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Enrollment at a Glance

It is very important that you review this booklet so you can fully understand how the Saguaro Benefits Program works.

This year, since we are changing our medical plan options, every employee who wants medical plan coverage for plan year 2001/2002 must enroll during the open enrollment period.

Important enrollment activities:

- This year you may enroll for benefits two new ways, the online or interactive voice response (IVR) telephone systems.
- When electing HMO or POS medical plan coverage, you will need to record a Primary Care Physician (PCP) for yourself and each covered dependent.
- When electing EDS or PDC dental plan coverage, you will need to record a Primary Care Dentist (PDP) for yourself and each covered dependent.
- You will need to enter your Social Security number in the enrollment system.
- You will need to enter the Social Security number for each person you are covering in the medical, dental or vision plans.

Use the following list to help you quickly find the information you need to successfully enroll.

ADOA Human Resources Web Site www.hr.state.az.us/benefits

Costs for Coverage page 6

Open Enrollment Meeting Schedule pages 9-10

CIGNA Physician Directory Information

www.cigna.com

(through 9/30/01) 1-800-613-4563

(after 9/30/01) HMO/POS: 1-800-244-6224

(after 9/30/01) PPO: 1-800-280-7651

Enrollment Worksheet page 30

Online Enrollment Web Site www.az.gov

Telephone Enrollment System (IVR) **1-866-740-7153**

Personal Identification Number

(PIN) Replacement

1-866-251-5672

or www.az.gov

Arizona Benefits Help Desk

1-866-251-5672

(24 hours a day/7 days a week)

Open Enrollment Dates:

August 13 through September 7, 2001

Open Enrollment 2001

Open enrollment is your opportunity to make changes to your coverage(s) that are appropriate for both you and your family. As a State of Arizona benefits-eligible employee, you may take the following actions during this year's open enrollment period:

- Make elections for the medical, vision and flexible spending accounts (FSA) plans. **You must enroll/re-enroll in the medical, vision and FSA plans to have coverages during the upcoming plan year.**
- Make elections for dental and life insurance coverages.
- Add/drop short-term disability (STD) insurance coverage.
- Add/drop dependents from your medical, dental, vision and life insurance coverage(s).
- Increase/decrease life insurance.

Note: All of our benefit plans are independent of each other. For example, you can elect medical coverage without electing dental coverage.

The open enrollment period begins on August 13 and continues through September 7. Changes that you make during open enrollment will go into effect on the first day of the new plan year - October 1, 2001. While STD and life insurance coverages are effective October 1, if you are being covered by either of these plans for the first time and are absent from work due to illness or injury on that date, the coverage doesn't begin until you return to your job.

What's New This Plan Year

Medical Plan Options

For our upcoming plan year, based on where you live, you will have up to three medical plan options: a Health Maintenance Organization (HMO), a Point of Service (POS) plan or Preferred Provider Organization (PPO) plan. See page 12 to learn the differences between these three types of plans.

These CIGNA plans have been selected because:

- The State has an established, successful working relationship with CIGNA. They have a proven track record with us and other large employers for providing quality health care, claims administration and customer service.
- By consolidating all of our medical plan coverages, we are able to purchase more with our health care dollars. With all of our employees covered by this one carrier, we are able to negotiate better rates for the benefits they provide. Having one primary carrier allows us to better control our health care costs and yours!
- By consolidating all of our medical coverages, we can administer our health care plans more consistently and efficiently.
- CIGNA has one of the largest networks of high-quality physicians and hospitals across the country, so in-network coverage may be available even out of state.

When electing HMO or POS medical coverage, you must choose a PCP actively participating in the CIGNA plan you are selecting. You are encouraged to visit CIGNA's web site (www.cigna.com) or to call

their toll-free number (1-800-613-4563) to determine whether your doctor is a member of their network.

As we are changing our medical plan options, it is necessary for **every** employee to make a medical plan election for the upcoming plan year. If you don't enroll for medical coverage by September 7, 2001, **you will have no medical coverage** for the 2001/2002 plan year unless you elect it after you have a qualified status change.

The Super Saver Medical Savings Account Plan is being discontinued effective October 1, 2001. If you participate in this plan or have participated and have an account balance, additional information will be mailed to you.

Depending on the plan option you select when you enroll for health benefits, you may find that your current provider does not participate in your new plan's network. If you are actively undergoing treatment from a non-participating provider at the time of enrollment, you may be eligible for "Transition of Care" service. See page 12 for more information.

Getting the most from your pharmacy benefit:

1. Ask your practitioner to prescribe:
 - 1st choice: a generic drug
 - 2nd choice: a brand name drug from the Preferred Brand list
2. Fill your prescriptions at a CIGNA network or contracted pharmacy or through the Tel-Drug program. Visit CIGNA's web site at www.cigna.com or call 1-800-613-4563 to find the network pharmacy nearest you.
3. Pay your portion of prescription charges using pre-tax dollars reimbursed from your Health Care Spending Account. Be sure to adjust your Health Care Spending Account election to cover any out-of-pocket prescription costs you expect to have during the 2001/2002 plan year. For more information on using the Health Care Spending Account, see page 22.

Prescription Drug Program

Whichever medical plan you elect, you will automatically participate in a three-tier prescription drug plan. You will always pay the lesser of the copay or actual cost for a prescription.

Tier	Prescription Type	Your Copay (for up to 30-day supply)
1	Generic	\$10
2	Preferred Brand	\$20
3	Non-Preferred Brand	\$40

Mail order prescriptions are also covered under CIGNA's online/mail/phone order program, Tel-Drug (www.teldrug.com). Prescriptions in this program are delivered to your home sealed in tamper-evident, discreetly labeled packaging. You can e-mail, phone or mail in most orders and refills and save the amount of one copay for a 90-day prescription.

Tier	Prescription Type	Mail Order Copay (for up to 90-day supply)
1	Generic	\$20
2	Preferred Brand	\$40
3	Non-Preferred Brand	\$80

About the Prescription Drug Tiers:

CIGNA maintains a formulary, an extensive list of safe and effective generic and preferred brand-name prescription drugs. CIGNA HealthCare's Pharmacy and Therapeutics Committee develops the list and updates it on a regular basis. Only those medications that have successfully passed federally required clinical testing and evaluation and have been proven effective are included in the list.

The three tiers covered under the prescription drug plan are:

Generic - These are generic drugs on CIGNA's formulary. A generic drug usually has a brand name equivalent. Generic drugs must meet the same FDA standards as brand-name drugs and are tested and certified by the FDA to be as effective as their brand name counterparts.

Preferred Brand - These are brand-name drugs on CIGNA's formulary.

Non-Preferred Brand - These are brand-name drugs that are not on CIGNA's formulary. Typically, they are not on the formulary because they have equally effective and less costly generic equivalents or one or more preferred-brand options.

Vision Plan Carrier

The State has chosen a new vision provider. The new vision plan features higher benefit levels and lower costs. The new vision plan carrier is Avesis, Inc. Plan features under the new provider are described on page 19.

Improved Enrollment Process

We are excited to offer two new and much easier ways to enroll in Saguaro Benefits for the 2001/2002 plan year—you can use the Web or our new phone enrollment system. Either one of these options allows you to make all of your benefit choices in one connection, including your Flexible Spending Accounts election.

If you are unable to enroll using the Web or the phone system, you will need to fill out a Benefits Election (BE-1) form. In addition, you will need to complete a Flexible Spending Account (BE-5) form to continue or start participating in the Flexible Spending Accounts. The BE-1 and Flexible Spending Account forms can be obtained by contacting your benefits liaison or you can pick up a form at an open enrollment meeting (schedule of meetings on pages 9-10).

You are strongly encouraged to use the Web or telephone to make your elections. Complete instructions on how to enroll in Saguaro Benefits begin on page 26.

Enroll on Time!

If you fail to enroll by the annual enrollment deadline, September 7, 2001, you will receive no medical or vision plan coverage for the 2001/2002 plan year. You will continue all of your other active elections, with the exception of the Health Care Spending Account and Dependent Care Spending Account which will default to "No Participation." Be sure to review your paycheck to see how your payroll deduction is affected by your enrollment.

If using the Web or phone enrollment systems, you'll have until midnight on September 7, 2001, to enroll. If using paper enrollment, your forms must reach your benefits liaison no later than September 7, 2001.

Costs for Coverage

Use these charts to determine what your 2001/2002 benefit costs will be.

MONTHLY PREMIUMS — MEDICAL PLANS

	SINGLE			FAMILY		
	Employee	State	Total	Employee	State	Total
Maricopa County and the town of Apache Junction						
HMO	\$25.00	\$209.76	\$234.76	\$125.00	\$461.88	\$586.88
POS	\$100.62	\$209.76	\$310.38	\$314.04	\$461.88	\$775.92
PPO	\$135.36	\$244.76	\$380.12	\$403.44	\$546.88	\$950.32
Pima County						
HMO	\$25.00	\$193.82	\$218.82	\$125.00	\$422.04	\$547.04
POS	\$76.82	\$193.82	\$270.64	\$254.56	\$422.04	\$676.60
PPO	\$144.18	\$228.82	\$373.00	\$425.44	\$507.04	\$932.48
Remaining Counties (excluding town of Apache Junction)						
PPO	\$25.00	\$320.12	\$345.12	\$125.00	\$737.82	\$862.82
Out of State						
PPO	\$25.00	\$410.30	\$435.30	\$125.00	\$963.24	\$1,088.24

Your available medical plan options and their costs will be based on the address of your primary residence. Seasonal or secondary addresses cannot be used.

MONTHLY PREMIUMS—DENTAL PLANS

	SINGLE			FAMILY		
	Employee	State	Total	Employee	State	Total
Delta Dental	\$8.22	\$15.24	\$23.46	\$34.44	\$41.48	\$75.92
MetLife Dental	\$6.02	\$15.92	\$21.94	\$25.94	\$44.62	\$70.56
Employers Dental Services (EDS)	\$2.76	\$5.82	\$8.58	\$15.12	\$9.78	\$24.90
Protective DentalCare	\$2.50	\$6.00	\$8.50	\$14.00	\$10.28	\$24.28

MONTHLY PREMIUMS—VISION PLAN

Avesis, Inc.	SINGLE	FAMILY
	Employee	Employee
Coverage	\$6.48	\$17.54

MONTHLY PREMIUMS—SUPPLEMENTAL EMPLOYEE LIFE/AD&D INSURANCE PLAN

Your Age	Employee Per \$5,000 of Coverage
Under 30	\$0.50
30 – 39	\$0.70
40 – 49	\$1.80
50 – 59	\$3.80
60 – 69	\$6.70
70+	\$10.60

MONTHLY PREMIUMS—DEPENDENT LIFE INSURANCE PLAN

Coverage Amount	Employee
\$2,000*	\$0.92
\$4,000	\$1.84
\$6,000	\$2.76
\$12,000	\$5.52

*This coverage is only available to employees currently covered at this level.

