	\$0.00
Unlimited Use Health Care Flexible Spending Account	Waived Unlimited Use Flexible Spending Account	\$0.00

Beneficiary Designations			
Basic Life Insurance			
Name	Relationship	Percent	Designation
Jennifer J Marino	Spouse	90%	Primary
Stephanie Diana Walczynski	Beneficiary	5%	Primary
Carlo Esteban Marino	Beneficiary	5%	Primary
Basic Accidental Death & Dismemberment			
Name	Relationship	Percent	Designation
Jennifer J Marino	Spouse	90%	Primary
Stephanie Diana Walczynski	Beneficiary	5%	Primary
Carlo Esteban Marino	Beneficiary	5%	Primary
Additional Life Insurance			
Name	Relationship	Percent	Designation
Jennifer J Marino	Spouse	100%	Primary
Stephanie Diana Walczynski	Beneficiary	50%	Contingent
Carlo Esteban Marino	Beneficiary	50%	Contingent
Additional Accidental Death & Dismemberment			
Name	Relationship	Percent	Designation
Jennifer J Marino	Spouse	100%	Primary
Stephanie Diana Walczynski	Beneficiary	100%	Contingent

- The Confirmation page displays with your elections. Print a copy of this page for your records. A Confirmation Statement will be mailed to your home address the week of May 18th. Compare the Confirmation page with the Confirmation Statement. If they do not match, log back into the Benefit Enrollment System and make the appropriate changes. If you made any changes, a new Confirmation Statement will be mailed to you the week of June 1st.

- Click the "Continue" button.

- The last screen you should see is the "Thank You!" page as shown below.



For a more detailed instruction set, go to:
<http://ebc.maricopa.gov/ehi/pdf/2009/OE09/OEeventstoryboard.pdf>



For benefit-related questions please call: (602) 506-1010

For system-related issues call your PC Help Desk or (602) 506-HELP



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.

<i>Initiative</i>	<i>Description</i>	<i>Who is Eligible?</i>	<i>How to Access Services/Incentives</i>	<i>Cost/Incentive</i>
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	<p>Call 800-244-6224 and listen for the prompt for the 24-hour Health Information Line or call 800-564-8982 for nurse assistance.</p> <p>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 the "Health Information Line" link for more information about calling for live support or options to listen to a podcast.</p>	No Cost
Adult Immunizations	<p>Shots for:</p> <p>Flu (including Flu Mist)</p> <p>Pneumonia</p> <p>Tdap (Tetanus, Diphtheria & Pertussis)</p>	Employees and their dependents enrolled in a County-sponsored CIGNA medical plan; must meet CDC guidelines for age, frequency and risk factors.	<p>No appointment required for employee only on-site flu shot clinics; service is provided on a first come first served basis.</p> <p>Employees and dependents may access flu shots at CIGNA flu shot clinics; Employees and dependents may receive flu shots at local Walgreens pharmacies.</p> <p>Appointment required for Tdap shots through the Wellness Coordinator, 602-506-3758 or granthaml@mail.maricopa.gov</p>	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

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

<i>Initiative</i>	<i>Description</i>	<i>Who is Eligible?</i>	<i>How to Access Services/Incentives</i>	<i>Cost/Incentive</i>
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; You can save \$5 per pay period up to a total of \$120 annually. If you are newly eligible to receive the incentive as of your medical benefit effective date, you must complete your screening within 30 calendar days of your medical benefit effective date. Screenings must be completed each year before the end date of Open Enrollment in order to continue receiving the incentive.
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
Brush Biopsy	Early detection of oral cancer through a brush biopsy.	Employees and/or dependents enrolled in CIGNA Dental	Information available at http://ebc.maricopa.gov/ehi/pdf/2008/CIGNA_Dental/cignadental_biopsy.pdf	In-network: 20% co-insurance after deductible is met. Out-of-network: 40% co-insurance after deductible is met.
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>

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

<i>Initiative</i>	<i>Description</i>	<i>Who is Eligible?</i>	<i>How to Access Services/Incentives</i>	<i>Cost/Incentive</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 Look for class LIF114	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
Dental Cleanings	A third dental cleaning is available to employees and/or dependents who are pregnant or have diabetes.	Employees and/or dependents who are enrolled in Delta Dental.	Information available at http://ebc.maricopa.gov/ehi/pdf/2008/Delta_Dental/third_cleaning.pdf	No Cost
Dental Oral Health Integration Program - Dental Oral Health Maternity Program SM	Since women with periodontal gum disease may be at increased risk for pre-term babies and that treatment for gum disease may reduce the likelihood of premature birth of women at risk, this program enhances dental benefits for expectant mothers. Eligible members may receive 100% reimbursement of copay or co-insurance for select covered services performed during pregnancy such as oral evaluation, periodontal scaling and root planing, periodontal maintenance, treatment of inflamed gums around wisdom teeth, and the frequency limitations for cleanings is waived to include an additional cleaning.	Employees and/or dependents who are enrolled in CIGNA Dental and a CIGNA Medical plan.	Information available at http://ebc.maricopa.gov/ehi/pdf/2008/CIGNA_Dental/cignadental_oralhealth_mp.pdf	No Cost
Dental Oral Health Integration Program - Oral Health Diabetes and Cardiovascular Programs	Research has linked periodontal (gum) disease to complications for heart disease, stroke and diabetes. This program provides employees and/or dependents with 100% reimbursement of their out-of-pocket payment to the dentist for: periodontal root scaling & planing and periodontal maintenance. Periodontal maintenance is increased to four times per year under the program.	Employees and/or dependents who are enrolled in CIGNA Dental and a CIGNA Medical plan and who participate in the CIGNA WellAware Program for diabetes or heart disease.	Information available at http://ebc.maricopa.gov/ehi/pdf/2008/CIGNA_Dental/cignadental_oralhealth_ip.pdf	No Cost

