Baltimore County Public Schools

Benefits Enrollment & Reference Guide

Open Enrollment Period October 10 – November 11, 2016

Effective January 1, 2017 – December 31, 2017

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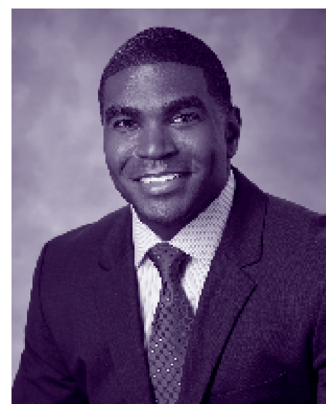
The purpose of this Benefits Enrollment and Reference Guide is to provide information about your benefit options and how to enroll for coverage or make changes to existing coverage. This Guide is only a summary of your choices and does not fully describe each benefit option. Please refer to your Employee Benefit Guide or Certificate of Coverage for information about the plans.

Every effort has been made to ensure that the information in this Guide is accurate; however, the provisions of the actual contracts for each plan will govern in the event of any discrepancy. Copies of the Employee Benefit Guides, plan contracts, and other plan materials are available upon request from the Office of Benefits, Leaves and Retirement at our Web site, **www.bcps.org/offices/benefits/forms**, or from the insurance carriers.



October 2016

Our annual Open Enrollment period for 2017 begins on Monday, October 10, 2016, and ends on Friday, November 11, 2016, at 4pm. For 2017, the premium costs for those enrolled in the Cigna Open Access Plus-in/out of network Plan (OAP) will see a higher percentage increase in accordance with the Master Agreements negotiated in 2012. If you are participating in the Cigna OAP plan and your providers are in network, I would encourage you to consider enrolling in the Cigna Open Access Plus in network plan (OAPIN) for 2017 since significant savings are possible with the OAPIN plan. We will continue to strive to offer an attractive package of benefits to meet your needs and to support the vision of Blueprint 2.0.

For 2017, several provisions of the Affordable Care Act will remain in effect. The primary effect of the 2017 requirements will involve temporary and contractual employees of BCPS who are currently not eligible for benefits. BCPS employees currently not eligible for benefits may be able to enroll in the benefits offered through the State of Maryland Health Care Exchange.

The Benefits Enrollment Guide provides details on your 2017 plan options. Taking time to review these materials carefully will help you make informed choices about your benefits.

Just a Few Reminders
Employee Self-Service (ESS) will be available this year for viewing your current benefit choices and employees will be able to enroll on line for medical, dental, vision and Long-term Disability (LTD). Please note if you do not wish to make changes to any of your benefits, no action from you is required. The only exception is enrollment in Flexible Spending Accounts (FSA). Re-enrollment in this benefit is required annually for employees who wish to participate.

Enrollment changes may also be completed using the paper enrollment form.

There are no changes to the medical plans. Cigna and Kaiser are being offered for 2017. Plans include the Cigna Open Access Plus – in network (OAPIN) and a Preferred Provider Organization (PPO) type plan - Open Access Plus – in/out of network (OAP) and the Kaiser Permanente HMO. Please review the details and costs of these plans. No action is required if you wish to maintain your medical coverage.

There are no changes to our dental plans. CareFirst PPO and CareFirst Traditional plans and the Cigna Dental DHMO are still in effect for 2017. No action is required if you wish to maintain your dental coverage.

CareFirst – Davis Vision remains our vision provider. No action is required if you wish to maintain your vision coverage. You must make a NEW election to participate in the Flexible Spending Accounts (FSA). Please note BCPS must follow strict IRS regulations regarding the administration of this benefit. Please be sure to review the information contained in this benefit guide.

If you have any questions, please refer to the contact listings in the back of this Enrollment Guide, call the Office of Employee Benefits, Leaves and Retirement at (443) 809-8943, or e-mail at benefits@bcps.org. We hope you continue to be pleased with these programs as we endeavor to maintain a competitive benefits package for you and your family.

Sincerely,
S. Dallas Dance, Superintendent

Important Resources

Office of Benefits, Leaves and Retirement

Phone: 443-809-8943
Fax: 410-887-8950
E-mail: benefits@bcps.org

Web site: www.bcps.org/offices/benefits
(Visit our Web site for many of the forms we use)
Office Hours: Monday through Friday, 8:30am – 4:45pm

Medical Options HMOs	Kaiser Permanente	Cigna OAPIN & OAP
BCPS Service Area		National
Group Number	7434-6	3216080
Internet Web site	my.kp.org/mida/bcps or www.kp.org	www.mycigna.com
Member Services (ID cards, verify provider participation, claims)	800-777-7902	800-896-0948
Hospital Precert/Health Consult Service	800-777-7904	800-896-0948
Healthy Pregnancy Program	800-444-6696	800-896-0948
TDD Line	410-339-5545	800-896-0948
Behavioral Health Providers	866-530-8778	800-274-7603
Behavioral TDD Line	800-828-1140	800-896-0948
Mail Order		855-401-9868

Dental Options	CareFirst	CareFirst	Cigna-DHMO
Managed Dental Plan Name	Regional Dental PPO	Regional Dental Traditional	DHMO
Network Provider	Preferred	Participating	In-Network Only
Group Number	7J91	7J91	3216080
Internet Web site	www.carefirst.com	www.carefirst.com	www.mycigna.com
Provider Listing	www.carefirst.com	www.carefirst.com	www.cigna.com/dental
Member Services (ID cards, claims)	866-891-2802	866-891-2802	800-896-0948
Provider Services	866-891-2804	866-891-2804	800-342-5234

Other Numbers	
Flexible Spending Accounts – Benefits Strategies	888-401-3539 www.benstrat.com
Vision Insurance – Carefirst Davis	888-336-7125 – New cards only 877-691-5856
EAP Provider	Internal: Janice Zimmerman 410-887-5414 External: CIGNA Behavioral Health – 1-888-431-4334 or www.cignabehavioral.com (password: Baltimore)
Employee Wellness Program	443-809-9471 EmpWellness@bcps.org
Long-term Disability	410-561-8900 Ext. 4 or 888-943-8447
Life Insurance – Prudential	800-778-3827
Cancer Insurance – Washington National Ins. Co.	800-541-2254
COBRA Administration	443-809-8943
First Financial Credit Union	410-321-6060
Sick Bank Enrollment – TABCO employees	410-828-6403
Sick Bank Enrollment – All other employees	443-809-4240

Retirement Contacts	
BCPS Office of Retirement	443-809-8949 Fax: 410-887-8950
Maryland State Retirement Agency (SRA)	401-625-5555 or 800-492-5909 www.sra.state.md.us
Baltimore County Employees' Retirement System (BCERS)	410-887-8246 www.baltimorecountymd.gov

What's New For This Plan Year ▪ 2017

At-a-Glance ...

All Open Enrollment information is available from the BCPS web site at **http://www.bcps.org/offices/benefits/** by clicking on the Open Enrollment link.

Here is a Look at What's New for 2017

- In order to provide an improved customer service experience to our employees, our FSA Plan administrator has changed to Benefit Strategies. Employees who wish to participate in a Health Care FSA or a Dependent Care FSA can enroll directly with Benefit Strategies by visiting **http://benstrat.navigatorsuite.com** or by calling **888-401-3539.**
- Employees do not need to submit FSA enrollment documentation to the Office of Benefits, Leaves and Retirement. For more information about FSAs, please see page 44 or visit our Web site at **http://www.bcps.org/offices/benefits/**.

The BCPS Employee Wellness program has been growing tremendously. We continue to encourage all employees to learn more about the offerings of the Employee Wellness program. For more information please see page 6 or visit our Web site at http://www.bcps.org/offices/sss/employee_wellness/.

An open enrollment statement will be sent to you in December 2016 confirming your elections for January 1, 2017. Review this document carefully and compare the information to your copy of the enrollment form. If there is an error, please contact the Office of Employee Benefits, Leaves and Retirement immediately at 443-809-8943, so that changes can be made in a timely manner.

Important Reminders

- Dependents may be covered until the end of the month they turn age 26 for most benefit programs.
- Participation in a FSA is not automatic. You must re-enroll annually during open enrollment. Monies remaining in the account 90 days after the end of the plan year cannot be returned. The last day for filing claims is March 31.
- Employees enrolled in Cigna or Kaiser Health Plans who wish to maintain their current benefit choices do not need to complete a benefit enrollment form. Your selections will roll over for 2017.

Benefits and Eligibility ▪ 2017

Basic Benefits

With the exception of the defined benefit pension plans, the costs for the basic benefits for all regular part-time and full-time employees are paid in full by Baltimore County Public Schools. Basic benefits include:

- Paid Holidays*
- Paid Vacation & Compensable Non-Duty Work Days*
- Paid Sick Leave*
- Paid and Unpaid Leaves of Absence*
- Tuition Reimbursement*
- Employee Assistance Program
- Employee Wellness Program
- $15,000 of Basic Term Life Insurance
- Employee Vision Coverage*
- First Financial Federal Credit Union – membership available
- Defined Benefit Pension Plan

**Contact your supervisor or the Department of Human Resources for more information regarding your eligibility for these benefits.*

Optional Benefits

In general, full and part-time employees may choose to enroll in any combination of the benefits listed below. BCPS contributes a large portion toward the purchase of health and welfare benefits. This allows you the flexibility to choose the benefit plans that best meet your needs.

The Flexible Benefits Program for BCPS is a cafeteria plan as defined by Section 125 of the Internal Revenue Code. A cafeteria plan allows you to pay for certain employee benefits with pre-tax deductions from your paycheck. You pay for most benefits on a before-tax basis, which lowers the taxes taken out of each paycheck.

Your before-tax benefits include:

- Medical
- Dental
- Vision (Must be .5 FTE to be eligible)
- Cancer & Intensive Care Insurance (not offered to new hires after 7/1/2007)
- Optional Term Life Insurance – up to 10x salary, first $35,000 is before tax.
- Whole Life Insurance with Long-term Care
- Critical Illness Insurance

Your after-tax benefits include:

- Personal Accident Insurance
- Long-term Disability Insurance (Must be .5 FTE to be eligible)
- Optional Term Life Insurance – up to 10x salary, amount over $35,000 is after tax. Maximum is $1 million.
- Whole Life Insurance with Long-term Care
- Critical Illness Insurance

Benefits and Eligibility *(continued)*

Eligibility

Employees

You are eligible to participate in the BCPS Flexible Benefits Program if you are a:

- Regular full-time employee
- Part-time employee working .5 FTE or more

Dependent Eligibility

Eligible family members include your:

- Legal spouse
- Domestic partner (please read the Frequently Asked Questions on page 58 for the definition of a domestic partner)
- Dependent children, which includes:
    - Biological children
    - Stepchildren
    - Legally adopted children
    - A child for whom you have legal guardianship, including grandchildren
    - Children of your eligible domestic partner
    - Children who are the subjects of a Qualified Medical Child Support Order (QMCSO) that creates the right of the child to receive health insurance benefits under an employee or retiree's coverage.

Dependent children are covered through the end of the month that they turn 26 years of age. Dependent children who are married are eligible. For information about coverage options for a dependent who has turned 26, please see COBRA on page 12.

Employee Wellness Program

The BCPS Employee Wellness program works to promote a culture of deliberate wellness. Wellness is personal. It's an individual journey toward balance, and a healthy lifestyle. Like walking, we need to take it one step at a time, keeping the pathway in front of us. This involves focusing on the positive and possible, and working together. It is not about judgment but about support.