MONTHLY PREMIUMS—SHORT-TERM DISABILITY PLAN

Employee
\$.89 per \$100 of your monthly base salary, to a maximum of \$5,000
Example: Monthly salary = \$2,500 Monthly premium = \$22.25

Eligibility

All state employees regularly scheduled to work 20 hours or more each week, except those listed below, and their eligible dependents may participate in the Saguario Benefits Program, provided they comply with the contractual requirements of their selected health care plan.

These employees are not eligible for Saguario Benefits:

- employees who work less than 20 hours/week (or 40 hours bi-weekly);
- employees in seasonal, temporary, emergency or clerical pool positions;
- patients or inmates employed in State Agency institutions;
- non-state employee officers and enlisted personnel of the National Guard of Arizona; and
- employees in positions established for rehabilitation purposes.

Your eligible dependents are:

- your legal spouse.
- your unmarried children who are under age 19 or under age 25 if considered by an educational institution (trade school, community college, or university) to be a full-time student. Children can be natural/birth, adopted, placed by court order or placed in the home pending adoption, foster children or step-children. Step-children must reside in the household of the employee.

(If your dependent child is attaining the maximum age and is disabled, immediately contact your benefits liaison regarding procedures to continue coverage for that dependent in accordance with A.R.S. Section 20-1407.)

Pre-Tax Benefits

Since some of your monthly insurance premiums and contributions to your flexible spending account(s) are made on a pre-tax basis, your taxable income is reduced. This means you will be paying less state, federal and social security (FICA) taxes.

The Internal Revenue Service (IRS) restricts the enrollment status changes that you can make during the plan year when your monthly insurance premiums and contributions to flexible spending account(s) are paid on a pre-tax basis. IRS rules allow enrollment changes:

- During annual open enrollment.
- In the event you have a qualified status change. If you have a qualified status change, you have 31 days to change your affected benefit elections.

The employee benefits that are eligible for pre-tax premium payments or contributions under the Saguario Benefits Program are:

- Medical plan
- Dental plan
- Vision plan
- Flexible Spending Accounts
 - Health Care Spending Account
 - Dependent Care Spending Account
- Life insurance plan (up to \$35,000)

After-tax plans do not have the same IRS restrictions during the plan year. You can reduce or cancel after-tax plans during the plan year without an enrollment event. Examples of after-tax plans are:

- Short-term disability insurance plan
- Life insurance plan (over \$35,000)
- Dependent life insurance plan

If you are thinking of reducing or canceling any coverage, be sure to consider any carrier restrictions that may apply. For example, annual increases to Supplemental Life Insurance are limited.

Social Security

Any reduction in your taxable pay for Social Security purposes could lead to a reduction in your future Social Security benefits. For most employees, the reduction in Social Security benefits will be insignificant when compared to the value of paying lower taxes today. However, if this is of concern to you, please consult a tax advisor.

Qualified Status Changes

A qualified status change permits employees to make certain mid-year changes to their benefits that are consistent with the qualifying event. If you have a qualified status change and want to make a change in benefits, you must notify your benefits liaison, in writing, within 31 days of the event to request the change. Following is a list of some, but not all, eligible qualified status changes:

- Change in employee's marital status - marriage, divorce, legal separation, annulment, death of spouse
- Change in dependent status - birth, adoption, placement for adoption, death, or dependent eligibility due to age, marriage, student status
- Change in employment status - employee, spouse, dependent
- Change in work schedule - increase/decrease in hours worked by employee, spouse, dependent
- Change in residence or place of work causing change in health plan availability - employee, spouse, dependent
- Significant change in spouse's group benefit cost or coverage

Open Enrollment Meetings

Open enrollment meetings are located throughout the State of Arizona to assist you in making informed decisions concerning your health benefits. This year we have scheduled presentation meetings, question and answer (Q&A) sessions and benefit festivals. Summaries of the features of our new medical plans will be available at all of these open enrollment events.

Presentation meetings are an opportunity for employees to hear the insurance representatives make formal presentations about their plans. The presentation meetings will begin at the time designated on the schedule that follows and are approximately two hours in length.

Q&A sessions are in a different format. These sessions are designed for you to discuss the plans with carrier and ADOA representatives, and obtain literature such as provider directories. All Q&A sessions have starting and ending times designated on the schedule. You may arrive when it is convenient for you during this time period. If you have specific questions on the open enrollment materials that you received, please bring the materials with you to the session.

During this year's benefit festivals, you can talk to the carriers one-on-one, enroll for benefits online using the new Saguaro Program Online Enrollment System and attend briefings. Note: You must have your Personal Identification Number (PIN) to enroll online. The Festivals begin at 9:00 and end at 2:00. Throughout the day, at regular intervals, the medical and vision plan carriers will hold briefings (please see the schedule that follows for starting times). The carriers will have information such as plan literature and provider directories available for you at the festivals. ADOA benefits representatives will also be available to answer any questions that you may have.

Due to security regulations, some meetings are restricted to employees of that particular agency only. An example would be Corrections personnel employed at a prison.

Open Enrollment Meeting Schedule

City	Address	Date	Presentation (P), Q&A, Briefing (B) or Festival (F)	Time
Belmont	◇ Navajo Depot, Arizona Army National Guard, Training Building #3	August 13	P	2:00p
Bisbee	DES, Conference Room, 209 Bisbee Rd.	August 28	Q&A	1:30p - 3:00p
Bullhead City	DES, FAA Conference Room, 829 Hancock Rd.	August 31	P	1:30p
Chinle	↔ DES, FAA, N. Hwy 191 Building 7395A, Intersection U.S. 191, Indian Route (I.R. 7)	August 29	P	2:30p DST *
Coolidge	Arizona Training Center, 2800 N. Highway 87, Gym	August 17	P	9:00a
DJC Catalina	◇ DJC, Catalina, Chapel, 14500 N. Oracle Rd.	August 16	P	1:00p
Douglas	DES, Conference Room, 615 2nd Street	August 28	Q&A	8:00a - 9:30a
Douglas Prison	◇ Douglas Prison, Admin. Conference Room, Route 191	August 28	Q&A	10:00a - 11:30a
Flagstaff	City Hall, Council Chambers, 211 W. Aspen	August 13	P	9:30a
Flagstaff	↔ City Hall, Council Chambers, 211 W. Aspen	August 22	P	9:00a
Florence Prison	◇ ASPC, East Butte Ave., South Unit Visitation Room	August 17	Q&A	1:00p - 2:30p
Fort Grant	◇ Fort Grant Prison, Highway 266, Warden's Conference Room, Admin Bldg.	August 23	Q&A	1:30p - 3:00p
Fredonia	Fire Department, 20 W. Brown	August 20	Q&A	1:00p - 2:30p
Globe	DES, 605 S. 7th St., Large Conference Room	August 23	Q&A	8:30a - 10:00a
Holbrook	ADOT, 2407 E. Navajo Blvd., Training Facility	August 28	P	1:30p
Kayenta	↔ DES, Conference Room, Highway 163	August 21	Q&A	2:00p DST *
Kingman	Police Department, Conference Room, 2730 E. Andy Divine Ave.	August 30	P	10:00a
Kingman	Police Department, Conference Room, 2730 E. Andy Divine Ave.	August 30	P	1:30p
Lake Havasu	Police Department, 2630 N. McCulloch Blvd.	August 31	P	9:00a
Mesa	Sheraton, 200 N. Centennial Way	August 22	P	8:00a
Nogales	City Hall, Council Chambers, 1018 Grand Avenue	August 29	P	8:30a
Page	↔ City Hall, Council Chambers, 697 Vista Ave.	August 21	P	8:30a
Payson	Town Hall, Council Chambers, 303 N. BeeLine Hwy.	August 28	Q&A	9:00a - 10:30a
Phoenix	1700 W. Washington, Lobby	August 13	F	9:00a - 2:00p
Phoenix	1700 W. Washington, Grand Canyon Room	August 13	B	7:30a - 3:30p
Phoenix	1700 W. Washington, Lobby	August 14	F	9:00a - 2:00p
Phoenix	1700 W. Washington, Grand Canyon Room	August 14	B	7:30a - 3:30p
Phoenix	◇ Courts, 1501 W. Washington, Training Room	August 15	P	9:00a
Phoenix	Attorney Generals Office, 15 S. 15th Ave., Basement Capital Center, Rooms A&B	August 15	P	1:00p
Phoenix	Environmental Quality, 3033 N. Central, Room 1709	August 16	P	1:30p
Phoenix	Industrial Commission, 800 W. Washington, Auditorium	August 16	P	8:30a
Phoenix	Arizona Ind. for the Blind, 3013 W. Lincoln, Lunch Room	August 17	P	1:30p
Phoenix	Military Affairs, 5636 E. McDowell, Auditorium	August 17	P	8:00a
Phoenix	ADOT, Auditorium, 206 South 17th Ave.	August 20	P	9:00a
Phoenix	ASRS, Boardroom, 3300 N. Central, 10th Floor	August 21	P	8:30a
Phoenix	Water Resources, 500 N. 3rd Street, Conference Rooms A&B	August 23	P	8:30a

Open Enrollment Meeting Schedule

City	Address	Date	Presentation (P), Q&A, Briefing (B) or Festival (F)	Time
Phoenix	◇ DJC/Adobe Mountain, 2800 W. Pinnacle Peak Rd., Visitation Room	August 24	Q&A	8:00a - 9:30a
Phoenix	◇ DJC/Black Canyon, 24601 N. 29th Ave., Training Room	August 24	Q&A	10:00a - 11:30a
Phoenix	◇ DPS, 2102 W. Encanto, East Classroom	August 24	P	1:30p
Phoenix	AHCCCS, 701 E. Jefferson, Gold Room	August 28	P	8:30a
Phoenix	Industrial Commission, 800 W. Washington, Auditorium	August 28	P	1:30p
Phoenix	Crowne Plaza, 2532 W. Peoria	August 29	P	8:00a
Phoenix	ADOT, Auditorium, 206 S. 17th Ave.	August 30	P	1:00p
Phoenix	Arizona State Hospital, 2500 E. Van Buren, Training Education Building Rm. 4&5	August 30	P	7:00a
Phoenix	◇ ASPC, Buckeye, 26701 S. State, Route 85, Large Visitation Room	August 31	Q&A	10:00a - 11:30a
Phoenix	◇ ASPC, Lewis, 26700 S. State, Route 85, Training Room	August 31	Q&A	8:00a - 9:30a
Phoenix	◇ ASPC, Perryville, 2014 North Citrus Rd., Training Room	August 31	Q&A	1:45p - 3:15p
Phoenix	ADOA Training, 1616 W. Adams, Auditorium (Basement)	September 4	P	8:30a
Phoenix	State Capital, Governors Reception Room, 1700 W. Washington, 2nd Floor	September 6	P	7:30a
Prescott	Yavapai College, Prescott, 1100 E. Sheldon Street Bld. #3, Room #131	August 14	P	9:30a
Prescott	Yavapai College, Prescott, 1100 E. Sheldon Street Bld. #3, Room #131	August 14	P	1:30p
Safford Library	Phelps Dodge Room, 808 7th Ave.	August 24	P	9:00a
Safford Prison	◇ Safford Prison, Graham Visitation Rm., 8000 Cook Rd.	August 24	Q&A	1:00p - 2:00p
Show Low	Council Chambers, 200 W. Cooley	August 29	P	8:30a
Sierra Vista	Police Department, Conf. Rm., 911 N. Coronado Drive	August 27	Q&A	1:30p - 3:00p
Tucson	400 W. Congress	August 15	F	9:00a - 2:00p
Tucson	400 W. Congress, Conference Room #444	August 15	B	9:00a - 4:00p
Tucson	Tucson Deaf & Blind Performing Arts Auditorium, 1200 W. Speedway (West of I-10)	August 27	P	9:00a
Tucson Prison	◇ Tucson Prison, Building #47, 10000 S. Wilmont Rd.	August 16	P	8:30a
Winslow	↔ Adobe Inn, Banquet Room, 1701 N. Park Dr.	August 30	Q&A	8:30a - 10:00a
Winslow Prison	◇ Coronado Visitation Room, 2100 S. Highway 87	August 30	Q&A	10:30a - 12:00p
Yuma	Convention Center, 1440 Desert Hills Dr., East Wing Conference Room	September 5	P	10:30a
Yuma	Convention Center, 1440 Desert Hills Dr., East Wing Conference Room	September 5	P	1:30p
Yuma Prison	◇ Yuma Prison, 23115 S. Avenue "B", Cheyenne Visitation Unit	September 6	P	8:30a