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

<i>Initiative</i>	<i>Description</i>	<i>Who is Eligible?</i>	<i>How to Access Services/Incentives</i>	<i>Cost/Incentive</i>
Diabetes Management Program	Meet 9 conditions to participate; <i>Click here to review the brochure.</i>	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 <i>granthaml@mail.maricopa.gov</i>	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
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 <i>granthaml@mail.maricopa.gov</i>	No Cost
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

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

<i>Initiative</i>	<i>Description</i>	<i>Who is Eligible?</i>	<i>How to Access Services/Incentives</i>	<i>Cost/Incentive</i>
Health First	Ultrasound screenings for osteoporosis (bone density), carotid artery, abdominal aortic aneurysm (AAA), peripheral arterial disease, and ankle-brachial index (ABI)	All employees	By appointment through Health First by calling 800-209-4848	Screening Fees: Cartoid \$45 AAA (Abdominal Aortic Aneurysm) \$45 ABI (Ankle-Brachial Index) \$45 Bone Density \$25 All tests package price of \$125 Three Vascular tests without the Bone Density for \$115. Tests can also be purchased separately.
Health Coaching	Voluntary coaching program for employees with certain risks identified through the Biometric Screening Program and/or Health 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 Assessment who have certain risk factors	Health Coach will contact you directly by phone	No Cost
Health 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 assessment tool are available on EHI Home page	No Cost; You can save \$5 per pay period up to a total of \$120 annually. If you are newly eligible to receive the incentive as of your medical benefit effective date, you must complete your assessment within 30 calendar days of your medical benefit effective date. Assessments may be completed each year before the end of Open Enrollment to continue receiving the incentive.

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

<i>Initiative</i>	<i>Description</i>	<i>Who is Eligible?</i>	<i>How to Access Services/Incentives</i>	<i>Cost/Incentive</i>
Healthful 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.	Diabetic employees and/or dependents who are enrolled in a County-sponsored WHI prescription plan	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
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
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 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

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

<i>Initiative</i>	<i>Description</i>	<i>Who is Eligible?</i>	<i>How to Access Services/Incentives</i>	<i>Cost/Incentive</i>
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 consecutive months, you should review your coverage level options in the Benefit Enrollment System under the Additional Life page. The coverage level options listed below identify if you are eligible to receive the incentive for additional life insurance. <ul style="list-style-type: none"> ◦ Non-Tobacco User ◦ Tobacco User 	Rate reduction for non-smokers when additional life insurance is purchased. Refer to life insurance rates in life insurance section.
Non-Tobacco User Incentive	Non-tobacco using employees and 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	Review the Non-Tobacco User Incentive options in the Benefit Enrollment System since they have changed for the new plan year. The options are listed below: <ul style="list-style-type: none"> ◦ I am a user of Tobacco products ◦ I am not a Tobacco products user but a covered dependent is ◦ No one (employee & covered dependents(s)) uses Tobacco products Please note that the incentive is available only when the employee and all covered dependents do not use tobacco products. Employees who do not provide accurate information and receive the incentive to which they are not eligible for will be subject to disciplinary action up to and including termination.	Save up to \$480 per year (\$20 per pay period) on your County-sponsored 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

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

<i>Initiative</i>	<i>Description</i>	<i>Who is Eligible?</i>	<i>How to Access Services/Incentives</i>	<i>Cost/Incentive</i>
Work Life Balance	Classes offered through various mediums by Magellan Health Services.	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
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 funding for the program.

NOTIFICATIONS

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.

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 S. 4th Avenue, Suite B100, 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. 4th Avenue, Suite B100, 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. 4th Avenue, Suite B100, 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. 4th Avenue, Suite B100, 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 S. 4th Avenue, Suite B100, 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 S. 4th Avenue, Suite B100, 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	ADP	Flexible Spending Accounts
Delta Dental	Dental	ADP	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:

ADP, Inc.
Telephone number 1-800-770-7981
<https://www.benefitdirect.adp.com>

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 calendar 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 and Premiums

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 31 calendar days for the regularly scheduled monthly premiums.

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.

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 impose 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 calendar days prior to your effective date of coverage. The pre-existing condition exclusion does not apply to pregnancy or to a child who is enrolled in the plan within 30 calendar 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 Department 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 plan 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.



WHO TO CONTACT



Maricopa County Employee Health Initiatives Department (Benefits Office)

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

EHI Home { www.maricopa.gov/benefits
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
HSA Banking Unit Customer Service Line - (866) 524-2483
Well Aware Disease Management - (800) 249-6512 to enroll
or (877) 888-3091 for questions
Healthy Pregnancies, Healthy Babies - (800) 615-2906
Healthy Rewards - (800) 870-3470
www.cigna.com
www.mycigna.com
www.mycignaplans.com
(username: Maricopa2009 / password:cigna)

Pharmacy Plans*

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

Behavioral Health / EAP*

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

Vision

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

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

Automatic Data Processing, Inc. (ADP)
Flexible Spending Accounts
(800) 654-6695
Fax: (866) 392-4090
www.flexdirect.adp.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.info.legalplans.com (password - 1500518)

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

Biometric Screening Administrator
CIGNA Onsite
(800) 694-4982
<https://www.cignascreenings.com/maricopa>



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