The Employee Wellness Program works to provide a variety of programs and offerings that address the various components of wellness: emotional, intellectual, physical, social, financial, and spiritual.

Within every BCPS school and site is at least one employee who serves as the Wellness Champion. Wellness Champions are responsible for communicating information about the offerings of the Employee Wellness program to all of the staff at their school or site. If you do not know who the Wellness Champion is at your school or site, or if you are interested in becoming a Wellness Champion, please e-mail **EmpWellness@bcps.org**.

Employee Wellness Offerings Include:

- Onsite Biometric Screenings
- Health Assessments
- Flu Vaccine Clinics
- Eat Well, Work Well
- Hungry Harvest
- Fitness Center Discounts
- 10,000 Steps Toward Wellness
- On-site Fitness Classes
- Financial Wellness Seminars
- Healthiest Loser
- Healthy Wage
- Weight Watchers Discount
- Smoking cessation
- CPR Training
- Site based activities
- Health promotion days:
  - October – breast cancer awareness, wear pink Tuesday October 16
  - February – American Heart Association, wear red Friday February 3
  - Rock Your Red, February 24
  - March – nutrition promotion, wear and eat green Friday March 17
  - 5k Wellness Day, May 6 for employees and their families
- For more details about these offerings and the BCPS Employee Wellness Program, please visit: **http://www.bcps.org/offices/sss/employee_wellness/**

Employee Assistance Program (EAP)

What is EAP?

The Employee Assistance Program (EAP) is a **no cost, confidential employee benefit**. EAP provides services and support to the employee and their household members (family) to assist with personal concerns and/or work-related concerns that may impact job performance, health, emotional well-being, and the overall quality of life.

EAP services include but are not limited to:

- Counseling: Up to (10) Face-to-Face sessions with a counselor in your area.
- Consultation and support by phone: Consultations may be related to questions about behavioral health related topics, assistance with problem identification, problem-solving skills, approaches and/or resources to address behavioral concerns.
- Legal assistance: Free, 30-minute consultation with an attorney face-to-face or by phone.
- Financial: Free 30-minute telephonic consultation by phone with a qualified specialist on issues such as debt counseling or planning for retirement.
- Child care: Resources and referrals for child care providers, before and after school programs, camps, adoption organizations and information on parenting questions and prenatal care.
- Elder care: Resources and referrals for home health agencies, assisted living facilities, social and recreational programs, and long-distance care giving.
- Pet care: Resources and referrals for pet sitting, obedience training, veterinarians and pet stores.
- Identity theft: 60-minute free consultation with a fraud resolution specialist.

Who provides the EAP services and supports and what is their contact information?

The BCPS EAP has both an internal and external EAP. Internal EAP: Can be reached confidentially by phone at **410-887-5414** during normal business hours. Web site address: **www.bcps.org/offices/personnel_services/eap**

External EAP:
The BCPS external EAP is managed through Cigna Behavioral Health and can be reached 24 hours a day, 365 days a year at **1-888-431-4334**. Employees can also go online to: **www.cignabehavioral.com**. Employer ID: baltimore.

Open Enrollment

Open Enrollment

Open Enrollment is the annual time period in which benefit eligible employees can make changes to their benefit elections. This year's Open Enrollment period is from October 10, 2016 through November 11, 2016.

How to Enroll

Benefit changes can be made electronically through Employee Self Services. Benefits changes can also be made by completing the Benefits Enrollment Change form found on page 59. Completed forms must be received in the Office of Benefits, Leaves and Retirement no later than November 11, 2016. Forms may be sent via interoffice mail, US mail, faxed to **410-887-8950**, or e-mailed to **benefits@bcps.org**.

To enroll in a Health Care FSA and/or Dependent Care FSA, please visit **http://benstrat.navigatorsuite.com** or call Benefit Strategies at **888-401-3539**.

Important facts to consider during Open Enrollment

- The benefit elections you make during Open Enrollment stay in effect until the end of the 2017 Plan Year (January 1, 2017 to December 31, 2017). This is an IRS requirement which allows our Plans to qualify as pre-tax deductions.
- Employees who experience a qualifying life event will be permitted to make changes to their benefit elections. Changes must be requested within 30 days of the qualifying life event. Please see page 11 for information about qualifying life events.
- Employees may choose which eligible family members they want to include in each benefit election. For example, you may cover yourself and your dependents for medical benefits, but only yourself for dental coverage.
- If you and your spouse are both BCPS employees, you can each enroll in individual coverage, or one of you can elect two person or family coverage. If you elect coverage separately, you cannot cover one another as dependents. Similarly, eligible dependent child(ren) may only be covered under one of you.
- Proof of dependent eligibility is required. Documentation may be copies of a marriage certificate, birth certificate, or adoption papers. Documentation must include the employee's name and last four digits of their social security number. Failure to provide this identifying information could result in a delay of coverage. Documentation may be sent via interoffice mail to the Office of Benefits, Leaves and Retirement, Greenwood, via fax to **410-887-8950**, or scanned and e-mailed to **benefits@bcps.org**. Copies are acceptable, please do not send originals to our office.
- Employees who submit false information intended to provide health care coverage for alleged dependents not eligible for such coverage may be subject to discipline up to and including termination of employment. Such employees will also be held financially responsible for all claims filed, and will be required to reimburse the Board for any payments made on behalf of or for the benefits of an ineligible person claimed as a dependent.

Pre-Enrollment and Post-Enrollment Confirmation Statements

Benefit eligible employees will receive two personalized benefit statements to assist them during Open Enrollment.

Pre-Enrollment Confirmation Statements will be sent in the beginning of October. This form shows your current benefits elections. Please review the statement carefully to determine if you wish to make changes to your benefit plan during the Open Enrollment Period. If you do not wish to make any changes to your benefit plan, no further action is needed; unless you wish to elect a Health Care FSA or a Dependent Care FSA (employees must re-enroll in this benefit every year, if they want to participate).

Post-Enrollment Confirmation Statements will be sent in mid-December. This form will show what your elections are after Open Enrollment. Please review the form for accuracy. If any processing errors have been made, please notify the Office of Benefits, Leaves and Retirement as soon as possible either by calling **443-809-8943** or by e-mail at: **benefits@bcps.org.**

Open Enrollment *(continued)*

Informational Sessions

Four benefits informational sessions will be offered at locations throughout Baltimore County during Open Enrollment. Benefit plan representatives and employees from the Office of Benefits, Leaves and Retirement will be available during the informational sessions to answer questions. Active employees are highly encouraged to attend one of these sessions in order to make educated decisions about their benefits elections.

Informational sessions will take place at the following locations and times:

Date/Time	Location
Tuesday October 11, 3-6pm	Dundalk Middle School cafeteria
Thursday October 20, 3-6pm	Milford Mill Academy cafeteria
Wednesday October 26, 3-6pm	Loch Raven High School cafeteria
Thursday November 3, 3-6pm	Pulaski Park Suite 213

Webinar Sessions

Two webinar sessions will be offered in the beginning of Open Enrollment. These sessions will offer employees an overview of their BCPS benefit options in addition to giving employees an opportunity to ask questions.

Webinar sessions will be held on the following dates:

Date/Time
Monday October 17, 12-12:30pm
Monday October 24, 4-4:30pm

Employees will need computer and phone access to participate in a webinar session. To register please e-mail: **benefits@bcps.org**

New Hire Enrollment

Newly Hired Employees

As a newly hired employee you have 60 days from your first day of employment to enroll in benefits. If you do not elect benefits during the 60 day window, you must wait until the annual Open Enrollment period to enroll.

How to Enroll

Newly hired employees must complete the Benefits Enrollment Change form found on page 59. Completed forms should be submitted to the Office of Benefits, Leaves and Retirement during the 60 day window. Forms may be sent via interoffice mail, US mail, faxed to **410-887-8950**, or e-mailed to **benefits@bcps.org**.

To enroll in a Health Care FSA and/or Dependent Care FSA, please visit **http://benstrat.navigatorsuite.com** or call Benefit Strategies at **888-401-3539**.

Important facts to consider as New Hire

- Benefits for newly hired employees will take effect the first day of the month, following either your employment date or the date that you submit your forms to the Office of Benefits, Leaves, and Retirement, whichever is later. For example, if you submit a form on March 15, your benefit coverage will being April 1.
- The benefit elections you make as a new hire stay in effect until the end of the 2017 Plan Year (January 1, 2017 to December 31, 2017). This is an IRS requirement which allows our Plans to qualify as pre-tax deductions.
- Employees who experience a qualifying life event will be permitted to make changes to their benefit elections. Changes must be requested within 30 days of the qualifying life event. Please see page 11 for information about qualifying life events.
- Employees may choose which eligible family members they want to include in each benefit election. For example, you may cover yourself and your dependents for medical benefits, but only yourself for dental coverage.
- If you and your spouse are both BCPS employees, you can each enroll in individual coverage, or one of you can elect two person or family coverage. If you elect coverage separately, you cannot cover one another as dependents. Similarly, eligible dependent child(ren) may only be covered under one of you.
- Proof of dependent eligibility is required. Documentation may be copies of a marriage certificate, birth certificate, or adoption papers. Documentation must include the employee's name and last four digits of their social security number. Failure to provide this identifying information could result in a delay of coverage. Documentation may be sent via interoffice mail to the Office of Benefits, Leaves and Retirement, Greenwood, via fax to **410-887-8950**, or scanned and e-mailed to **benefits@bcps.org**. Copies are acceptable, please do not send originals to our office.
- Employees who submit false information intended to provide health care coverage for alleged dependents not eligible for such coverage may be subject to discipline up to and including termination of employment. Such employees will also be held financially responsible for all claims filed, and will be required to reimburse the Board for any payments made on behalf of or for the benefits of an ineligible person claimed as a dependent.

Verifying your Benefit Elections

As a newly hired employee you must check your paystub to make sure the proper deductions are being taken. Contact the Office of Benefits, Leaves, and Retirement immediately if you notice a discrepancy.

Changes to Your Benefits During the Plan Year

Baltimore County Public Schools' benefits program allows you to choose the benefits you need while providing valuable tax advantages. Your share of the cost for your benefits is paid with pre-tax payroll deductions. This means that employee payroll deductions for benefits are not subject to State, Federal, and O.A.S.D.I. taxes.

In order to maintain this favorable tax treatment, the Internal Revenue Service (IRS) has established rules that govern our benefit program. Most importantly, the IRS requires that the benefits you elect remain in effect for the entire Plan Year (1/1/2017-12/31/2017) unless you experience a qualifying life event.

Qualifying Life Events

The following are considered qualifying life events:

- Marriage, divorce, death of a spouse, or legal separation
- Birth or adoption of a new child

  Please note: Children must be added to your coverage even if you already have family coverage.
- Loss or gain of non-BCPS coverage by the employee's spouse or domestic partner
- Loss or gain of coverage due to a change in employment status (i.e. switching from part-time and full-time, commencement or return from an unpaid leave of absence)
- Loss of dependent child status (i.e. dependent has reached age 26)
- Eligibility for Medicare or Medicaid
- A judgment, decree or order that requires health coverage for an employee's dependent

How to enroll following a Qualifying Life Event

It is the employee's responsibility to notify the Office of Benefits, Leaves and Retirement within 30 days of each qualifying life event, if they wish to make a change to their benefit plan. Employees must provide a completed Benefits Enrollment Change form found on page 59, along with any required documentation (i.e. copies of birth certificate, marriage certificate). Documentation must include the employee's name and last four digits of their social security number. Failure to provide this identifying information could result in a delay of coverage.