Key:

- Q&A Question and Answer Session
- ◇ Restricted Access
- ↔ Navajo Translation Services by ADOA
- * Chinle and Kayenta are on Day Light Savings Time

Persons with a disability may request a reasonable accommodation by calling (602) 542-5008 or by sending an e-mail to benefits@ad.state.az.us. Please make your request as early as possible prior to the meeting, so the accommodation can be made.

Saguaro Program Medical Plans

In the plan year 2001/2002, benefits-eligible state employees, depending on where they live, may choose from up to three medical plan options: a Health Maintenance Organization (HMO), a Point of Service (POS) plan or Preferred Provider Organization (PPO) plan.

- **Employees residing in Pima and Maricopa counties and in the town of Apache Junction** can elect coverage under the HMO, POS or PPO options. In an HMO, you are covered for in-network care only, except in case of emergency. Under the POS plan, you have an in-network benefit that works like an HMO, with an out-of-network benefit like a PPO. In a PPO, you don't have to select a primary care physician; you can use any provider, but the plan will pay more if you use in-network physicians, hospitals or facilities.
- **Employees residing in remaining Arizona counties (excluding the town of Apache Junction) or outside the State** can elect coverage under the PPO option. In a PPO, you don't have to select a primary care physician; you can use any provider, but the plan will pay more if you use in-network physicians, hospitals or facilities.
- Current Arizona State law allows employees to enroll in an HMO (with certain restrictions) even if they do not live in the HMO's service area. If you live outside of the HMO service area and you want to enroll in an HMO, please contact your benefits liaison.

Medical plan comparison charts contain a partial listing of the benefits. A more detailed summary of the plans' features will be available at this year's open enrollment meetings and benefits festivals. All benefits are subject to plan limitations and exclusions. The comparison chart begins on page 14. Definitions for many of the terms in the chart can be found in the Glossary in this booklet.

After you enroll for coverage, please review the materials mailed to you by the medical plan carrier so you are familiar with and understand the terms and conditions of the new plan before you begin to use services. Specific questions concerning a plan can be directed to the CIGNA Member Services department. Their phone number is listed inside the back cover of this booklet.

Three Medical Choices

Where they are available, the Saguaro Program offers these types of medical plan options:

Health Maintenance Organization (HMO)—You receive all your care from HMO providers only, except in emergencies. You select a Primary Care Physician (PCP) to manage your health care in the network. You can select a different PCP for you and each covered family member. (PCP identification number(s) will be required when enrolling for this coverage.)

Point of Service (POS)—Every time you need care, you choose from two ways to access it: in-network (from the plan's network providers) or out-of-network (from the providers of your choice). Your costs are typically less when you receive in-network services and some services are covered in-network only. When enrolling in a POS plan, you must name a Primary Care Physician (PCP) who will coordinate all of your in-network care. You can select a different PCP for you and each covered family member. (PCP identification number(s) will be required when enrolling for this coverage.)

Preferred Provider Organization (PPO)—A PPO plan is a network of hospitals, doctors and service providers that agree to discounted fees. While you can use any provider for care, typically your costs are less when you receive services in-network. If you go to a provider who is not a member of the PPO network, after you first satisfy a deductible, the plan generally pays 70 percent of the usual, customary and reasonable cost for care and you pay the remaining 30 percent, plus any costs not covered by the plan.

If You and Your Spouse are State Employees

If both spouses are State of Arizona employees:

- Both may elect single medical plan coverage.
- One may elect family medical plan coverage while the other opts for no coverage.
- One spouse may elect single medical plan coverage and one spouse may elect family coverage (if they have one or more eligible dependents). Note: the total premium may exceed the statutory monthly employer contribution and result in an additional employee payroll deduction for medical plan coverage.

Transition of Care

Depending on the plan option you select when you enroll for health benefits, you may find that your current provider does not participate in the CIGNA HealthCare network for the medical plan option you selected. If you are actively undergoing treatment from a non-participating provider at the time of enrollment, you may be eligible for “Transition of Care” service.

Situations eligible for transition of care services include:

- Women in their second or third trimester of pregnancy at the time of eligibility.
- Acute conditions in active treatment or chronic conditions being actively treated at the time of plan eligibility.
- Terminal conditions as defined by Hospice.
- Members actively engaged in certain rehabilitation programs.

If you wish to request transition services, you and your provider will need to complete the “CIGNA HealthCare Medical Transition Care Benefit Request Form” Copies of this form will be available at all enrollment meetings or you can request one by calling CIGNA’s Member Services department. You’ll need to submit this form *directly* to CIGNA Health Services department, along with supporting medical information, prior to receiving services from any non-participating provider and within the first 30 days of enrollment as a CIGNA HealthCare member. A separate form is needed for each provider involved in your care.

Contact CIGNA Member Services at the phone number listed inside the back cover of this booklet for more information.

Important Things to Consider When Making Your Medical Coverage Election

- You can waive medical plan coverage. Typically, you will only want to decline coverage through the State if you have coverage from another source.
- To receive benefits under the HMO plan and maximize your benefits under the POS plan, your care must be coordinated through a Primary Care Physician (PCP). Your PCP must provide referral to any specialists. Under the PPO plan, referrals to specialists are not required. Your PPO benefit will be based on whether the specialist is a network member or not.

- The provider networks are different for each of the medical plan options (HMO, POS and PPO). Review the medical plan provider directories to see if your doctors are in the option you are electing. Remember, a doctor may be in more than one network. For example, a doctor can be both an HMO and POS in-network provider.
- You receive no coverage for routine vision care under any of the medical plan options. You may choose coverage for care and materials under the State’s vision plan. (See page 19.)
- You can pay for your out-of-pocket medical expenses for yourself and your eligible dependents with pre-tax dollars when you participate in the Health Care Spending Account.
- Medical, dental and vision are separate plans. In addition, you may choose a different coverage category for each plan. For example, you can choose dental coverage for yourself and your family and medical for yourself only.

CIGNA Plan Names (as of 7/17/01, based on your location)

When you access the CIGNA website or call their member services department, you will want to refer to the following names:

If you enroll in this plan:	The Plan Name is:	Your Network is:	The Retail Pharmacy Plan Name is:	The Mail Order Pharmacy Plan Name is:
HMO	• CIGNA Healthplan (CHP)	• Phoenix CareNetwork HMO • Southern Arizona Network HMO (Tucson)	• Managed Care Pharmacy	• Tel-Drug
POS	• CIGNA Point of Service (POS)	• Central and Northern Arizona Network POS (Phoenix) • Southern Arizona Network POS (Tucson)	• Managed Care Pharmacy	• Tel-Drug
PPO	• Preferred Provider Organization (PPO)	• Preferred Provider Organization (PPO)	• RxPrime	• Tel-Drug

Medical Plans Comparison Chart

Saguaro Program Medical Plans – October 1, 2001

Basic Covered Services	HMO	Point-Of-Service		PPO	
	In-Network (Copayment)	In-Network	Out-of-Network	In-Network	Out-of-Network
Individual Deductible	N/A	N/A	\$300	None	\$300
Family Deductible	N/A	N/A	\$600	None	\$600
Coinsurance Maximum (excluding Deductible)	N/A	N/A	\$3,000/\$6,000	\$1,000/\$2,000	\$3,000/\$6,000
Lifetime Maximum	N/A	N/A	\$2,000,000	N/A	\$2,000,000
Lifetime Maximum for TMJ, orthognathic surgical Treatment or vestibuloplasty	N/A	N/A	<i>Covered in-network only</i>	N/A	N/A
Room & Board (private room when medically necessary)	No charge	No charge	30%	No charge	30%
Intensive Care Unit	No charge	No charge	30%	No charge	30%
Physician Hospital Visits	No charge	No charge	30%	No charge	30%
Surgery/Anesthesia/Asst Surgeon	No charge	No charge	30%	No charge	30%
X-Ray and Laboratory	No charge	No charge	30%	No charge	30%
In-Patient Mental Illness and Substance Abuse	No charge	No charge	<i>Covered in-network only</i>	No charge	30%
Physician Office Visits	\$10 copay per visit. Maximum 1 copay per day per provider.	\$10 copay per visit. Maximum 1 copay per day per provider.	30%	\$10 copay per visit. Maximum 1 copay per day per provider	30%
Specialist Visits	\$10 copay per visit. Maximum 1 copay per day per provider.	\$10 copay per visit. Maximum 1 copay per day per provider.	30%	\$10 copay per visit	30%
Childhood Immunizations-Well child	No charge	No charge	<i>Covered in-network only</i>	\$10 copay per visit	30%
Well-Baby Visit	\$10 copay per visit	\$10 copay per visit	<i>Covered in-network only</i>	\$10 copay per visit	30%
Well-Woman Care (GYN visit & Pap smear test)	\$10 copay per visit	\$10 copay per visit	<i>Covered in-network only</i>	\$10 copay per visit	30%
Periodic Adult Physical Exam	\$10 copay per visit	\$10 copay per visit	<i>Covered in-network only</i>	\$10 copay per visit	30%
Adult Immunizations (e.g. pneumoc., flu)	\$10 copay per visit	\$10 copay per visit	<i>Covered in-network only</i>	\$10 copay per visit	30%
Well Man Care (Office visit and PSA blood test)	\$10 copay per visit	\$10 copay per visit	<i>Covered in-network only</i>	\$10 copay per visit	30%
Allergy Testing	\$10 copay	\$10 copay	<i>Covered in-network only</i>	\$10 copay	30%
Antigen Administration (desensitization/treatment)	\$10 copay	\$10 copay	<i>Covered in-network only</i>	\$10 copay	30%
Family Planning Services:					
Voluntary Tubal Ligation	\$10 copay	\$10 copay	30%	\$10 copay	30%
Vasectomy	\$10 copay	\$10 copay	30%	\$10 copay	30%
Implantable contraceptive products (1 per 5 yrs)	\$10 copay (covered as any other procedure)	\$10 copay (covered as any other procedure)	30%	Covered as any other procedure	30%
Contraceptive appliances during office visit	\$10 copay	\$10 copay	30%	\$10 copay	30%
Infertility visits	\$20 copay	\$20 copay	<i>Covered in-network only</i>	\$20 copay	30%

Out-of-Network benefit levels are subject to reasonable and customary limitations.