Plan selection cannot be changed due to a qualified life event. Only the level of coverage can be changed depending on the life event.

Completed forms and documentation should be submitted to the Office of Benefits, Leaves and Retirement during the 60 day window. Forms may be sent via interoffice mail, US mail, faxed to **410-887-8950**, or e-mailed to **benefits@bcps.org**.

Notice of HIPAA Special Enrollment Rights

If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan. An enrollment request must be made within 30 days of your other coverage ending.

COBRA

Continuation Coverage Rights Under COBRA

Once you become covered under a group health plan (the Plan) you have COBRA rights. COBRA continuation coverage is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage is a federal law that may become available to you or other members of your family who are covered under the Plan when you or your covered dependents would otherwise lose group health coverage.

COBRA Eligibility

If you are an employee you will be become a COBRA qualified beneficiary if you lose your coverage for any of the following reasons:

- Your hours of employment are reduced
- Your employment ends for any reason other than gross misconduct

If you are the spouse or domestic partner of an employee, you will become a COBRA qualified beneficiary if you lose your coverage for any of the following reasons:

- Your spouse/domestic partner dies
- Your spouse/domestic partner's hours are reduced
- Your spouse/domestic partner's employment ends for any reason other than gross misconduct
- Your spouse/domestic partner becomes entitled to Medicare benefits
- You become divorced or legally separated, or terminate your domestic partnership

Your dependent children will become COBRA qualified beneficiaries if they lose coverage for any of the following reasons:

- The parent-employee dies
- The parent-employee's hours are reduced
- The parent-employee's employment ends for any reason other than gross misconduct
- The parent-employee becomes entitled to Medicare benefits
- The child no longer qualifies as a "Dependent child"

Important facts to consider about COBRA

- The cost of COBRA continuation coverage is the total cost of the premium (what was previously the employee's cost, plus the Board contribution) plus an administration charge of 2%.
- COBRA continuation coverage is temporary. The following limitations apply:
  - If COBRA is offered as a result of employee death, divorce/separation, or a dependent child losing eligibility, continuation coverage can last for a maximum of 36 months.
  - If COBRA is offered as a result of employment terminating, or a reduction in employee hours, continuation coverage can last for a maximum of 18 months.

Extensions of COBRA

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Office of Benefits, Leaves and Retirement within 30 days, you and your family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a maximum total of 29 months. The disability would have had to have started before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must provide written notice to: The Office of Benefits, Leaves and Retirement, 6901 Charles Street, Building B, Towson, MD 21204.

If your family experiences a second COBRA qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second event is given to the Plan. This extension may be available if:

- The employee or former employee dies
- The employee or former employee gets divorced/legally separated
- The child no longer qualifies as a "Dependent child"

Medical, Dental, and Vision Deductions for Full-Time Employees

Effective 1/1/2017 – 12/31/2017

	Total Premium or Equivalent	Board Annual Share	Your Annual Share	Your bi-weekly Deduction *
MEDICAL INSURANCE **				
CIGNA OAPIN (In Network)				
Individual	$7,729.80	$6,570.33	$1,159.47	$57.97
Parent/Child	15,315.12	13,017.85	2,297.27	114.86
Two Adults	18,446.28	15,679.34	2,766.94	138.35
Family	20,797.68	17,678.03	3,119.65	155.98
CIGNA OAP (In/Out Network)				
Individual	$8,726.52	$6,981.22	$1,745.30	$87.27
Parent/Child	17,289.48	13,831.58	3,457.90	172.89
Two Adults	20,824.32	16,659.48	4,164.86	208.24
Family	23,478.60	18,782.88	4,695.72	234.79
Kaiser Permanente HMO				
Individual	$8,643.72	$7,347.16	$1,296.56	$64.83
Parent/Child(ren)	17,124.84	14,556.11	2,568.73	128.44
Two Adults	20,626.44	17,532.47	3,093.97	154.70
Family	23,255.88	19,767.50	3,488.38	174.42
DENTAL INSURANCE **				
CareFirst Regional Dental PPO				
Individual	$300.24	$195.16	$105.08	$5.25
Parent/Child or Two Adults	650.52	422.84	227.68	11.38
Family	986.28	641.08	345.20	17.26
CareFirst Regional Dental Traditional				
Individual	$340.20	$195.16	$145.04	$7.25
Parent/Child or Two Adults	713.40	422.84	290.56	14.53
Family	1,198.32	641.08	557.24	27.86
CIGNA Dental DHMO				
Individual	$503.88	$195.16	$308.72	$15.44
Parent/Child(ren) or Two Adults	966.00	422.84	543.16	27.16
Family	1, 452.12	641.08	811.04	40.55
VISION INSURANCE				
CareFirst Davis Vision				
Individual (Free if FTE is .5 or greater)	$26.28	$26.28	$-	$-
Family (includes Parent/Child and Two Adults)	101.16	26.28	74.88	3.74

**All employee benefits deductions are based upon 20 pay periods*

***Domestic Partner benefits may be subject to imputed income*

Medical, Dental, and Vision Deductions for Part-Time Employees

Effective 1/1/2017 – 12/31/2017

	Part-Time Employee Bi-Weekly Deduction* Your Full-Time Equivalency (FTE)				
MEDICAL INSURANCE **					
CIGNA OAPIN (In Network)	**.900**	**.800**	**.700**	**.600**	**.500**
Individual	$90.82	$123.67	$156.53	$189.38	$222.23
Parent/Child	179.95	245.04	310.13	375.22	440.31
Two Adults	216.75	295.14	373.54	451.93	530.33
Family	244.37	332.76	421.15	509.54	597.93
CIGNA OAP (In/Out Network)					
Individual	$122.18	$157.08	$191.99	$226.89	$261.80
Parent/Child	242.05	311.21	380.36	449.52	518.68
Two Adults	291.54	374.84	458.13	541.43	624.73
Family	328.70	422.62	516.53	610.45	704.36
Kaiser Permanente HMO					
Individual	$101.57	$138.30	$175.04	$211.77	$248.51
Parent/Child(ren)	201.22	274.00	346.78	419.56	492.34
Two Adults	242.36	330.02	417.69	505.35	593.01
Family	273.26	372.09	470.93	569.77	668.60
DENTAL INSURANCE **					
CareFirst Regional Dental PPO	**.900**	**.800**	**.700**	**.600**	**.500**
Individual	$6.23	$7.20	$8.18	$9.15	$10.13
Parent/Child or Two Adults	13.49	15.61	17.72	19.84	21.95
Family	20.46	23.67	26.87	30.08	33.28
CareFirst Regional Dental Traditional					
Individual	$8.23	$9.20	$10.18	$11.15	$12.13
Parent/Child or Two Adults	16.64	18.76	20.87	22.99	25.10
Family	31.06	34.27	37.47	40.68	43.88
CIGNA Dental DHMO					
Individual	$16.42	$17.39	$18.37	$19.34	$20.32
Parent/Child(ren) or Two Adults	29.27	31.39	33.50	35.62	37.73
Family	43.75	46.96	50.16	53.37	56.57
VISION INSURANCE					
CareFirst Davis Vision	**.900**	**.800**	**.700**	**.600**	**.500**
Individual (Free if FTE is .5 or greater)	$-	$-	$-	$-	$-
Family (includes Parent/Child and Two Adults)	3.74	3.74	3.74	3.74	3.74

Cost of Coverage for Part-Time Employees

The cost of medical and dental coverage varies according to your full-time equivalency (FTE). All employees are assigned an FTE based on the hours worked as a percentage of the number of hours a full-time employee in that same position would work. For example, an employee who works 20 hours during a week in a position which defines full-time employment as working 40 hours each week would have an FTE of .5.

** All employee benefits deductions are based upon 20 pay periods* *** Domestic Partner benefits may be subject to imputed income*

Your Medical Options – Highlights

BCPS offers eligible employees the choice of the following medical plan options:

- Kaiser Permanente HMO
- Cigna Open Access Plus In-Network – OAPIN
- Cigna Open Access Plus – OAP

None of these plans contain a pre-existing condition limitation. This means that each plan will not exclude benefits for illnesses you had when you joined BCPS.

About Our Medical Plan Options

The medical plans offered through BCPS' flexible benefits program have different ways of delivering health care. BCPS gives you the choice of one Health Maintenance Organization (HMO) plan, one Open Access In-Network plan (OAPIN), and one Open Access in- or out- of-network plan (OAP). The differences between the HMO plan and the Open Access plans are the levels of coverage and the selection of providers. An HMO and Open Access Plus In-Network plan (OAPIN) offers one level of coverage and you must use the network of participating providers. The Open Access Plus (OAP) allows for both in- and out-of – network providers. The flexibility to seek care outside the network translates into a higher price tag from your paycheck. You decide which plan works best for you.

On the following pages you will find a comparison of the benefits provided under each medical option.

Important Note: *This enrollment guide is neither a contract nor a summary description of your health plan choices. If you have specific questions about a particular plan before enrolling in it, call the Office of Benefits, Leaves and Retirement.*

Kaiser Permanente HMO

The Kaiser Permanente HMO option requires the selection of a Primary Care Physician (PCP) to obtain the highest level of coverage. A PCP is typically a general practitioner, a family practitioner, an internist, or a pediatrician. You and each covered member of your family must choose a PCP from the plan's provider directory. The most current provider directory information is available from each plan's Web site, from Member Services, or you may call the Office of Benefits, Leaves and Retirement to obtain a paper copy of the directory. The Open Access Plus In–Network (OAPIN) and the Open Access Plus (OAP) plans do not require a PCP but it is recommended that a PCP be used to coordinate care.

Your PCP provides your medical care or refers you to a specialist, as necessary. Your PCP will get to know your medical history and your individual health care needs.

Primary Care Physicians make sure that you are not receiving unnecessary medical treatment and that the medications that you are taking are safe and effective. There are generally no claim forms to complete or submit. Call the Member Services number on your medical plan identification card for information on changing your PCP.

The Kaiser Permanente HMO product allows employees and their dependents to receive excellent coordination of care, because all of Kaiser Permanente's providers are closely connected. Participants of this plan experience the convenience of having many of their health services in one central location, creating efficiency in health care delivery and saving participants' time and money.

Your Medical Options—Highlights *(continued)*

Cigna Open Access Plus In-Network (OAPIN)

Cigna's Open Access Plus In-Network plan allows you to choose the doctors, health professionals and facilities that work best for you, from a selection of Cigna In-Network providers.

Details about the Cigna OAPIN Plan

Primary Care Physician (PCP)
You decide if you want to choose a PCP as your personal doctor to help coordinate care and act as a personal health advocate. It's recommended but not required.

In-network
For your health care to be covered by the plan, you must choose a health care professional who is part of the Cigna® network.

No-Referral Specialist Care
If you need to see a specialist, you do not need a referral to see a doctor who participates in the Cigna network – just make the appointment and go! Pre-certification may be necessary for hospitalizations and some types of outpatient care, but there is no paperwork for you.

Out-of-network
If you choose to see a doctor who is not in the network, your care will not be covered except in emergencies.

Emergency and Urgent Care
When you need care, you're covered, 24 hours a day, worldwide.

Questions and Answers

What if my doctor isn't on your list?
That means your PCP does not participate in the Cigna network. To receive coverage from your health plan, you must select a doctor from the Cigna list of participating doctors and other health care professionals. If you decide to continue seeing your current doctor, your care will not be covered by your plan.

Do I need a referral to see a specialist?
Though you may want your personal doctor's advice and assistance in arranging care with a specialist, you do not need a referral to see a participating specialist. If you choose an out-of-network specialist, your care will not be covered by your plan.

How does my plan cover my care?
When you visit a doctor who participates in the Cigna network, you receive in-network coverage and will have lower out-of-pocket costs. That's because our participating health care professionals have agreed to charge lower fees, and your plan covers a larger share of the charges. If you choose to visit a doctor outside of the network, your care will not be covered by your plan.

What if I need to be admitted to the hospital?
In an emergency, your care is covered. Requests for non- emergency hospital stays other than maternity stays must be approved in advance or "pre-certified." This enables Cigna HealthCare® to determine if the services are covered. Pre-certification is not required for maternity stays of 48 hours for vaginal deliveries or 96 hours for caesarean sections. Depending on your plan, you may be eligible for additional coverage. Any hospital stay beyond the initial 48 or 96 hours must be approved.

Who is responsible for obtaining pre-certification?
Your doctor will help you decide which procedures require hospital care and which can be handled on an outpatient basis. If your doctor participates in the Cigna network, he or she will arrange for pre-certification. If you use an out-of-network doctor, you are responsible for making the arrangements and your care will not be covered. Your plan materials will identify which procedures require pre-certification.

How do I find out if my doctor is in the Cigna network before I enroll?
Our dedicated Enrollment Information Line is available 24/7 to help you learn about the benefits and advantages of Cigna. Call today and a knowledgeable Enrollment Specialist will provide you with assistance in identifying participating physicians and related service providers.

Call us at **1-800-896-0948** or go to the online provider directory found on www.cigna.com

What is Case Management?
Case management is a program that assists customers with the hardships of an illness. A nurse Case Manager will help to coordinate the most appropriate care and works with you, your family and your physicians for the best results.

Your Medical Options—Highlights *(continued)*

Cigna Open Access Plus (OAP)

Cigna's Open Access Plus plan allows you to choose the doctors, health professionals and facilities that work best for you, with coverage for providers both in and out of the Cigna network.

Details about the Cigna OAP Plan:

Primary Care Physician (PCP)
You decide if you want to choose a PCP as your personal doctor to help coordinate care and act as a personal health advocate. It's recommended but not required.

In-network
Choose to see doctors or other health professionals who participate in the Cigna network to keep your costs lower and eliminate paperwork.

No-referral specialist care
If you need to see a specialist, you do not need a referral to see a doctor who participates in the Cigna network – just make the appointment and go! Pre-certification may be necessary for hospitalizations and some types of outpatient care, but there is no paperwork for you.

Out-of-network
You also have the freedom to visit doctors or use facilities that are not part of the Cigna network, but your costs will be higher and you may need to file a claim.

Emergency and urgent care
When you need care, you're covered, 24 hours a day, worldwide.

Questions and Answers

What if my doctor isn't on your list?
That means your PCP does not participate in the Cigna network. To receive your maximum coverage, you should select a doctor from the Cigna list of participating doctors and other health care professionals. You can continue seeing your current doctor, even if he or she is not in Cigna's network. However, in that case, you will pay higher out-of-pocket costs, and your care will be covered at the out-of-network coverage level.

Do I need a referral to see a specialist?
Though you may want your personal doctor's advice and assistance in arranging care with a specialist in the network, you do not need a referral to see a participating specialist. If you choose an out-of-network specialist, your care will be covered at the out-of-network coverage level.

What is the difference between in-network and out-of-network coverage?
Each time you seek medical care, you can choose your doctor – either a doctor who participates in the Cigna network or someone who does not participate. When you visit a participating doctor, you receive "in-network coverage" and will have lower out-of-pocket costs. That's because our participating health care professionals have agreed to charge lower fees, and your plan covers a larger share of the charges. If you choose to visit a doctor outside of the network, your out-of-pocket costs will be higher.

What if I need to be admitted to the hospital?
In an emergency, your care is covered. Requests for non-emergency hospital stays other than maternity stays must be approved in advance or "pre-certified." This enables Cigna HealthCare to determine if the services are covered. Pre-certification is not required for maternity stays of 48 hours for vaginal deliveries or 96 hours for cesarean sections. Depending on your plan, you may be eligible for additional coverage. Any hospital stay beyond the initial 48 or 96 hours must be approved.

Who is responsible for obtaining pre-certification?
Your doctor will help you decide which procedures require hospital care and which can be handled on an outpatient basis. If your doctor participates in the Cigna network, he or she will arrange for pre-certification. If you use an out-of-network doctor, you are responsible for making the arrangements. Your plan materials will identify which procedures require pre-certification.

What if I go to an out-of-network physician who sends me to a network hospital? Will I pay in-network or out- of-network charges for my hospitalization?
Cigna HealthCare will cover authorized medical services provided by an Open Access Plus participating hospital at your in-network benefits level – whether you were sent there by an in- or out-of-network doctor.

How do I find out if my doctor is in the Cigna network before I enroll?
Our dedicated Enrollment Information Line is available 24/7 to help you learn about the benefits and advantages of Cigna. Call today and a knowledgeable Enrollment Specialist will provide you with assistance in identifying participating physicians and related service providers. Call us at **1-800-896-0948** or go to the online provider directory found on **www.cigna.com**.

What is Case Management?
Case management is a program that assists customers with the hardships of an illness. A nurse Case Manager will help to coordinate the most appropriate care and works with you, your family and your physicians for the best results.

Cigna Prescription Drug Coverage

With Cigna's pharmacy benefit, you'll be able to receive phone and online support.

The prescription program covers most medications which require a prescription by either State or Federal law and are prescribed by a licensed practitioner. Insulin is covered; however, it requires a physician's prescription.

Co-payments – 30 day

- Generic drug- $10.00 copay.
- Brand name drug on the Cigna Pharmacy formulary- $20.00 copay.
- Brand name drug that is non-formulary - $35.00 copay.
- Brand name drugs that have an FDA generic equivalent require a $35 copay plus the cost difference between the brand name drug and its generic equivalent regardless of physician's instructions.

A brand-name drug is protected by a 17-year patent that limits production to one manufacturer. When the patent expires, other companies may manufacture a "generic" version of the drug. The generic is just like the brand-name drug and follows the same FDA safety rules.

The generic is essentially a chemical copy of the brand-name drug. The name, color or shape may be different, but the active ingredients are the same. Examples of generic medications are simvastatin, the generic equivalent of Zocor®, or omeprazole, the generic for Prilosec®.

Acute Medications

For prescription drugs needed for shorter-term needs such as antibiotics, the plan allows for a 30-day supply per copay up to a maximum 102-day supply with refills based on your physician's instructions. Prescriptions filled at a retail Pharmacy require one copay per monthly supply.

Maintenance Medications

For prescription drugs needed on an on-going (sometimes daily basis), the plan allows for a 90-day supply of maintenance medication with refills based on your physician's instructions. Prescriptions filled at a retail Pharmacy require one copay per monthly supply. Mail order prescriptions require two copays for up to 102 day supply.

Cigna Home Delivery Pharmacy

You'll save when you switch from retail to Cigna's accurate, fast home delivery. Other benefits include:

- FDA-approved medications
- Free standard shipping
- 102-day refills
- Daily dose reminders through e-mail, text or phone

Cigna Specialty Pharmacy Services

Are you managing a complex chronic condition that requires a "specialty medication"? Cigna Specialty Pharmacy Services can help you manage your health and prescription needs in the privacy of your home, with 24/7 access to customer service and pharmacists, expert coaches trained on your condition, reminder services and more.

To start a new order, please call us at: **1-800-351-3606**. You can manage delivery of your maintenance prescriptions online at **www.myCigna.com**.

For specialty medications, your prescription drug plan requires you to fill through Cigna Home Delivery Pharmacy. You're allowed one fill at a retail pharmacy before you are required to use Cigna Home Delivery Pharmacy. Otherwise, your plan will not cover the cost of your medication.

Prior Authorization

Some prescription medications require a Prior Authorization review in certain situations before being covered. Prior Authorization verifies that a medication is appropriate for the diagnosis, dosage, frequency and duration of therapy. To initiate a request, have your doctor contact Cigna Pharmacy at **1-877-530-4437**.

Step Therapy

Step Therapy is a prior authorized program which means that certain medications need approval before they are covered. In Step Therapy you and your doctor follow a series of steps when choosing your medication. Step Therapy encourages you to try the most cost-effective and appropriate medications available to treat your condition. Typically, these medications are generics or low cost brands. You need to try these first before more expensive medications are approved.

Cigna Prescription Drug Coverage *(continued)*

When you fill a prescription for a Step Therapy medication, we'll send you and your doctor a letter explaining what steps you need to take before you refill your medication. This may include trying a generic or lower cost alternative, or asking Cigna for authorization for coverage of your medication. At any time, if your doctor feels a different medication isn't right for you due to medical reasons, he/she can request authorization for continued coverage of a Step Therapy medication.

Prescription Drug List

Cigna's Prescription Drug List (PDL) is an extensive listing of generic and brand name prescription medications. Your pharmacy plan covers the cost of medications on the PDL – all you have to pay is your plan's copays, coinsurance and/ or deductibles. Sometime after Open Enrollment, you'll be able to access that list on myCigna.com.

Your PDL splits medications into three categories, or tiers:

- 1st Tier, Generic Medications:
  Generics have similar strength and active ingredients as their brand name counterparts. You will usually pay less for generic medications.
- 2nd Tier, Preferred Brand Medications:
  These medications will usually cost more than a generic, but may cost less than a non-preferred brand.
- 3rd Tier, Non-Preferred Brand Medications:
  Non-preferred brands generally have generic alternatives and/or one or more preferred brand options within the same drug class. You will usually pay more for non-preferred medications.

How can myCigna.com help me make the most of my pharmacy plan?

You can:

1. Search our list of over 62,000 retail network pharmacies to find a pharmacy near you. If you are on the go and want to access our list on your smartphone, it is GPS accessible which means that we can help you find a pharmacy nearest to you.
2. See your pharmacy claim history, plan details and account balances.
3. Use the prescription drug price quote tool to see and compare real-time drug prices at local retail pharmacies and Cigna Home Delivery Pharmacy[SM]. Pricing is shown specifically for your pharmacy plan. The prescription drug price quote tool is also designed to work easily on your smartphone for use on the go.
4. See a complete list of covered prescription drugs and see the category under which they are covered.

Resources and Programs Available to All Cigna Participants

myCigna.com

Nothing is more important than your good health. That's why there's **www.myCigna.com**—your online home for assessment tools, plan management, medical updates and much more.

On www.myCigna.com you can:

- Choose your doctor and create a personalized list of nearby doctors, hospitals, treatment facilities and much more.
- Print temporary ID cards.
- Verify plan details such as coverage, copays and deductibles.
- Keep track of medical conditions, medications, allergies, surgeries, immunizations and emergency contacts.
- Learn about health conditions, treatments and medications using an interactive medical library.
- Find information and estimate costs in your region for specific medical procedures and treatments.

Register today. It's this easy:

1. Go to myCigna.com and select "Register."
2. Enter your personal details like name, address and date of birth.
3. Confirm your identity with secure information like your Cigna ID, social security number or complete a security questionnaire. This will make sure only you can access your information.
4. Create a user ID and password.
5. Review and submit.