Saguaro Program Medical Plans – October 1, 2001

Basic Covered Services	HMO	Point-Of-Service		PPO	
	In-Network (Copayment)	In-Network	Out-of-Network	In-Network	Out-of-Network
Infertility Treatment (excluding in vitro, embryo/zygote transfer, GIFT, donor sperm expenses)	50% coinsurance	50% coinsurance	<i>Covered in-network only</i>	50% coinsurance	50% coinsurance
X-Ray and Laboratory	No charge	No charge	30%	No charge	30%
Prenatal Care and Program	\$10 copay for initial visit for diagnosis of pregnancy	\$10 copay for initial visit for diagnosis of pregnancy	<i>Covered in-network only</i>	\$10 copay for initial diagnosis, 100% thereafter	30%
Mammography Screening: Age 35 – 39 = 1 baseline, 40 – 49 = every 2 yrs, 50 and older = annual)	No charge; (although physicians may use age schedule as a guideline, actual screening is based on patient need)	No charge; (although physicians may use age schedule as a guideline, actual screening is based on patient need)	<i>Covered in-network only</i>	No charge	30%
Surgery Facility and Associated Physician Fees					
In physician's office	\$10 copay	\$10 copay	30%	\$10 copay	30%
In freestanding ambulatory facility	No charge	No charge	30%	No charge	30%
In hospital outpatient surgical center	No charge	No charge	30%	No charge	30%
Outpatient Mental Illness	\$10 copay	\$10 copay	<i>Covered in-network only</i>	\$10 copay	30%
Outpatient Substance Abuse	\$10 copay	\$10 copay	<i>Covered in-network only</i>	\$10 copay	30%
Hospital Emergency Room	\$75 copay, waived if admitted	\$75 copay, waived if admitted	Emergency paid at in-network benefit level	\$75 copay, waived if admitted	\$75 additional deductible
Out of Area Emergencies	\$75 copay, waived if admitted	\$75 copay, waived if admitted	Emergency paid at in-network benefit level	\$75 copay, waived if admitted	Emergency paid at in-network benefit level
Urgent Care Center	\$20 copay	\$20 copay	30%	\$20 copay	30%
Ambulance (for medical emergency or required interfacility transport)	No charge	No charge	Emergency paid at in-network benefit level	No charge	Emergency paid at in-network benefit level
Prescription Drugs					
Retail 30 day supply/copay; The following items are also covered: birth control pills, insulin, insulin syringes, diabetic supplies such as lancets, glucose strips, reagent and a serum glucose monitoring device. Also covered: drugs for attention deficit disorder; obesity reduction under provider guidance.			Rx obtained at network pharmacy is covered at in-network level, even if a non-participating provider issues prescriptions		Rx obtained at network pharmacy is covered at in-network level, even if a non-participating provider issues prescriptions
Generic	\$10 copay	\$10 copay	\$10 copay	\$10 copay	\$10 copay
Preferred Brand	\$20 copay	\$20 copay	\$20 copay	\$20 copay	\$20 copay
Non-Preferred Brand	\$40 copay	\$40 copay	\$40 copay	\$40 copay	\$40 copay

Out-of-Network benefit levels are subject to reasonable and customary limitations.

Saguaro Program Medical Plans – October 1, 2001

Basic Covered Services	HMO	Point-Of-Service		PPO	
	In-Network (Copayment)	In-Network	Out-of-Network	In-Network	Out-of-Network
Prescription Drugs (continued)					
Mail Order (90-day supply)					
Generic	\$20 copay	\$20 copay	\$20 copay	\$20 copay	\$20 copay
Preferred Brand	\$40 copay	\$40 copay	\$40 copay	\$40 copay	\$40 copay
Non-Preferred Brand	\$80 copay	\$80 copay	\$80 copay	\$80 copay	\$80 copay
Organ and Tissue Transplantation & Donor Coverage	No charge	No charge	<i>Covered in-network only</i>	No charge	30%
Hearing Exam (every 12 months)	\$10 copay per exam	\$10 copay per exam	<i>Covered in-network only</i>	\$10 copay per exam	30%
Hearing Aids	100% up to \$2,000 per member per year at CIGNA contracted hearing center.	100% up to \$2,000 per member per year at CIGNA contracted hearing center.	<i>Covered in-network only</i>	100% up to \$2,000 per member per year	100% up to \$2,000 per member per year
Rehabilitation Services, Short-Term Physical Therapy Occupational Therapy Speech Therapy Inpatient Rehab Setting Respiratory Therapy Cardiac Rehab	Rehabilitation limited to 60 visits per contract year with a \$10 copay	Rehabilitation limited to 60 visits per contract year with a \$10 copay.	30% to a maximum of \$5,000 per year; reduced by in-network benefits	Inpatient – no charge; Outpatient – Rehab limited to 60 visits per contract year with a \$10 copay per visit	30% to a maximum of \$5,000 per year
Skilled Nursing Facility	No charge; maximum 90 days per contract year.	No charge; maximum 90 days per contract year.	30% up to 90 days per year; reduced by in-network benefits	No charge, 90 day limit	30%, up to 90 days per year
Home Health/Home Infusion Care	No charge, no limit	No charge, no limit	30%	No charge, no limit	30%
Hospice Care (Inpatient facility or home hospice for Life expectancy of 6 months or less)	No charge, no limit	No charge, no limit	30%	No charge, no limit	30%
Durable Medical Equipment (DME) Includes equipment which can withstand repeated use, serves a medical purpose, not useful in absence of illness/injury, not disposable. Also included, is standard power operated wheelchair when medically necessary.	No charge	No charge	<i>Covered in-network only</i>	No charge	30%
Corrective Appliances (Orthotics and Prosthetics): Orthotics to include items which support a weakened body part and prosthetics to include items which replace a missing body part. Includes initial fitting and purchase of standard model unless patient's Medical needs cannot be met, then upgrade as medically necessary. repair, replacement and servicing payable as medically necessary.	No charge	No charge	<i>Covered in-network only</i>	No charge	30%
Chiropractic Comparison	12 visits per year at \$10 copay	12 visits per year at \$10 copay	<i>Covered in-network only</i>	Rehab limited to 60 visits per contract year with a \$10 copay per visit	30%

Out-of-Network benefit levels are subject to reasonable and customary limitations.

Saguaro Program Dental Plans

Following is a brief description of the dental plans that are available to eligible Saguaro Benefits Program participants. The dental comparison chart that follows on page 18 is not a complete listing and description of the dental benefits. All benefits are subject to plan limitations and exclusions. Employees and their eligible dependents who reside out-of-state may choose from the two Indemnity/PPO dental plans for coverage.

Delta Dental Plan of Arizona Indemnity/PPO Plan:

Those covered by Delta Dental Plan of Arizona may see a licensed dentist anywhere in the world. More than 80% of Arizona's dentists participate in the Delta Dental Plan and agree to accept Delta's allowable fee as payment in full (after any deductible and/or copayments are met). Amounts in excess of the allowable fee will not be billed to the patient. In addition, even if you choose to see a non-participating dentist, Delta still provides benefits, although typically at reduced levels.

MetLife Dental Indemnity/PPO Plan:

Participants are free to choose a participating (PDP) or non-participating (non-PDP) dentist anywhere in the world. After the plan year deductible and copayments are met, PDP dentists accept negotiated fees as payment in full; these fees are typically 15-30% below average charges. Non-covered services provided by a PDP dentist are also charged at the lower rate. Covered expenses from a non-participating dentist are considered at the reasonable and customary allowance (greater than or equal to the 90th percentile of the charges made by dentists in the area for the same procedure).

Employers Dental Services (EDS) Prepaid Plan:

Founded in 1974, EDS provides one of the most extensive Arizona networks and local customer service. EDS's Customer Service Department, located in Tucson, is open Monday - Friday during regular business hours, for your convenience. There are no deductibles, no claim forms and no yearly maximums. EDS also offers a prescription benefit through Arizona Prescription Network (APN). APN offers substantial discounts on prescription drugs purchased through affiliated pharmacies for your entire household.

Protective DentalCare Prepaid Plan (formerly United Dental Care):

Members must access care through their pre-selected family dentist. Each family member may select his/her own family dentist from the Protective DentalCare Directory of Dentists. You may select or change your family dentist by calling Protective's Customer Service at the number listed on the inside of the back cover of this booklet. Members may self-refer for specialty care. All covered services through Protective DentalCare contracted family dentists will be provided at the copayment as listed in the Benefits Schedule for Protective's Pinnacle Plan.

Dental Plans Comparison Chart

Benefit	Delta Dental	MetLife Dental	Employers Dental Services/EDS*	Protective DentalCare* (formerly UDC)
Plan Type	Indemnity/PPO	Indemnity/PPO	Prepaid	Prepaid
Deductibles	\$50/\$150	\$50/\$150	No Deductibles	No Deductibles
Preventive Care	100% paid	100% paid	100% paid, after applicable copay	100% paid, after applicable copay
Office Visit Oral Exam Prophylaxis/cleaning Fluoride treatment X-rays	Deductible waived	Deductible waived	\$3/visit copay No charge No charge No charge for child No charge	\$5/visit copay No charge \$3 copay No charge No charge
Basic Restorative	80% paid	80% paid	Fixed Copays:	Fixed Copays:
Office Visit Sealants (to age 19) Fillings Extractions Periodontal Oral Surgery			\$3 \$12/tooth \$12-\$25 (amalgam) \$15 (single) \$50/quadrant Copay/procedure	\$5 \$5/tooth \$9-\$20 (amalgam) \$15 (single) \$50/quadrant Copay/procedure
Major Restorative	50% paid	50% paid	Fixed Copays:	Fixed Copays:
Office Visit Crowns Dentures Fixed Bridgework Crown/Bridge Repair Inlays	(Allowance Given)	(Covered Expense)	\$3 \$170-\$275 copay copay lab fees \$112-\$125	\$5 \$235 copay copay \$20 (crown/brdg) \$130-\$215
Orthodontia	50% paid	50% paid	By Treatment Plan:	By Treatment Plan:
Child Adult			\$1,800/\$2,475 \$2,000/\$2,675	25% discount off Plan Specialists normal retail charges
TMJ Services	No Coverage	No Coverage	Fixed Copays:	Fixed Copays:
Exams, Services, etc.			\$0-\$850	\$85-\$115
Maximum Benefits	Per Person	Per Person	No Dollar Limit	No Dollar Limit
Annual combined preventive, basic and major services	\$1,000/person	\$1,000/person	Benefits paid for participating dentists and/or orthodontists only.	Benefits paid for participating dentists and/or orthodontists only.
Orthodontia Lifetime	\$1,500/person	\$1,500/person		

* Requires you to select a Participating Dental Provider (PDP) when enrolling. In addition, if you are selecting a PDP listed as “roster only,” it takes time to get on the roster after enrollment. You must be on the roster prior to receiving non-emergency care.