Access to myCigna Mobile App

Life can be busy and complicated. So, we created a simple-to-use tool that can help make your life easier (and healthier) while you're on the go. The myCigna Mobile App helps you personalize, organize and access your important plan information on your phone or tablet. The app has a new look and feel and it's available in Spanish too!

Health Matters – Confidential Health Assessment

At Cigna, your health matters. We're here to make your journey easier. We offer personalized support that meets you where you are, so we can help you get to where you need to be. Simply logon into your myCigna.com account to check out the newest suite of digital tools and online activities.

When you take the health assessment, you answer simple questions about your health and the result is a thorough review of your overall health. It's quick, personal and it's confidential.

Come play.

1. Log in to myCigna.com beginning
2. Go to the "My Health" tab
3. Click on the health assessment tile
   - Choose your game piece to begin
   - Answer questions and complete each step of your assessment journey
   - Finish with information, recommendations and connections to health improvement opportunities

24 Hour Health Information Line

What do you do when your child spikes a fever in the middle of the night? Don't worry, wonder or wait — whenever there's a question about health just call **800-896-0948** to connect with the Health Information Line and talk directly with a specialist trained as a nurse, 24 hours a day, 7 days a week.

Discount Programs – Healthy Rewards

Save money when you purchase health and wellness products and services through the Cigna Healthy Rewards® program. Visit mycigna for online program information or call **1-800-870.3470**.

Programs include-

- Weight and Nutrition
- Fitness and Mind/Body
- Vision, dental and hearing care
- Vitamins, health and wellness products
- Alternative medicine

ONE CONNECTION to total health and well-being

Everyone has different needs when it comes to improving their health and well-being. Do you always know all of your options? Where to get a quick answer? Or where to go for help with a more serious situation?

You now have a team of health specialists – including individuals trained as nurses, coaches, nutritionists, clinicians and counselors – who will listen, understand your needs and help you find solutions, even when you're not sure where to begin.

- Dial one phone number for support – any day, any time.
- Expect service that meets your personal needs, without any extra cost.
- Access confidential assistance from reliable, compassionate professionals.

Partner with a health advocate to take a more active role in your health:

- Maintain good eating and exercise habits
- Receive support and encouragement to set and reach health improvement goals
- Better manage conditions, including coronary artery disease, low back pain, arthritis, high blood pressure, high cholesterol and more.

Learn skills at your own pace online :

- Identify triggers to better cope with and reduce stress
- Improve your sleep
- Increase your physical activity and improve your nutrition.

One phone call lets you:

- Get information to better understand your treatment options - so you and your doctor can choose what works for you.
- Understand preventive screenings and annual exams to meet your needs and preferences.
- Know what to expect and how to prepare if you need to spend time in the hospital or need surgery.
- Get answers to questions about your benefits and finding your way through the health care system.
- Access support 24-hours-a-day when you need help understanding treatment options. For example, how to treat your child's high fever.

Here is one number you need to know:
1.877.459.6150 for your health needs or myCigna.com

GO YOU®

Offered by: Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, or their affiliates.

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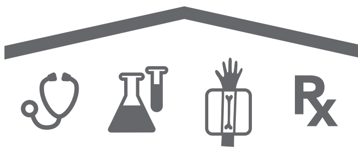
About Kaiser Permanente

It's one neat package

At Kaiser Permanente, we combine health plans, facilities, and practitioners in one neat package—making your membership convenient and easy to use. Our members have relied on this all-in-one model of health care for more than 65 years, and it's something we continue to perfect.



Your health plan made simple

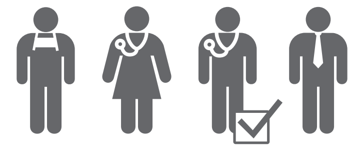
Your health plan is the key to the care you need and so much more, including:

- Freedom to email your doctor's office, anytime, day or night.
- Online tools that let you make appointments, order most prescription refills, and read most lab test results (and so much more).
- Urgent care clinics open on evenings and weekends to suit your needs.
- Health and wellness programs, both online and off, to help you stay well.

Where you go for personalized care

Every Kaiser Permanente facility in our area is connected to your electronic health record, which keeps your care team informed and ready to give you the right care at the right time.

Our medical centers combine state-of-the-art technology and expert physicians in convenient medical centers. Most include pharmacy, lab, and X-ray services on site so you can spend more time on things you enjoy.



A care team focused on you

With Kaiser Permanente, you get a choice of personal physicians for you and your family. To find one that's right for you, just go online to **kp.org/doctor**. All of our Kaiser Permanente physicians work closely together to help you get well and stay well. This teamwork is part of our focus on prevention and our commitment to providing you with personalized care.

What's new in your area

With medical centers close to where you live and work, health care has never been more convenient. To find a location near you, visit **kp.org/facilities** or download a free app for your smartphone or mobile device from the App Store or from Google Play.

Maryland

1 Annapolis Medical Center

2 Camp Springs Medical Center

3 City Plaza Medical Center

4 Columbia Gateway Medical Center

5 Kaiser Permanente Frederick Medical Center

6 Gaithersburg Medical Center

7 Kensington Medical Center

8 **EXPANDING** Largo Medical Center

9 Marlow Heights Medical Center

10 Prince George's Medical Center

11 Severna Park Medical Center

12 Shady Grove Medical Center

13 Silver Spring Medical Center

14 South Baltimore County Medical Center – Open 24/7/365 Days

15 Summit Behavioral Health Center

16 Towson Medical Center

17 White Marsh Medical Center

18 Woodlawn Medical Center

Virginia

19 Ashburn Medical Center

20 Burke Medical Center

21 Fair Oaks Medical Center

22 Falls Church Medical Center

23 Kaiser Permanente Fredericksburg Medical Center†

24 Manassas Medical Center

25 **MOVING** Penderbrook Medical Center

26 Reston Medical Center

27 Springfield Medical Center

28 Tysons Corner Medical Center

29 Woodbridge Medical Center

Washington, D.C.

30 Kaiser Permanente Capitol Hill Medical Center

31 Northwest D.C. Medical Office Building

For information about the services all our medical centers provide, visit **kp.org/facilities.**

Medical Options At-a-Glance

Medical Options At-a-Glance Chart

(Summary Plan Document Prevails; visit www.bcps.org/offices/benefits for full details)

Plan Name		Cigna OAPIN	
Plan Facts	Member Services	Cigna (Medical & Pharmacy) 800-896-0948 Cigna (Mental Health) 800-274-7603 EAP - CIGNA Behavioral Health 1-888-431-4334	
	Group Number	3216080	
Benefit Levels			
Calendar Year Deductible (Jan 1 - Dec 31) - Individual - Family		Individual $0 Family $0	
Coinsurance		You pay 0% Plan pays 100%	
Calendar Year Out-of-Pocket Maximum - Individual - Family		Medical: Individual $1,100 Family $3,600	Prescription: Individual $5,500 Family $9,600
Lifetime Maximum		Unlimited	
PROFESSIONAL SERVICES			
Office Visits - PCP - Specialist		Primary Care Physician You pay $15 per visit Specialist You pay $20 per visit	
Physical/Speech/Occupational Therapy Office Visit		You pay $20 per visit 40 days for each therapy per calendar year	
Chiropractic Office Visit		You pay $20 per visit Limited to 40 days per calendar year	
Diagnostic Laboratory Tests, X-Rays		Physician's Office You pay 0% Plan pays 100% Associated PCP or Specialist visit copay may apply.	
Allergy Shots/Other Covered Injections		You pay 0% Plan pays 100%	
Allergy Serum		You pay 0% Plan pays 100%	
Allergy Testing		You pay 0% Plan pays 100%	

Kaiser Permanente	Cigna OAP	
800-777-7902 Kaiser (Mental Health) 866-530-8778	**In-Network** Cigna (Medical & Pharmacy) 800-896-0948 Cigna (Mental Health) 800-274-7603 EAP - CIGNA Behavioral Health 1-888-431-4334	**Out-of-Network** Cigna (Medical & Pharmacy) 800-896-0948 Cigna (Mental Health) 800-274-7603 EAP - CIGNA Behavioral Health 1-888-431-4334
7434-6	3216080	3216080
HMO		
None None	Individual $200 Family $400	Individual $300 Family $600
N/A	You pay 15% Plan pays 85% after the deductible is met	You pay 25% Plan pays 75% after the deductible is met
Individual $3,500 Family $9,400	Medical: Individual $1,000 Family $2,000 Prescription: Individual $5,600 Family $11,200	Medical Individual $1,500 Family $3,000 Prescription: Individual $5,600 Family $11,200
Unlimited	Unlimited	Unlimited
100% after $5 copay 100% after $5 copay (referral required)	Primary Care Physician You pay $20 per visit Specialist You pay $30 per visit	You pay 25% Plan pays 75% after the deductible is met
100% after $5 copay (maximum 30 visits or 90 days per contract year)	You pay $30 per visit 100 days all therapies combined per calendar year (In-network and Out-of-network)	You pay 25% Plan pays 75% after the deductible is met 100 days all therapies combined per calendar year (In-network and Out-of-network)
Discounts available- no referral	You pay $30 per visit Unlimited days per calendar year	You pay 25% Plan pays 75% after the deductible is met Unlimited days per calendar year
100%	Physician's Office You pay 0% Plan pays 100% Associated PCP or Specialist visit copay may apply.	You pay 25% Plan pays 75% after deductible is met
100% after $5 copay	You pay 0% Plan pays 100% no deductible	You pay 25% Plan pays 75% after the deductible is met
100%	You pay 0% Plan pays 100% no deductible	You pay 25% Plan pays 75% after the deductible is met
100% after $5 copay	You pay 15% Plan pays 85% after the deductible is met	You pay 25% Plan pays 75% after the deductible is met

Medical Options At-a-Glance Chart *(continued)*

(Summary Plan Document Prevails; visit www.bcps.org/offices/benefits for full details)

Plan Name		Cigna OAPIN
Plan Facts	Member Services	Cigna (Medical & Pharmacy) 800-896-0948 Cigna (Mental Health) 800-274-7603 EAP - CIGNA Behavioral Health 1-888-431-4334
	Group Number	3216080
Benefit Levels		
PREVENTIVE CARE		
Well Child Visit/Immunization		You pay 0% Plan pays 100%
Routine Gynecological Exam (no referral required)		You pay 0% Plan pays 100%
Routine Pap Smear (no referral required)		You pay 0% Plan pays 100%
Routine Mammogram (once per 12 months)		You pay 0% Plan pays 100%
Routine Adult Physical		You pay 0% Plan pays 100%
PSA Testing		You pay 0% Plan pays 100%
HOSPITAL SERVICES (Inpatient & Outpatient)		
Semi-Private Room and Board		$100 copay per admission, then You pay 0% Plan pays 100%
Lab Tests and X-Rays (Outpatient)		Physician's Office You pay 0% Plan pays 100% Associated PCP or Specialist visit copay may apply.
Home Health Care		You pay 0% Plan pays 100% Unlimited days per calendar year
Skilled Nursing Facility/Rehab Facility Care		You pay 0% Plan pays 100% 100 days per calendar year
Physician/Surgical Services		You pay 0% Plan pays 100%
Anesthesia Services		You pay 0% Plan pays 100%

Kaiser Permanente	Cigna OAP	
800-777-7902 Kaiser (Mental Health) 866-530-8778	**In-Network** Cigna (Medical & Pharmacy) 800-896-0948 Cigna (Mental Health) 800-274-7603 EAP - CIGNA Behavioral Health 1-888-431-4334	**Out-of-Network** Cigna (Medical & Pharmacy) 800-896-0948 Cigna (Mental Health) 800-274-7603 EAP - CIGNA Behavioral Health 1-888-431-4334
7434-6	3216080	3216080
HMO		
100%	You pay 0% Plan pays 100% no deductible	You pay 25% Plan pays 75% after the deductible is met
100%	You pay 0% Plan pays 100% no deductible	You pay 25% Plan pays 75% after the deductible is met
100%	You pay 0% Plan pays 100% no deductible	You pay 0% Plan pays 100% no deductible
100%	You pay 0% Plan pays 100% no deductible	You pay 0% Plan pays 100% no deductible
100% (once per calendar year)	You pay 0% Plan pays 100% no deductible	You pay 25% Plan pays 75% after the deductible is met
100%	You pay 0% Plan pays 100% no deductible	You pay 0% Plan pays 100% no deductible
100%	You pay 15% Plan pays 85% after the deductible is met	You pay 25% Plan pays 75% after the deductible is met
100%	Physician's Office You pay 0% Plan pays 100% Associated PCP or Specialist visit copay may apply.	You pay 25% Plan pays 75% after deductible is met
100%	You pay 0% Plan pays 100% no deductible 130 days per calendar year (In-network and Out-of-network)	You pay 25% Plan pays 75% after the deductible is met 130 days per calendar year (In-network and Out-of-network)
100% (maximum of 100 days per plan year)	You pay 15% Plan pays 85% after the deductible is met 120 days per calendar year (In-network and Out-of-network)	You pay 25% Plan pays 75% after the deductible is met 120 days per calendar year (In-network and Out-of-network)
100%	You pay 15% Plan pays 85% after the deductible is met	You pay 25% Plan pays 75% per visit after the deductible is met
100%	You pay 15% Plan pays 85% after the deductible is met	You pay 25% Plan pays 75% after the deductible is met

Medical Options At-a-Glance Chart *(continued)*

(Summary Plan Document Prevails; visit www.bcps.org/offices/benefits for full details)

Plan Name		Cigna OAPIN
Plan Facts	Member Services	Cigna (Medical & Pharmacy) 800-896-0948 Cigna (Mental Health) 800-274-7603 EAP - CIGNA Behavioral Health 1-888-431-4334
	Group Number	3216080
Benefit Levels		
HOSPITAL SERVICES (Inpatient & Outpatient) (CONT.)		
Medical Consultations		Outpatient - Primary Care Physician You pay $15 per visit Specialist You pay $20 per visit Inpatient - You pay 0% Plan pays 100%
ICU/CCU		$100 copay per admission, then You pay 0% Plan pays 100%
Hospice Care		You pay 0% Plan pays 100%
Dialysis/Radiation/Chemotherapy (Inpatient)		$100 copay per admission then You pay 0% Plan pays 100%
Dialysis/Radiation/Chemotherapy (Outpatient)		You pay 0% Plan pays 100%
Physical/Speech/Occupational Therapy (Inpatient)		$100 copay per admission then You pay 0% Plan pays 100%
Physical/Speech/Occupational Therapy (Outpatient)		You pay $20 per visit, 40 days for each therapy per calendar year
Outpatient Diagnostic Services		You pay 0% Plan pays 100%
SUPPLIES		
Durable Medical Equipment		You pay 0%, plan pays 100%,(unlimited maximum) Hearing aids for adult and children: Unlimited dollar amount, 2 hearing aids every three years
Prosthetic Devices and Orthopedic Braces		You pay 0% Plan pays 100% Unlimited Maximum per Calendar Year
Diabetic Supplies		You pay 0% Plan pays 100%

Kaiser Permanente	Cigna OAP	
800-777-7902 Kaiser (Mental Health) 866-530-8778	**In-Network** Cigna (Medical & Pharmacy) 800-896-0948 Cigna (Mental Health) 800-274-7603 EAP - CIGNA Behavioral Health 1-888-431-4334	**Out-of-Network** Cigna (Medical & Pharmacy) 800-896-0948 Cigna (Mental Health) 800-274-7603 EAP - CIGNA Behavioral Health 1-888-431-4334
7434-6	3216080	3216080
HMO		
100%	Outpatient - Primary Care Physician You pay $20 per visit Specialist You pay $30 per visit Inpatient - You pay 15% Plan pays 85% after the deductible is met	Outpatient and Inpatient You pay 25% Plan pays 75% after the deductible is met
100%	You pay 15% Plan pays 85% after the deductible is met	You pay 25% Plan pays 75% after the deductible is met
100%	You pay 0% Plan pays 100% no deductible	You pay 0% Plan pays 100% no deductible
100%	You pay 15% Plan pays 85% after the deductible is met	You pay 25% Plan pays 75% after the deductible is met
100% after $5 copay	You pay 0% Plan pays 100% no deductible	You pay 25% Plan pays 75% after the deductible is met
100%	You pay 15% Plan pays 85% after the deductible is met 100 days per calendar year (In-network and Out-of-network)	You pay 25% Plan pays 75% after the deductible is met 100 days per calendar year (In-network and Out-of-network)
100% after $5 copay	You pay $30 per visit 100 days per calendar year (In-network and Out-of-network)	You pay 25% Plan pays 75% after the deductible is met 100 days per calendar year (In-network and Out-of-network)
100%	You pay 0% Plan pays 100%	You pay 25% Plan pays 75% after the deductible is met
100% of allowed benefit for basic DME; Hearing aids for adults and children 1 per ear every 36 months to $1,000 max per ear for adults; $1,400 max per ear for children.	You pay 0%, plan pays 100%,(unlimited maximum) Hearing aids for adult and children: Unlimited dollar amount, 2 hearing aids every three years	You pay 0%, plan pays 100%,(unlimited maximum) Hearing aids for adult and children: Unlimited dollar amount, 2 hearing aids every three years
100% of allowed benefit	You pay 0% Plan pays 100% no deductible Unlimited Maximum per Calendar Year	You pay 25% Plan pays 75% after deductible is met Unlimited Maximum per Calendar Year
80% of allowed benefit	You pay 0% Plan pays 100% no deductible	You pay 25% Plan pays 75% after deductible is met

Medical Options At-a-Glance Chart *(continued)*

(Summary Plan Document Prevails; visit www.bcps.org/offices/benefits for full details)

Plan Name		Cigna OAPIN
Plan Facts	Member Services	Cigna (Medical & Pharmacy) 800-896-0948 Cigna (Mental Health) 800-274-7603 EAP - CIGNA Behavioral Health 1-888-431-4334
	Group Number	3216080
Benefit Levels		
EMERGENCY SERVICES		
Emergency Room if admitted if discharged		You pay $50 per visit (copay waived if admitted)
Urgent Care		Copay waived if admitted, You pay $25 per visit, no deductible
Ambulance (Air Ambulance if medically necessary)		You pay 0% Plan pays 100%
MATERNITY/INFERTILITY SERVICES*		
Pre- and Postnatal Care and Delivery		Initial Visit to confirm pregnancy Primary Care Physician You pay $15 per visit Specialist You pay $20 per visit Global Maternity Professional Fees You pay 0% Plan pays 100% Inpatient Facility $100 copay per admission, then You pay 0% Plan pays 100%
Sterilization/Reverse Sterilization		Physician's Office Primary Care Physician You pay $15 per visit Specialist You pay $20 per visit Inpatient Facility $100 copay per admission, then You pay 0% Plan pays 100% Outpatient Facility You pay 0% Plan pays 100% Excludes reversal of sterilization
Elective Abortions in Inpatient and Outpatient Facility		Primary Care Physician You pay $15 per visit Specialist You pay $20 per visit Inpatient Facility $100 copay per admission, then You pay 0% Plan pays 100% Outpatient Facility; Physician's Services You pay 0% Plan pays 100%

*****Important Notice About Maternity Coverage and Newborn Length of Stay*** *Under federal law, group health plans and health insurance issuers offering group insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to: Less than 48 hours following a normal vaginal delivery or; Less than 96 hours following a cesarean section.However, the plan or health insurance issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or the newborn earlier.In addition, under federal law, plans and issuers may not set the level of benefits or out-of-pocket*

Kaiser Permanente	Cigna OAP	
800-777-7902 Kaiser (Mental Health) 866-530-8778	**In-Network** Cigna (Medical & Pharmacy) 800-896-0948 Cigna (Mental Health) 800-274-7603 EAP - CIGNA Behavioral Health 1-888-431-4334	**Out-of-Network** Cigna (Medical & Pharmacy) 800-896-0948 Cigna (Mental Health) 800-274-7603 EAP - CIGNA Behavioral Health 1-888-431-4334
7434-6	3216080	3216080
HMO		
100% 100% after $35 copay	You pay $70 per visit no deductible (copay waived if admitted) Copay waived if admitted, You pay $30 per visit, no deductible	You pay $70 per visit no deductible (copay waived if admitted) Copay waived if admitted, You pay $30 per visit, no deductible
100% if medically necessary	You pay 0% Plan pays 100% no deductible	You pay 0% Plan pays 100% no deductible
100%	Initial Visit to confirm pregnancy Primary Care Physician You pay $20 per visit Specialist You pay $30 per visit Global Maternity Professional Fees You pay 5% Plan pays 95% after the deductible is met Inpatient Facility, Outpatient Facility You pay 15% Plan pays 85% after the deductible is met	You pay 25% Plan pays 75% after the deductible is met
Applicable cost share based upon place of service. Reverse sterilization not covered.	Primary Care Physician You pay $20 per visit Specialist You pay $30 per visit Inpatient Facility, Outpatient Facility, Physician's services You pay 15% Plan pays 85% after the deductible is met Excludes reversal of sterilization	You pay 25% Plan pays 75% after the deductible is met Excludes reversal of sterilization
Applicable cost share based upon place of service	Primary Care Physician You pay $20 per visit Specialist You pay $30 per visit Inpatient Facility, Outpatient Facility, Physician's services You pay 15% Plan pays 85% after the deductible is met	You pay 25% Plan pays 75% after deductible is met

costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or the newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. Please contact your health plan's member services unit.