See carrier materials for benefit and provider details and any extras.

Preventive care: Indemnity/PPO plans, two normal cleanings and exams/plan year; prepaid, once/six months generally.

Before having major services performed, contact your dentist and/or your plan to determine your costs.

Additional Employee Benefit Plans

Vision Care Insurance

You may elect vision coverage for yourself, or for yourself and your family, through the State's new vision plan carrier, Avesis, Inc. You pay all premiums for the plan. Please note that employees with single medical coverage may elect family vision coverage through Avesis or vice versa. State employees who waive health coverage may elect vision coverage.

You may choose from a participating network provider or non-participating provider. However, when you select a participating network provider you receive a higher benefit. If you purchase non-covered options from a participating network provider, the providers have contracted with Avesis to provide these options at a reduced rate to Avesis members.

When visiting an **In-Network Provider**: Choose one of these three options for receiving your benefit:

1. You pay an annual \$10 copayment for their exam and receive covered optical materials (standard spectacle lenses and frame, within plan allowance) with no additional copayment per plan year. **OR**
2. You may utilize their benefits for elective contact lenses. You make a \$10 copayment for an exam and receive an additional \$130 allowance toward the cost of contact lenses and related professional services per plan year. Contact lenses are covered 100% after the copayment if Avesis determines that they are medically necessary. The contact lens benefit is in lieu of the exam, spectacle lenses and frame for that plan year. **OR**
3. You may receive a \$150 one time (lifetime) benefit allowance (in-network only) toward the cost of Lasik surgery in place of all other benefits for that plan year.

When visiting an Out-of-Network Provider: You must pay the provider and submit an itemized statement for reimbursement of vision care expenses. Avesis will then reimburse you up to the amounts shown in the plan's fee schedule listed below. Please provide the following information with your itemized statement when filing a claim: member I.D., member name, patient name and date of birth, member mailing address and the group plan (State of Arizona).

When visiting an out-of-network provider, you will be reimbursed for eligible expenses according to the following fee schedule:

Vision Examination:	\$50
Single Vision Lenses:	\$30
Bifocal Lenses:	\$45
Trifocal Lenses:	\$55
Lenticular Lenses:	\$110
Frames:	\$50
Contact Lenses:	
Elective:	\$150 (in place of all other benefits for that plan year)
Medically Necessary:	\$300 (in place of all other benefits for that plan year)
Lasik Surgery:	Not covered

To receive additional information about the coverages provided through Avesis, please contact them directly at the phone number listed inside the back cover of this booklet. When calling Avesis, please tell them you are a State of Arizona employee.

Life Insurance

Benefits-eligible employees are automatically enrolled for \$12,000 of basic life insurance coverage at no cost to the employee. The State also pays for an additional \$12,000 of Accidental Death and Dismemberment (AD&D) insurance coverage, all or a portion of which is payable in the event of your accidental death or dismemberment. A \$12,000 Seat Belt Benefit may also be payable if you die in an automobile accident and are wearing a seat belt. The life insurance coverage is provided through Standard Insurance Company.

Additional employee supplemental life insurance coverage is available to employees at the cost listed in the Premium Rate Chart on page 6. The premium rates are based on how old you are and increase at these ages: 30, 40, 50, 60, 70. Please check your rate each year. The employee supplemental AD&D coverage is the same as the supplemental life amount that you elect.

During open enrollment you may increase or decrease your supplemental coverage, in multiples of \$5,000, or cancel your supplemental coverage.

- The maximum annual increase that you can elect is \$20,000.
- The maximum amount of supplemental life insurance that you can have through the State's group plan is three times your annual salary, or \$200,000, whichever is less.

Supplemental coverage above \$35,000 is paid on an after-tax basis, so:

- Supplemental coverage may be cancelled or reduced to \$35,000 at any time.
- Supplemental coverage up to \$35,000 can only be changed during open enrollment or in conjunction with a qualified status change, subject to annual maximum increase rules and maximum coverage limits.

Spouse and dependent life insurance coverage is available to employees at the cost listed on the Premium Rate Chart on page 6. Your spouse and eligible children (to 19 years of age or to 25 years of age, if full-time student) are each insured for the amount you elect: \$4,000, \$6,000 or \$12,000. (Those currently enrolled in the \$2,000 coverage level will be able to maintain that coverage; however, no new enrollments will be allowed at the \$2,000 level.) The premium you will pay is for all your eligible dependents, no matter how many eligible dependents you have. All dependent life premiums are on an after-tax basis.

In the event of your death, employee life and AD&D benefits are paid to your designated beneficiary. If you decide to elect coverage for your dependents, you are automatically the beneficiary for your spouse and children.

Note: When designating a beneficiary for your life insurance, please keep in mind that minor beneficiaries usually cannot directly receive an insurance benefit until reaching age 18. While parents are usually guardians of their minor children's person, in most states, unless previously established by a court of law, parents are not the guardian of their minor children's estate. Minor beneficiary designations cause delays in benefit processing until an appropriate method of payment has been established, such as through probate court.

It is important to keep your beneficiary information current. During open enrollment, you may change your beneficiary using the Web or IVR enrollment systems or by completing a BE-1 or BE-2 form. You may change your beneficiary designation during the year by completing a BE-1 or a BE-2.

Short-Term Disability Insurance

If you elect the Group Short-Term Disability (STD) Plan and become unable to work due to illness, pregnancy, or injury, you receive a weekly benefit from Standard Insurance Company. There are no pre-existing condition limitations, but you must meet the actively at work provision on or after the effective date of October 1, 2001 if electing STD during open enrollment.

You are considered disabled if you are unable to perform with reasonable continuity the material duties of your occupation. The disability cannot be self-inflicted, work-related or a result of war. Benefit payments continue up to six months if you remain disabled. Benefits are prorated for each day of a partial week of disability after the commencement of benefits.

If you are electing STD coverage as a newly hired employee or continuing STD coverage for the 2001/2002 plan year, your benefits will start on your first day of disability due to accident or the 31st day of disability due to illness or pregnancy. However, if you previously waived STD coverage, are enrolling in the plan during this year's open enrollment period (or when you have a qualified change in status) and become disabled during the first 12 months following the coverage effective date, your benefits will start on the 61st day of disability due to illness or pregnancy.

Upon receipt of verifying documentation and approval by Standard Insurance Company, you receive sixty-six and two thirds percent (66 $\frac{2}{3}$ %) of your base pay. The weekly minimum benefit is \$57.69; the weekly maximum is \$769.27. Group STD benefits are in addition to any sick leave to which you may be entitled.

Your monthly cost for STD coverage is \$.89/\$100 of your monthly base salary, to a maximum of \$5,000 of monthly salary. This employee paid premium is deducted after taxes. This means that any benefits you may receive will be tax free. The table below will give you an idea of the cost and benefit on a monthly basis.

MONTHLY SALARY	MONTHLY PREMIUM	MONTHLY DISABILITY BENEFIT
\$1,200.00	\$10.68	\$ 800.00
\$1,500.00	\$13.35	\$1,000.00
\$2,000.00	\$17.80	\$1,333.33
\$2,500.00	\$22.25	\$1,666.66

Because you pay STD coverage on an after-tax basis, you may drop your STD coverage during the year. However, mid-year enrollment can only occur in conjunction with an appropriate qualified status change if the request is made within 31 days of the change. (See page 8 for more information.)

Flexible Spending Accounts

A Flexible Spending Account (FSA) allows you, through payroll deduction, to deposit money in an account on a pre-tax basis. The funds that you deposit can then be used to pay for eligible expenses that are not covered by other benefits of the Saguaro Program.

As you review your open enrollment materials, it is an excellent time to weigh your options concerning Flexible Spending Accounts. The Internal Revenue Service (IRS) code provides taxpayers with two methods to assist with health and dependent care expenses. The first method is Federal and/or State income tax credits. The second method is Flexible Spending Accounts. You may choose to utilize one method or the other; however, while you can use both methods, *you may not use both methods for the same expense.*

There are two types of Flexible Spending Accounts offered to State employees during open enrollment and upon qualified status change events. These accounts cover completely different types of expenses. The first account is for reimbursement of health care expenses for you and your dependents. The second account helps you pay for day care expenses for your dependents.

ASI administers our Flexible Spending Accounts. See the inside back cover of this booklet for their contact information.

Health Care Spending Account

The Health Care Spending Account utilizes pre-tax dollars to assist employees with coverage for health expenses not paid through other Saguardo Benefits Program coverage. Examples include: copayments for office visits or prescription drugs, coinsurance, health care expenses in excess of plan maximums, annual deductibles and excluded plan expenses, such as for acupuncture. This plan is for expenses incurred by you and all of your eligible dependents, even if you or your dependents aren't covered under the State's health plans.

You determine and direct a specific dollar amount to be deposited into your account each year. Then, through payroll deduction, a specified pre-tax dollar amount is deposited in your account each pay period. The maximum annual amount that you can deposit into your Health Care Spending Account is \$5,000. The funds in your account are available for reimbursement to you, to recoup your eligible payments.

Federal law requires that if you are filing for reimbursement of medical expenses and the amount submitted is greater than your accrued account balance, your reimbursement will be for the amount of the claim up to the annual amount you elected to contribute to your Health Care Spending Account, less any previous claim reimbursements.

It is important to decide the amount that you will have withheld for the year carefully. Federal law directs that any remaining balance at the end of the plan year *cannot be refunded to you, transferred to another account, or carried forward to the next plan year.*

Dependent Care Spending Account

The Dependent Care Flexible Spending Account is a benefit that helps employees recoup eligible payments for child care and elder care expenses by utilizing pre-tax dollars. This account is for dependent care expenses not dependent medical expenses. Dependent medical expenses are covered under the Health Care Spending Account previously discussed.