Medical Options At-a-Glance Chart *(continued)*

(Summary Plan Document Prevails; visit www.bcps.org/offices/benefits for full details)

Plan Name		Cigna OAPIN
Plan Facts	Member Services	Cigna (Medical & Pharmacy) 800-896-0948 Cigna (Mental Health) 800-274-7603 EAP - CIGNA Behavioral Health 1-888-431-4334
	Group Number	3216080
Benefit Levels		
MATERNITY/INFERTILITY SERVICES[2]		
Artificial Insemination (requires pre-authorization)		Primary Care Physician You pay $15 per visit Specialist You pay $20 per visit Inpatient Facility $100 copay per admission, then You pay 0% Plan pays 100% Outpatient Facility; Physician's Services You pay 0% Plan pays 100% Unlimited dollar maximum
InVitro Fertilization (requires pre-authorization)		Primary Care Physician You pay $15 per visit Specialist You pay $20 per visit Inpatient Facility $100 copay per admission, then You pay 0% Plan pays 100% Outpatient Facility; Physician's Services You pay 0% Plan pays 100% Unlimited dollar maximum
MENTAL HEALTH AND SUBSTANCE ABUSE		Max (10) EAP visits with Cigna Behavioral or BCPS – Call 410-887-5414 or Cigna Behavioral 888-431-4334
Pre-authorization Required		Yes
Mental Health Inpatient Services		$100 copay per admission, then You pay 0% Plan pays 100%

Kaiser Permanente	Cigna OAP	
800-777-7902 Kaiser (Mental Health) 866-530-8778	**In-Network** Cigna (Medical & Pharmacy) 800-896-0948 Cigna (Mental Health) 800-274-7603 EAP - CIGNA Behavioral Health 1-888-431-4334	**Out-of-Network** Cigna (Medical & Pharmacy) 800-896-0948 Cigna (Mental Health) 800-274-7603 EAP - CIGNA Behavioral Health 1-888-431-4334
7434-6	3216080	3216080
HMO		
Applicable cost share based upon place of service	Primary Care Physician You pay $20 per visit Specialist You pay $30 per visit Inpatient Facility, Outpatient Facility, Physician's services You pay 15% Plan pays 85% after the deductible is met Unlimited dollar maximum	You pay 25% Plan pays 75% after deductible is met $100,000 lifetime maximum
50% of allowed benefit lifetime maximum of $100,000 per member	Primary Care Physician You pay $20 per visit Specialist You pay $30 per visit Inpatient Facility, Outpatient Facility, Physician's services You pay 15% Plan pays 85% after the deductible is met Unlimited dollar maximum	You pay 25% Plan pays 75% after deductible is met $100,000 lifetime maximum
Max (10) EAP visits with Cigna Behavioral or BCPS – Call 410-887-5414 or Cigna Behavioral 888-431-4334	Max (10) EAP visits with Cigna Behavioral or BCPS – Call 410-887-5414 or Cigna Behavioral 888-431-4334	Max (10) EAP visits with Cigna Behavioral or BCPS – Call 410-887-5414 or Cigna Behavioral 888-431-4334
Yes	Yes	Yes
100%	You pay 15% Plan pays 85% after the deductible is met	You pay 25% Plan pays 75% after the deductible is met

Medical Options At-a-Glance Chart *(continued)*

(Summary Plan Document Prevails; visit www.bcps.org/offices/benefits for full details)

Plan Name		Cigna OAPIN
Plan Facts	Member Services	Cigna (Medical & Pharmacy) 800-896-0948 Cigna (Mental Health) 800-274-7603 EAP - CIGNA Behavioral Health 1-888-431-4334
	Group Number	3216080
Benefit Levels		
MENTAL HEALTH AND SUBSTANCE ABUSE[3]		
Mental Health Outpatient Services		Office Visit You pay $20 per visit Outpatient Facility You pay 0% Plan pays 100%
Substance Abuse Inpatient Services		$100 copay per admission, then You pay 0% Plan pays 100%
Substance Abuse Outpatient Services		Office Visit You pay $20 per visit Outpatient Facility You pay 0% Plan pays 100%
OTHER SERVICES		
Kidney, Cornea, Bone Marrow Transplants		Primary Care Physician You pay $15 per visit Specialist You pay $20 per visit Inpatient Facility $100 copay per admission, then You pay 0% Plan pays 100% Outpatient Facility; Physician Services You pay 0% Plan pays 100%
Heart, Heart-Lung, Lung, Pancreas, Liver Transplants (requires pre-authorization)		Primary Care Physician You pay $15 per visit Specialist You pay $20 per visit Inpatient Facility $100 copay per admission, then You pay 0% Plan pays 100% Outpatient Facility; Professional Fees You pay 0% Plan pays 100%

Kaiser Permanente	Cigna OAP	
800-777-7902 Kaiser (Mental Health) 866-530-8778	**In-Network** Cigna (Medical & Pharmacy) 800-896-0948 Cigna (Mental Health) 800-274-7603 EAP - CIGNA Behavioral Health 1-888-431-4334	**Out-of-Network** Cigna (Medical & Pharmacy) 800-896-0948 Cigna (Mental Health) 800-274-7603 EAP - CIGNA Behavioral Health 1-888-431-4334
7434-6	3216080	3216080
HMO		
100% after $5 copay for individual visits; $5 copay for group therapy visits.	Office Visit You pay $30 per visit Outpatient Facility You pay 0% Plan pays 100% after the deductible is met	You pay 25% Plan pays 75% after the deductible is met
100%	You pay 15% Plan pays 85% after the deductible is met	You pay 25% Plan pays 75% after the deductible is met
100% after $5 copay for individual visits; $5 copay for group therapy visits.	Office Visit You pay $30 per visit Outpatient Facility You pay 0% Plan pays 100% after the deductible is met	You pay 25% Plan pays 75% after the deductible is met
100%	Primary Care Physician You pay $20 per visit Specialist You pay $30 per visit Inpatient Facility, Outpatient Facility, Physician's services You pay 15% Plan pays 85% after the deductible is met (covered at 100% at LifeSource Center)	You pay 25% Plan pays 75% after deductible is met
100%	Primary Care Physician You pay $20 per visit Specialist You pay $30 per visit Inpatient Facility, Outpatient Facility, Physician's services You pay 15% Plan pays 85 % after the deductible is met (covered at 100% at LifeSource Center)	You pay 25% Plan pays 75% after deductible is met

Medical Options At-a-Glance Chart *(continued)*

(Summary Plan Document Prevails; visit www.bcps.org/offices/benefits for full details)

Plan Name		Cigna OAPIN
Plan Facts	Member Services	Cigna (Medical & Pharmacy) 800-896-0948 Cigna (Mental Health) 800-274-7603 EAP - CIGNA Behavioral Health 1-888-431-4334
	Group Number	3216080
Benefit Levels		
OTHER SERVICES (continued)		
Organ Transplant Procurement		Unlimited
Organ Transplant Travel		Travel maximum $10,000 per transplant (only available if using Lifesource Facility)
Cardiac Rehabilitation		You pay $20 per visit 40 days per calendar year
PRESCRIPTION DRUG SERVICES		
Retail		Prescription services provided through Cigna. Copays are per fill at participating pharmacies up to a 30-day supply. Patients may purchase up to 90 day supply at retail, however (3) copays will apply for 90 day supply. Mandatory generic – $10 Formulary brand – $20 Non-formulary brand – $35
Mail Order		Prescription services provided through Cigna. Copays are per fill up to a 90-day supply. Mandatory generic $20 Formulary brand - $40 Non-formulary brand - $70
VISION		Routine vision services not covered
DENTAL		Routine dental services not covered
COMMENTS		• Chiropractic care, Acupuncture & massage therapy discount available. No referral required. www.mycigna.com

Kaiser Permanente	Cigna OAP	
800-777-7902 Kaiser (Mental Health) 866-530-8778	**In-Network** Cigna (Medical & Pharmacy) 800-896-0948 Cigna (Mental Health) 800-274-7603 EAP - CIGNA Behavioral Health 1-888-431-4334	**Out-of-Network** Cigna (Medical & Pharmacy) 800-896-0948 Cigna (Mental Health) 800-274-7603 EAP - CIGNA Behavioral Health 1-888-431-4334
7434-6	3216080	3216080
HMO		
100% covered if recipient is the member	Unlimited	Unlimited
Limited benefit	Travel maximum $10,000 per transplant (only available if using Lifesource Facility)	Not Applicable
100% after $5 copay	You pay $30 per visit Unlimited days per calendar year	You pay 25% Plan pays 75% after the deductible is met Unlimited days per calendar year
Copays are per fill up to a 60-day supply. Mandatory generic – $5 Brand – $5 At a participating community pharmacy: Mandatory generic – $15 Brand – $15	Prescription services provided through Cigna. Copays are per fill at participating pharmacies up to a 30-day supply. Patients may purchase up to 90 day supply at retail, however (3) copays will apply for 90 day supply. Mandatory generic – $10 Formulary brand – $20 Non-formulary brand – $35	Prescription services provided through Cigna. Copays are per fill at participating pharmacies up to a 30-day supply. Patients may purchase up to 90 day supply at retail, however (3) copays will apply for 90 day supply. Mandatory generic – $10 Formulary brand – $20 Non-formulary brand – $35
Copays are per fill for maintenance prescriptions up to a 90-day supply. Mandatory generic – $5 Brand – $5	Prescription services provided through Cigna. Copays are per fill up to a 90-day supply. Mandatory generic $20 Formulary brand - $40 Non-formulary brand - $70	Prescription services provided through Cigna. Copays are per fill up to a 90-day supply. Mandatory generic $20 Formulary brand - $40 Non-formulary brand - $70
$5 copayment for routine exam; discount on lenses & frames available	Routine vision services not covered	Routine vision services not covered
None	Routine dental services not covered	Routine dental services not covered
• Chiropractic care, acupuncture & massage therapy discount available. No referral required. my.kp.org/mida/bcps or www.kp.org	• Chiropractic care, Acupuncture & massage therapy discount available. No referral required. www.mycigna.com	• Chiropractic care, Acupuncture & massage therapy discount available. No referral required. www.mycigna.com

Your Dental Options – Highlights

BCPS Offers Three Dental Options:

- CareFirst BlueCross BlueShield Regional Dental PPO
- CareFirst BlueCross BlueShield Regional Dental Traditional
- Cigna Dental Care DHMO

Regional Dental PPO

The CareFirst Dental PPO Program offers two levels of benefits in one plan. When you need dental care, you may see the dentist of your choice. Benefit levels and out-of-pocket expenses are determined based upon whether you receive dental care from a preferred dentist.

In-Network Benefits

When you use a Preferred Provider, you receive the highest level of coverage with the least amount of out-of-pocket expense. In order to choose a preferred dentist, please refer to the Preferred Dental Provider directory or contact Member Services at **866-891-2802.**

Out-of-Network Benefits

You may choose to use dentists outside of the network, but your costs may be higher. There are two types of out-of-network dentists:

- **Participating dentists** are not preferred dentists, but they have agreed to bill only up to the allowed benefit amount by CareFirst BlueCross BlueShield, thus limiting your out-of-pocket expense.
- **Non-participating dentists** have no agreement with CareFirst BlueCross BlueShield and may bill you up to their charges, which may increase your out-of-pocket expense. Members who receive care from non-participating dentists must pay for their services at the time the services are rendered and must file a claim for reimbursement directly from CareFirst BlueCross BlueShield.

Plan Highlights

- Each enrolled family member receives up to $1,000 in paid benefits per calendar year
- Flexibility to choose any dentist
- CareFirst Preferred and Participating Providers will file claims for you and cannot balance bill you
- Preventive care is available with no out-of-pocket expense if a CareFirst Preferred Provider is used

Regional Dental Traditional

The CareFirst Traditional Dental Program allows you the freedom to choose any dentist. If you seek care from a CareFirst participating provider, the dentist cannot bill you the difference between their charge and the allowed amount. You are only responsible for deductibles and coinsurance. A non-participating provider will bill for any amount over CareFirst's allowed benefit.

Plan Highlights

- Each enrolled family member receives up to $750 in paid benefits per calendar year
- Flexibility to choose any dentist
- CareFirst's Participating Providers will file claims for you and cannot balance bill

Cigna Dental Care

Cigna Dental Care is a dental health maintenance organization (DHMO). You must select and seek services from your DHMO facility. No benefits are available if non-participating dentists are used. For the most current information regarding participating dentists in your area, call **800-896-0948**. You may also visit Cigna's Web site at **www.Cigna.com/dental**. Both resources are available 24 hours a day. You may change your primary dentist selection by calling Member Services. In most cases, the change will take effect on the first day of the following month.