The purpose of Dependent Care Spending Account is to allow you, or you and your spouse if you are married, to work while your eligible dependents are cared for. Eligible dependents are children under 13 years of age, disabled dependents of any age, a disabled spouse and/or a dependent parent. If you request reimbursement for a dependent from your Dependent Care Spending Account, you must also be claiming them as dependents on your federal income tax.

You determine and direct a specific dollar amount to be deposited into your account each year. Then, through payroll deduction, a specified pre-tax dollar amount is deposited in your account each pay period. The maximum annual amount that you can deposit into your Dependent Care Spending Account is \$5,000 for single employees or married employees filing a joint federal income tax return. The limit is \$2,500 for married employees filing separate tax returns.

These additional IRS rules apply to your Dependent Care Spending Account contributions:

- While you can contribute up to \$5,000 each year, the amount you contribute cannot be greater than your annual income or the annual income of your spouse. For example, if your spouse earns \$4,500 per year, your maximum annual contribution is \$4,500.
- If your spouse is a full-time student or disabled, you can also participate. If that is the case, your spouse's income is assumed to be \$200 per month if you have one person who qualifies for dependent care—and \$400 when two or more dependents qualify. Therefore, if you claim one person who is being cared for, your spouse's annual salary is assumed to be \$2,400. If two or more of your dependents are being cared for, your spouse's annual salary is assumed to be \$4,800.

If you are filing for reimbursement of dependent care expenses and the amount submitted is in excess of your accrued account balance, your reimbursement will be paid up to your current account balance. Each time your account is credited, you will automatically be reimbursed until your entire claim has been paid or you reach the maximum you contributed for the plan year.

You must carefully plan the dollar amount deposited into your account, because federal law directs that any remaining balance at the end of the plan year *cannot be refunded, transferred or carried forward to the next plan year.*

Flexible Spending IRS Information

For more information about the allowable expenses for the medical reimbursement account, please see IRS Publication 502. The ASI web site (www.asiflex.com) also has information regarding allowable expenses.

You cannot change your elections to your Health Care Spending Account or Dependent Care Spending Account accounts after open enrollment unless you have a status change as defined by the IRS. The requested change must be consistent with and because of the status change and be submitted within 31 days of the change. (See page 8.) If you have a status change:

- You may increase the amount in either account: Health Care Spending Account or Dependent Care Spending Account
- Mid-year reductions are *not* permitted for Health Care Spending Account accounts
- Mid-year reductions are permitted for Dependent Care Spending Account accounts

How To Enroll in a Flexible Spending Account

This year, when you enroll in the Saguardo Program using the Web or telephone enrollment systems, you will also be able to elect FSA participation. No separate enrollment will be necessary. If you are unable to enroll online or on the phone, you will need to get a Flexible Spending Account election (BE-5) form from your benefits liaison or at an open enrollment meeting. Complete, sign and date the form authorizing the State to establish your personal reimbursement account with ASI, our flexible spending account administrator. Return the completed form to your benefits liaison by September 7, 2001.

No matter how you enroll, you can use the worksheet on page 25 to help you determine the amount that you wish to deposit in your account(s). When you decide how much you want to set aside for the entire year, from October 1, 2001 through September 30, 2002, divide the amount by 26 pay periods to calculate how much will be deducted from each paycheck during the year for deposit into your personal account.

Important Notice: If you are enrolling for participation using the Flexible Spending Accounts form, be sure that the annual amount you show matches the per pay period deduction amount. For example, you cannot exactly make a \$1,000 annual deduction. You must choose to elect one of the following if you decide on a \$1,000 deduction:

- \$999.96 divided by 26 = \$38.46 per pay period **OR**
- \$1,000.22 divided by 26 = \$38.47 per pay period

Not matching the annual amount and the pay period amount on the enrollment form will result in a delay of your enrollment.

Using Your Flexible Spending Accounts

Once enrolled, ASI (the flexible spending account administrator), will mail you an Enrollment Kit which will include your first few claim forms. You may obtain more claim forms from your benefits liaison, ASI's web site, ASI or by photocopying one.

You may file claims for reimbursement of eligible expenses as often as you like. ASI processes and pays claims daily. Many plan participants have their reimbursement electronically transferred to their bank account (direct deposit) and receive confirmation by mail or e-mail.

Along with the completed, signed and dated claim form, you need to submit a copy of the itemized bill, statement or insurance carrier's Explanation of Benefits (EOB) form indicating the eligible expense.

How Much Can You Save?

Save money using the Health Care Spending Account for expenses that aren't covered under your medical, dental and vision options. Save more money using the Dependent Care Spending Account for expenses that you pay so you can work. These spending accounts allow you to put money into them before taxes are taken and then, when you need the money to pay eligible expenses, you ask to be reimbursed from your account.

Here's a per pay period example:

Without an FSA Account		With an FSA Account	
Gross Salary	\$1000	Gross Salary	\$1000
Federal/State Taxes (27%)	- 270	Day Care	- 175
Net Take Home	\$ 730	Prescription Co-Pays	- 30
Day Care	- 175	Major Dental Work	- 35
Prescription Co-Pays	- 30	Net Pay Before	\$ 760
Major Dental Work	- 35	Federal/State Taxes (27%)	- 205
Net Pay	\$ 490	Net Pay	\$ 555

This employee takes home an additional \$65 per paycheck without changing any expenses or working more hours. That's an additional \$1,690 per year.

It must include:

- the provider's name
- the service provided and the charge for that service
- the date the service was provided (not just the date paid)
- the name of the family member concerned

You have 90 days following the end of the plan year to submit all remaining claims incurred during the plan year. All claims for the October 1, 2001 through September 30, 2002 plan year must be filed by December 31, 2002.

Determining Your Flexible Spending Account Contributions

INSTRUCTIONS: Use this form to estimate the expenses that will be incurred for services from October 1, 2001 through September 30, 2002, by all members of your family who qualify as dependents (IRS definition).

Health Care Spending Account: You should include medical, dental and vision expenses that will not be paid by insurance. **Dependent Care Spending Account:** Consider only dependent care expenses you incur to enable you and your spouse (if you're married) to be employed or attend school on a full-time basis. *Hint:* You may want to review bills and your checkbook register over the past year to aid in projecting these expenses.

PART 1: ESTIMATED HEALTH CARE EXPENSES NOT PAID BY INSURANCE

MEDICAL EXPENSES (including vision and hearing services):

HMO, In-Network POS, In-Network PPO

\$ _____ Physician copayments
 _____ Number of visits/year
 \$ _____ Prescription copayments
 \$ _____ Immunizations/allergy shots
 \$ _____ Other medical services
 \$ _____ Non-covered exams; e.g., for school
 \$ _____ Glasses, contacts
 \$ _____ Hearing aids (above plan payment)
 \$ _____ Noncovered services

Out-of Network POS, Out-of-Network PPO

\$ _____ Annual Deductible
 \$ _____ Co-insurance, covered expenses
 \$ _____ Prescription copayments
 \$ _____ Annual physical
 \$ _____ Other Medical Expenses
 \$ _____ Vision and hearing exams
 \$ _____ Glasses, contacts or Lasik surgery
 \$ _____ Hearing aids (above plan payment)

DENTAL EXPENSES:

Prepaid/Managed Plan

\$ _____ Copayments
 \$ _____ Fillings
 \$ _____ Crowns, bridges
 \$ _____ Periodontal work
 \$ _____ Orthodontics (Braces)
 \$ _____ Other dental services

Indemnity/PPO Plan

\$ _____ Annual Deductible
 \$ _____ Co-insurance, basic restorative
 \$ _____ Co-insurance, major restorative
 \$ _____ Orthodontics (Braces)
 \$ _____ Other dental services

PART 2: ESTIMATED DEPENDENT CARE EXPENSES

\$ _____ Preschool
 \$ _____ After-school
 \$ _____ Day care for eligible children or disabled adults
 \$ _____ Other dependent care expenses

PART 3: TOTAL EXPENSES

\$ _____ Total Unpaid Health Care Expenses
 \$ _____ Total Dependent Care Expenses
 \$ _____ Total Eligible Expenses

To estimate your tax savings using the reimbursement accounts multiply your total by 30%. (Your actual savings will be based on your marginal tax rate.)

_____ x 0.30 = _____
 (Total Eligible Expenses) (Estimated Tax Savings)

Enrolling in Saguaro Benefits

To Enroll (24 hours a day/7 days a week): www.az.gov or 1-866-740-7153

This year, since we are changing our medical plan options, every employee who wants medical plan coverage for 2001/2002 must enroll during the open enrollment period. You can enroll in the Saguaro Benefits Program one of three ways—you can use the Web, our new interactive voice response (IVR) telephone enrollment system, or a Benefits Election (BE-1) form. You must select and use one enrollment method. *You are strongly encouraged to use the Web or telephone to make your elections.*

Please note: It is important to make sure that all dependents you want covered under the medical, dental, vision or life plans are added during open enrollment. If you are enrolling a spouse or dependent not previously enrolled whose last name is different from yours, please provide backup documentation, such as a marriage license or birth certificate, to your benefits liaison. Any dependents not listed during open enrollment cannot be added until the next open enrollment period unless you have an appropriate qualified status change. (See page 8 for more information about qualified status changes.)

Prior to October 1, a confirmation statement will be sent to your home. Once you've received your copy, keep it as a record of your final elections. Don't forget to verify your payroll deductions once your new elections become effective. For medical, dental, life, vision and short-term disability insurances the new deductions will appear on your October 19, 2001, paycheck. For flexible spending accounts the new deductions will appear on your October 5, 2001, paycheck.

New for 2001/2002—Online Enrollment—the Preferred Option!

Preparing To Enroll

Web site enrollment has numerous advantages:

- It's easy.
- It's simple.
- It's more accurate.
- You see your recorded elections immediately.
- You get e-mail confirmation of your elections immediately.

We encourage you to use our online enrollment system when making your 2001/2002 benefit elections.

About Your Personal Identification Number (PIN)

You will need a Personal Identification Number (PIN) to enroll via the Web or IVR systems. Your PIN will be mailed to you in early August. If you haven't received yours by August 13, or if you lose or forget your PIN, a replacement can be obtained by:

- Calling the Arizona Benefits Help Desk (available 24 hours a day/7 days a week) at **1-866-251-5672** and choosing the PIN option; or
- Using Arizona Benefits on the Web (www.az.gov) and making a PIN request online.

For security reasons, the Help Desk will not issue and mail a new PIN to any address other than the official one on file. Therefore, please ensure that your benefits liaison has your current mailing address on file.

Read your enrollment materials and complete the information on your Enrollment Worksheet (see page 30) before you access the web site to ensure that you have the essential items you will need handy. Additionally, please make sure you have all your dependent and beneficiary information available, as requested on the worksheet.

Web Enrollment

- Enroll early, beginning **August 13** and no later than the enrollment deadline, **September 7, 2001**.
- Access the online enrollment system at <http://www.az.gov>. Select the **ArizonaBenefits@YourService** link.
- Input your Social Security number and personal identification number (PIN) as requested.

You will access various panels to make elections and changes.

- *Benefits Election Panels* Make your elections (medical, dental, vision, life insurance, dependent life insurance, short-term disability insurance and FSAs).
- *Dependent Data Panels* Add or remove dependents for medical, dental, vision and life insurance coverage.
- *Beneficiary Data Panel* Declare beneficiaries for your life insurance.

The Benefits Election Panels list all of your available benefit options. Adding/changing information on the Benefits Elections Panels can be completed by entering the requested information or correcting any incorrect information. For example, if you wish to change your dental coverage from single to family, you select the dental plan option and make your election.

Note: If you select the HMO or POS medical plan, the Web will prompt you to input the Primary Care Physician (PCP) I.D. number for yourself and each of your covered dependents. You can find PCP I.D. numbers for CIGNA at www.cigna.com or by calling 1-800-613-4563. PCP directories will also be available at open enrollment meetings or from your benefits liaison. You will be required to enter the PCP I.D. number prior to advancing to the next Benefits Election Panel. (You can opt for the system to assign PCPs.) You will also need to indicate if the covered person is a new patient to the PCP selected.

For dependents, PCP selections are made on the Dependent Panel.

ArizonaBenefits@YourService


Info

Welcome to Arizona Benefits - The Saguaro Program

We hope you will find this web site an easy and convenient way to select your health benefits. Prior to beginning your online enrollment process, you will need to have:

- Your Social Security Number (University ID for ASU or AU)
- Your Personal Identification Number (PIN) that was mailed to your home address
- Reviewed your benefit choices and the provider directory via the Benefits web site at www.hr.state.az.us/benefits
- Selected a Physician/Dentist for yourself and dependents (some plan options require this information or provide you with the option to allow the carrier to assign one)

Elections on the Benefits Election Panels can be completed by following these steps:

1. Review the plan information provided on the screen.
2. Select the plan name you want to enroll in with the appropriate coverage level.
3. Click on the CONTINUE button after each election.
4. Repeat steps one, two and three for each coverage you wish to enroll in/change/leave as is/decline.
5. If you wish to add/remove dependents for medical, dental or vision coverage, go to the Dependent Data Panels and do so.

Completing Your Enrollment

After pressing the final CONTINUE button, the system will display the final review page. On this page you can make corrections to any item where an error has been detected by selecting the corresponding button. **Verify your elections carefully since you cannot change your elections after the enrollment deadline unless you have a qualified status change.** You will then need to press the SUBMIT button which will advance you to the confirmation page where you will be prompted to enter your e-mail address to receive confirmation. Press the SUBMIT button to process your enrollment and print your elections summary. You will then be instructed to EXIT the browser.

New for 2001/2002—Telephone Enrollment— an Alternative Option...

Preparing To Enroll

Read your enrollment materials and complete the information on your Enrollment Worksheet (see page 30) before you call the interactive voice response (IVR) telephone system to enroll. Make sure you have the essential items you will need handy. Additionally, please make sure you have all your beneficiary and dependent information available, as requested on the worksheet.

Telephone Enrollment

- Enroll early, beginning **August 13** and no later than **September 7, 2001**. Keep in mind that phone lines typically get busier the closer you get to the deadline.
- Call **1-866-740-7153**. If busy, consider using the online enrollment system or call back at a different time (but before your deadline!).
- Input your Social Security number and personal identification number (PIN) as requested.

Main Menu

- Select the appropriate option to make your benefit elections.
- Select the appropriate option to add or change dependent or beneficiary information.

You will be prompted to make a decision about each benefit (medical, dental, vision, life insurance, dependent life insurance, short-term disability insurance, Health Care Spending Account and Dependent Care Spending Account).

When making your medical, dental, and vision choices, you will be required to first select the plan. You will then be prompted to select the level of coverage (single or family). If you select family coverage, you will be asked to name (speak) the dependents to be covered under that plan.

Note: If you select the HMO or POS medical plan, the IVR system will prompt you to input the Primary Care Physician (PCP) I.D. number for yourself and each of your covered dependents. You can find PCP I.D. numbers for CIGNA at www.cigna.com or by calling 1-800-613-4563. PCP directories will also be available at open enrollment meetings or from your benefits liaison. You will be required to enter the PCP I.D. number prior to advancing to the next enrollment step. (You can opt for the system to assign PCPs.) You will also need to indicate if the covered person is a new patient to the PCP selected.

Once you have completed your enrollment, follow the system instructions to review your elections. **Verify your elections carefully since you cannot change your elections after your enrollment deadline unless you have a qualified status change.**

Completing Your Enrollment

- You will enter some enrollment information using your phone's dial pad and some will be provided verbally. Speak clearly when prompted to provide your enrollment information, such as dependent and beneficiary information. If you have multiple dependents and/or beneficiaries to record, you may want to consider using our online enrollment system.
- After every election you make, the system will repeat your selection and ask you to confirm it.
- If you elect to contribute to the Health Care or Dependent Care Spending Accounts, the system will ask you to enter your per pay period election.
- After you have finished making your elections, the system will ask where you want your confirmation statement sent—to a facsimile or to your home address.

Paper Enrollment—One Last Option...

Paper enrollment will still be available if you are unable to enroll via the Web or IVR telephone system. You will need to fill out a BE-1 form. The BE-1 form can be obtained by contacting your benefits liaison or you can pick up a form at an open enrollment meeting. You must also complete a Flexible Spending Account enrollment form to participate in the Flexible Spending Accounts. (See pages 21-25 for more information on Flexible Spending Accounts.)

Instructions for Completing a BE-1 Form:

Section A: If changing current information or coverages, you must complete all areas.

Section B: If you want medical coverage, you must complete all areas.

Section C: Only complete this section if making coverage changes.

Section D: If enrolling for medical or vision plan coverage, or changing your dental election, be sure to list all family members you want covered. You must include birth dates and providers, as required, for your spouse and each dependent. If you are adding a dependent who is not your natural/birth child or a spouse with a different last name, be sure to attach copies of the applicable document such as a birth certificate, court papers or marriage certificate.

Section E: Only complete this section if making changes.

Section F: The amount of life insurance you indicate is the total amount of coverage desired excluding the basic \$12,000 life paid by the State. If increasing or decreasing your supplemental life and AD&D insurance, be sure to elect a new total amount of coverage; **don't** select only the amount of the change.

Section G: If you want vision coverage, you must check "single" or "family".

Section H: If changing current information or coverages, you must sign and date the form.

Keep the last copy for your records and as a temporary I.D. card. Return the rest of the form to your benefits liaison by the enrollment deadline, **September 7, 2001.**

2001/2002 Enrollment Worksheet

USE THIS WORKSHEET TO MAKE YOUR BENEFIT SELECTIONS BEFORE VISITING THE WEB SITE (www.az.gov) OR CALLING THE TELEPHONE ENROLLMENT SYSTEM (1-866-740-7153). The systems will be open August 13 through September 7, 2001.

Remember, **everyone** who wants medical, vision or FSA plan coverage for the new plan year must make new benefit elections in these areas. The rates for your benefits are shown on page 6 of this booklet so you can calculate your monthly benefit costs.

Your location (affects medical plan premium and options available): <input type="checkbox"/> Maricopa County or the town of Apache Junction <input type="checkbox"/> Pima County <input type="checkbox"/> Remaining Counties (excluding Apache Junction) <input type="checkbox"/> Out of State	Social Security number: _____ Enrollment system PIN: _____
---	---

1) MEDICAL Coverage level: <input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> CIGNA HMO* <input type="checkbox"/> CIGNA PPO <input type="checkbox"/> CIGNA POS* <input type="checkbox"/> Decline coverage <i>*When electing HMO or POS medical plan coverage, you will need to record a PCP I.D. number for yourself and each covered dependent and indicate if the covered person is a new patient for that PCP. Visit CIGNA's web site (www.cigna.com) or call 1-800-613-4563 for a listing of PCP I.D. numbers. Note dependent PCP information on the back of this worksheet.</i>	I.D. # for your PCP*: _____ Your monthly cost: \$ _____
--	--

2) DENTAL Coverage level: <input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Delta Denta <input type="checkbox"/> Protective DentalCare (PDC)* <input type="checkbox"/> MetLife Dental <input type="checkbox"/> Decline coverage <input type="checkbox"/> Employers Dental Services (EDS)* <input type="checkbox"/> Leave As Is <i>*When electing EDS or PDC dental plan coverage, you will need to record a participating dentist (PDP) for yourself and each covered dependent. Visit the plan's web site or call them for a listing of PDP I.D. numbers. Note dependent PDP I.D. numbers on the back of this worksheet.</i>	I.D. # for your PDP*: _____ Your monthly cost: \$ _____
--	--

3) VISION Coverage level: <input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Enroll <input type="checkbox"/> Decline coverage	Your monthly cost: \$ _____
---	-----------------------------

4) EMPLOYEE LIFE/AD&D INSURANCE You automatically receive \$12,000 basic life insurance coverage. Additional coverage amounts must be in increments of \$5,000. Increases each year may not exceed \$20,000. Your total additional life coverage amount cannot exceed three times annual salary or \$200,000. <input type="checkbox"/> Elect additional coverage <input type="checkbox"/> Decrease existing coverage <input type="checkbox"/> I am a smoker <input type="checkbox"/> Decline coverage <input type="checkbox"/> I have not smoked in six months (If you are a non-smoker, your additional coverage benefit amount is increased by \$1,000 at no additional charge.) <input type="checkbox"/> Leave As Is <i>Each employee must record a beneficiary for their insurance benefit. Note beneficiary information on the back of this worksheet.</i>	Increase/Decrease amount \$ _____ Your monthly cost: \$ _____
---	--

5) DEPENDENT LIFE INSURANCE <input type="checkbox"/> \$4,000 <input type="checkbox"/> Leave As Is <input type="checkbox"/> \$6,000 <input type="checkbox"/> Decline Coverage <input type="checkbox"/> \$12,000	Your monthly cost: \$ _____
--	-----------------------------

6) SHORT-TERM DISABILITY <input type="checkbox"/> Enroll <input type="checkbox"/> Leave As Is <input type="checkbox"/> Decline coverage	Your monthly cost: \$ _____
--	-----------------------------

Total Monthly Cost for Benefits Above (1 - 6):	\$ _____
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7) HEALTH CARE SPENDING/REIMBURSEMENT ACCOUNT <input type="checkbox"/> Annual contribution (maximum of \$5,000/yr.): \$ _____ <input type="checkbox"/> Decline enrollment Divide annual amount by 26 to calculate per-pay-period amount to be entered into enrollment system: \$ _____	
--	--

8) DEPENDENT CARE SPENDING/REIMBURSEMENT ACCOUNT <input type="checkbox"/> Annual contribution (maximum of \$5,000/yr.): \$ _____ <input type="checkbox"/> Decline enrollment Divide annual amount by 26 to calculate per-pay-period amount to be entered into enrollment system: \$ _____	
---	--

Dependent Enrollment

List the dependents you want covered when electing family benefit coverage and/or dependent life insurance. When enrolling dependents for HMO or POS medical plan coverage, you will need to select and record a Primary Care Physician (PCP) for each covered dependent. Visit CIGNA's web site (www.cigna.com) or call 1-800-613-4563 for a listing of PCP I.D. numbers. When enrolling dependents for EDS or PDC dental coverage, you will need to select and record a Participating Dental Provider (PDP) I.D. # for each covered dependent. You can enter up to 14 dependents. (Use an additional sheet if you need more space.)

Dependent Name	SSN	Date of Birth	Relationship	Full-Time Student?	Medical PCP I.D. #*	New PCP Patient?	Dental PDP I.D. #**
<i>Sample</i>	<i>123-44-5678</i>	<i>07-12-1954</i>	<i>Wife</i>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<i>1041234</i>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<i>0001234</i>
				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	

*Required if this person will be covered under CIGNA HMO or POS medical plan.

**Required if this person will be covered under EDS or PDC dental plan.

Beneficiary Data

List your beneficiary(ies) for your Life/AD&D Insurance. In the event of your death, employee life and AD&D benefits are paid to your designated trust or beneficiary(ies). If you decide to elect Dependent Life Insurance coverage, you are automatically the beneficiary for your spouse and children. You can enter up to 15 beneficiaries. (Use an additional sheet if you need more space.) *If the Beneficiary is a Trust, provide the following information: Name of Will, Trust or Legal Agreement; Address Where Filed; Administrator Where Filed; Date of Will or Trust.*

Beneficiary Name, Address and Phone	SSN*	Date of Birth	Relationship	Beneficiary Designation
<i>Sample</i> <i>123 First Street</i> <i>Phoenix, AZ 12345</i> <i>(602) 123-4567</i>	<i>123-44-5678</i>	<i>07-12-1954</i>	<i>Wife</i>	<input checked="" type="checkbox"/> Primary <input type="checkbox"/> Contingent
				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent

*Not a required field.

Completing Your Enrollment

We Value Your Opinion!

When enrolling for the Saguaro Program online via the Web or using the IVR telephone system, you will be asked to complete a survey about your enrollment experience. Please take the time to give us your feedback about this important process.



Contact Information

ADOA Human Resources web site www.hr.state.az.us/benefits

Online enrollment web site www.az.gov

Telephone enrollment system (IVR) 1-866-740-7153

Arizona Benefits Help Desk 1-866-251-5672
(24 hours a day/7 days a week)

September 7, 2001 is the enrollment deadline!

If you fail to enroll by the annual enrollment deadline, September 7, 2001, you will receive these default coverages for the 2001/2002 plan year:

Medical – no coverage

Vision – no coverage

Flexible Spending Accounts – no participation

All of your other active elections – continued coverage

Other Important Information

Payroll Deductions

Don't forget to verify your payroll deductions for changes you made to your plans or rate changes that are to be effective October 1, 2001. Changes will show on your mid-October 2001 paycheck. If you feel your payroll deduction is not accurate, you must notify your benefits liaison within 30 days of your payroll deduction change.

About this Booklet

Information provided in this booklet is intended solely as a guide to help you make important enrollment decisions.

The benefits described are highlights of the State of Arizona's benefit program provided through the Arizona Department of Administration.

This is a brief summary of the State's official plan documents and contracts that govern the plans. If there is any discrepancy between this information and the official documents, the official documents will always govern.

The State of Arizona reserves the right to change or terminate any of its plans, in whole or in part, at any time.

Published by:

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Web Site: www.hr.state.az.us/benefits

If you need this booklet in an alternative format, call Benefits at (602) 542-5008.

Frequently Asked Questions

1 I didn't receive a personal identification number (PIN) in the mail. What should I do?

You must have a PIN to enroll in the Saguaro Program using the Web or phone enrollment systems. Yours will be mailed to you in early August. If you haven't received yours by August 13, or if you lose or forget your PIN, a replacement can be obtained by:

- Calling the Arizona Benefits Help Desk at **1-866-251-5672** and choosing the PIN option; or
- Using Arizona Benefits on the Web (**www.az.gov**) and making a PIN request online.

For security reasons, the Help Desk will not issue and mail a new PIN to any address other than the official one on file. Therefore, please ensure that your benefits liaison or university benefits office has your current mailing address on file.

2 Both my spouse and I are State employees. What are our enrollment options?

While each of you must enroll for Saguaro Program coverages, you can elect the following:

- For medical, dental or vision coverage:

If you have no dependents: Both can choose single coverage or one can elect family coverage while the other waives it.

If you have one or more dependents: Only one of you will want to elect family coverage for the entire family, if the family wants medical coverage through the State. Whichever spouse elects the family coverage has the deductions taken out of his or her paycheck. (The other spouse should waive coverage. Selecting single *and* family medical or dental coverage can result in additional payroll deductions since the State's share of the combined premium cost will exceed the statutory monthly employer contribution amount for family coverage.)

- For Short Term Disability (STD):

This is a plan for employees only. Spouses must make their own elections.

- For Employee Supplemental Life/AD&D Insurance:

This is a plan for employees only. Spouses must make their own elections.

- For Dependent Life Insurance:

Both spouses may elect dependent coverage.

- For the Health Care Spending Account:

Each spouse can elect up to the annual maximum contribution.

- For the Dependent Care Spending Account:

Your combined contribution can't exceed the annual maximum contribution.

3 *What should I do if my spouse has benefits through another employer?*

Coordinate your coverages. Study what your spouse has and choose the Saguaro Program options that provide you with the most appropriate overall coverage. It is usually best to pick coverage that complements, not duplicates, the other coverage.

4 *How are Saguaro Program costs changing for the 2001/2002 plan year?*

Any change in the amount of your monthly medical plan cost depends on the plan in which you are currently enrolled and the new medical plan you select. The dental premium (the total cost) has increased, however the State will pay more so your cost will remain the same as last year. Vision plan benefits have increased while premiums have been reduced. Short-Term Disability Insurance premiums have been reduced. Employee Life Insurance premiums for employees age 40 or older have gone up slightly. Dependent Life Insurance premiums have remained the same.

5 *What is the advantage of paying for benefits with pre-tax dollars?*

Using pretax dollars to pay for benefits reduces your taxable income. When taxable income is reduced, you pay less in federal, state (if applicable), and Social Security taxes.

6 *If I don't enroll by the September 7, 2001 deadline, what will happen?*

If you fail to enroll by the annual enrollment deadline, you will receive no medical or vision plan coverage for the 2001/2002 plan year. You will continue all of your other active elections, with the exception of the Health Care Spending Account and Dependent Care Spending Account which will default to "No Participation."

7 *Why do I have to enroll for medical and vision coverages this year? In the past, if we didn't enroll, our elections would just remain the same for the new plan year.*

Since we are changing our medical and vision plan options, the plan you're in now will not be available next year. That's why it will be necessary for every employee to make new medical and vision plan elections. If you don't enroll during open enrollment, you will have no medical or vision plan coverage for the 2001/2002 plan year.

8 *What is the best way to determine which medical plan is right for me?*

There's a lot to consider. The key is for you to look at your own situation, study what the plans offer and their corresponding costs, and decide what is best for you.

9 *After enrollment, how will I know my choices have been properly recorded?*

A confirmation statement will be mailed to your home address during October—keep this as a record of your final elections. Don't forget to verify your payroll deductions in mid October, once your new elections become effective. Report any discrepancies to your benefits liaison immediately.

It is important that you report any enrollment discrepancy to your benefits liaison no later than 30 days from the scheduled start of your changed deductions. After this 30-day grace period, we will be unable to make any adjustments.

10 When will I receive an identification (I.D.) card if I enroll for medical coverage?

New enrollees will receive a packet of information about using their new plan. You will also receive a medical plan identification card by the end of September. If your card doesn't arrive by then, please contact your benefits liaison. Until you receive your card, your provider can call the medical plan's member services department to verify your enrollment.

After October 1, you can contact member services to request an additional I.D. card, change PCP, etc.

11 I'm enrolling for family coverage in the HMO. Can I select one Primary Care Physician (PCP) for my whole family?

While you can select one PCP for everyone, you may want to choose different PCPs for each family member. Each covered family member can have his or her own PCP. You will need to record a PCP for each covered person, even if you all use the same one.

12 How do I use my Primary Care Physician (PCP) and what kind of doctors are available to choose from when selecting a PCP?

Your HMO or POS plan PCP is responsible for directing all your care, including referrals to specialists and obtaining necessary precertifications. PCPs are General Practice, Family Practice, Pediatric or Internal Medicine specialists. Women can self-refer to an in-network OB/GYN.

13 How do I access the new enrollment system?

To access the Web enrollment system, using any Internet-ready computer, go to **www.az.gov**. For the telephone (IVR) system, dial **1-866-740-7153**.

Glossary

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

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

Billed Charge The amount the provider bills for services rendered.

Coinsurance The division of the allowed amount to be paid by the insurance company and the patient; i.e., 70/30 or 90/10. (The first percentage is paid by the company – 70 or 90).

Copayment The fixed fee that must be paid to the provider at the time services are provided, such as the pharmacist for a prescription (Rx).

Deductible The initial amount the patient must pay out of their pocket for covered services before benefits are payable by the insurance carrier for out-of-network POS or PPO plan services.

Emergency Defined by each plan in accordance with their standard definitions.

Health Maintenance Organization (HMO) A medical plan providing comprehensive medical benefits, including preventive care, when you agree to use a select group of network providers. Generally, all care is directed by your chosen Primary Care Physician (PCP). Your PCP will refer you to a specialist if medically appropriate.

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

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

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

Point of Service (POS) Plan A plan that provides benefits in two ways: in the plan's network or outside the network. Your costs are typically less when you receive services from inside the network and some services are only covered in-network. When enrolling in a POS plan, you must name a Primary Care Physician (PCP) who will coordinate all of your in-network care.

Preferred Provider A provider who has signed an agreement with the insurance carrier not to charge that carrier's members more than the insurer's allowed fees.

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

Pre-existing Condition A condition diagnosed and/or treated prior to the effective date of your coverage or for which a prudent person would have been treated.

Preferred Provider Organization (PPO) Plan A plan that provides benefits in an indemnity fashion, but pays a higher percentage of the cost of services if patients use a PPO-network provider than if they use non-PPO providers. If you go to a provider who is not a member of the PPO network, after you first satisfy a deductible, the plan generally pays 70 percent of the cost for care and you pay 30 percent.

Primary Care Physician (PCP) The physician responsible in an HMO or in-network in a POS plan for directing all patient care including referrals to specialists and obtaining necessary precertifications. This physician is a General Practice, Family Practice, Pediatric or Internal Medicine specialist. Women can self-refer to an in-network OB/GYN.

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