Plan Highlights

- There is no deductible
- There are no annual dollar maximums
- There are no claim forms for you to file
- All preventive care and some restorative care is available with zero copayments from you
- Complex procedures are available for low, pre-set patient charges that are published in the Patient Charge Schedule

Your Dental Benefits At-a-Glance Chart

Dental Plans

	CareFirst BlueCross BlueShield Regional Dental PPO Group# 7J91		CareFirst BlueCross BlueShield Regional Dental Traditional Group# 7J91	Cigna Dental DHMO Group# 10013509
Covered Service	In-Network (Preferred)	Out-of-Network (Participating or non-participating*)	Participating or non-participating*	In-Network Only
Deductible per calendar year**	$10 per person $20 per family	$25 per person $50 per family	$10 per person $25 per family	$-0-
Maximum Benefit per Calendar Year**	$1,000 per person		$750 per person	Unlimited
	PLAN PAYS:			
Preventive Care Exams, Cleanings, X-rays, Fluoride	100%	80%	100% when using a Participating Provider (Non-Participating Providers can balance bill)	100%
Restorative Care Fillings, Crowns, Root Canals	80% after deductible	60% after deductible	80% after deductible*	Most fillings and root canals: no out-of-pocket expense; copayments for other covered procedures range from $0 to $220
Periodontic Services	80% for limited services after deductible	60% for limited services after deductible	80% for limited services after deductible	Copayments for covered procedures range from $15 to $335, no deductible
Prosthetic Services, Dentures, Bridgework	50% after deductible	30% after deductible	50% after deductible	Copayments for covered procedures range from $15 to $335; no deductible
Emergency Care	Paid according to covered service. No additional emergency provisions are provided.			$0 ($54 after regularly scheduled hours)
Orthodontia Services	50% after deductible ($1,500 lifetime maximum)	50% after deductible ($1,000 lifetime maximum)	50% after deductible ($1,000 lifetime maximum)	Copayments vary from case to case. Maximum benefit of 24 months. See patient charge schedule for details.
	(for dependent children only to age of 19 - end of month)		(for dependent children only to age of 19 - end of month)	

* *CareFirst payments based on allowed benefits. Non-participating providers can bill any amount over the CareFirst BlueCross BlueShield allowed benefit.*
** *Calendar Year means January 1 through December 31.*

Vision Insurance

Davis Vision, one of the nation's leading managed vision care companies, will continue to provide vision benefits. Davis Vision has a provider network consisting of 22,000 private practitioners, independent optometrists and ophthalmologists, opticians, and retailers nationwide.

Expanded network
Many national and regional retail stores are now in-network, including Wal-Mart, Target Optical, Sears Optical, Pearle Vision, and Doctor's Visionworks! To find a vision provider, please visit www.carefirst.com and click on "Find a Doctor" or call Davis Vision at **888-336-7125**.

Collection of covered frames
If you select a frame from the Davis Vision Tower Collection, available at independent providers, you will not have a copay. If you select a non-Tower frame, you will be given up to $130 towards the retail cost.

Who is eligible
All employees who have a full-time equivalency of .500 or greater are eligible, and the Board pays 100% of the cost. You have the option of covering your dependents. If you and your spouse are both employees of BCPS, you may not insure each other and only one of you may provide coverage for your children.

Benefit	From Davis Vision Provider	From Out-Of-Network Provider*
Examination (every 12 months[1])	$20 Copay	Covered up to $35
Spectacle Lenses (every 24 months[2])	$20 Copay	Covered up to $25/single vision Covered up to $40/bifocal Covered up to $55/trifocal Covered up to $80/lenticular
Frames (every 24 months) Tower Collection Non-Tower Frames	Covered in full Covered up to $130	Covered up to $35
Contact Lenses[3] (every 24 months[2]) • Elective (in lieu of frames & lenses) • Medically Necessary**	Covered up to $130 $20 Copay	Covered up to $130 Covered up to $210
Laser Vision Correction	Discounted services	None

1 Based on your last date of service.

2 Basic single vision, lined bifocal or lined trifocal lenses.

3 Patients choosing contacts use their eligibility for a frame and lenses. Fitting is included if Davis Vision Collection contact lenses are prescribed. You are responsible for all charges after the allowed amount for non-Davis Vison Collection contact lenses.

** You are responsible for all charges for services received out-of-network and must file a claim for reimbursement up to the plan benefit. Claims must be submitted within twelve months of the date of service.*

*** Medically Necessary – Contact lenses prescribed for conditions where visual acuity cannot be adequately corrected with eyeglasses but can be corrected by contact lenses. Preapproval required.*

In-Network Providers

All in-network or participating Davis Vision providers will offer the following services at no additional cost.

- One year breakage warranty on plan eyeglasses
- Plastic or glass lenses
- Oversized lenses

Before selecting your eyewear, ask your doctor what is fully covered by your vision plan through Baltimore County Public Schools. To find a provider near you, please visit www.carefirst.com and click on "Find a Doctor" or call CareFirst Davis Vision at 888-336-7125.

Vision Insurance

Out-of-Network Providers

Should you choose to visit an eye care professional not in the Davis Vision network, you will still receive coverage; however, your out-of-pocket costs will be higher than if you had visited a network provider.

***Note:** Please be aware that non-Davis Vision providers will expect the entire payment up-front. You may then seek reimbursement by submitting a claim form to CareFirst Davis Vision. You will be reimbursed up to your allowed amounts.*

Discounted Rates on Special Services

In addition to your standard eye glass coverage, you will also be offered discounts or pre-negotiated fees for additional options.

- Laser Vision correction – when using a provider in the Davis Vision Laser Vision network, you are entitled to a discount of up to 25% off providers usual and customary charge or a 5% discount from the Laser center's advertised special.
- Lens 123 Mail Order Replacement Contact Lens Program – allows significant savings of up to 50% on replacement contact lenses. Lens 123 will guarantee the lowest price. You would simply call **1-800-LENS123** with a valid prescription for replacement contacts or additional boxes.
- 20% courtesy discount at most Davis Vision participating offices towards the purchase of items not covered, such as a second pair of glasses.

Prescription Changes

If your lens prescription changes before you are eligible for new lenses and that prescription meets at least one of the following criteria, lenses and frames will be replaced at a 12-month frequency:

a. a new prescription differs from the original by at least .50 diopter sphere or cylinder;
b. an axis change of 15 degrees or more;
c. a .5 prism diopter change in at least one eye.

For More Information

Call Davis Vision's dedicated Baltimore County Customer Service Department at **888-336-7125**, Mon. – Fri., 8am – 11pm, Sat. 9 am – 4 pm, Sun. noon – 4 pm, Eastern time.

To access the Davis Vision Web site, visit **www.carefirst.com** and click on *"Find a Doctor"* in the Solution Center. Then click on *"Vision"* under Search by Provider Type.

Example Costs for Glasses (Lenses & Frames)	
You can save a significant amount of money if you use a Davis Vision Provider as shown below.	
Example 1 Single vision Spectacle lenses with Tower Collection Frames from a Davis Vision Provider	**You Pay:** • $20 for lenses • Frames covered in full
Example 2 Single vision Spectacle lenses with Non-Tower Collection Frames from a Davis Vision Provider	**You Pay:** • $20 for lenses • Frames covered up to $130 retail; you pay the balance
Example 3 Single vision Spectacle lenses and Frames from an out-of-network provider	**You Pay:** • Lenses: Balance after $25 Allowance • Frames: Balance after $35 Allowance **Total $60**

Example Costs for Contact Lenses	
You can save a significant amount of money if you use a Davis Vision Provider as shown below.	
Example 1 Elective Contact Lenses from the Davis Vision Collection	**You Pay:** • $0 Fitting • Contact Lenses: covered in full
Example 2 Other Elective Contact Lenses (Non-Davis Vision Collection)	**You Pay:** • Fitting-Provider's charge • Contact Lenses: balance after $130 allowance
Example 3 Medically Necessary Contact Lenses	**You Pay:** • Fitting-Provider's charge • Contact Lenses-$20 copay from in-network provider • Contact Lenses: balance after $210 allowance from out-of-network provider

Special Services	
Tinting	$0
Standard Progressive Lenses	$50
Premium Progressive Lenses	$90 (Varilux™, Kodak™, Rodenstock™)
Scratch Resistant Coating	$20
Glare Resistant Treatment	$35
Plastic Photosensitive Lenses	$65 (Transitions™)
Polycarbonate Lenses	$30 (Polycarbonate lenses covered in full for dependent children, monocular patients and patients with prescription ≥ +/- 6.00 diopter.)

Flexible Spending Accounts (FSA) Highlights

Flexible Spending Account (FSA) Highlights

Who is Eligible?

All active employees working for Baltimore County Public Schools are eligible to participate in the Flexible Spending Accounts (FSA).

How Do Flexible Spending Accounts Work?

Flexible Spending Accounts allow you to set aside dollars from your salary, before paying taxes, to pay for certain out-of-pocket health and dependent care expenses. Tax savings result because you do not have to pay income or FICA taxes on the amount withheld from your paycheck or the reimbursement amount. You choose the amount to be deducted from your gross pay by projecting your health care and dependent care expenses for the Plan Year. The Plan Year starts January 1 and ends December 31. BCPS has pre-funded the elected amount for health care spending accounts, but not the dependent care accounts. Through automatic payroll deductions, the elected amount for health care and dependent care accounts is deposited into your flexible spending account. You can then use your debit card to pay for services or submit a claim to be reimbursed for your expenses.

How Do I Enroll?

BCPS FSA plan administrator is Benefit Strategies. You may enroll by visiting **http://benstrat.navigatorsuite.com** or by calling **888-401-3539.** New enrollees will receive their debit cards on or before January 1.

Type of FSA	Minimum Annual Contribution	Maximum Annual Contribution
Health Care	$100	$2,550
Dependent Care	$500	$5,000

Health Care Spending Account

You may set aside $100 to $2550 annually in a Health Care Spending Account to pay for qualified medical, prescription, over-the-counter (OTC) medical supplies, prescribed over-the-counter (OTC) medications, dental and vision care expenses. The health care expenses may be for you, your spouse, or your dependents (as long as you claim them as dependents on your tax return). Some examples of eligible medical expenses are: orthodontia, copayments, deductibles, acupuncture, chiropractic care, hearing aids and batteries, eyeglasses, smoking cessation expenses, LASIK eye surgery, prescription drug copayments, and prescribed OTC Medications.

How Do I Use My Health Care FSA?

Employees enrolled in the health care FSA will receive a pre-funded health care benefit card which is similar to a debit card. The card can be used to pay for health care goods and services at the time of service or purchase. The card may also be used to pay for your prescription and eligible over-the-counter (OTC) items at participating pharmacies.

You may also choose to submit paper claims on line to Benefit Strategies for health care FSA reimbursement. After paying for qualified expenses, you may submit the FSA claim form along with required documentation to the plan administrator on line. With each reimbursement, you'll receive a statement showing the status of your account. The plan administrator will send you a check reimbursing you up to the amount of your annual election. You also have the option of your FSA reimbursements being deposited directly into your bank account. For more information on the claim process and for a list of all eligible expenses, please visit: **www.benstrat.com/participants_fsa.php**.

Dependent Care Spending Account

The Dependent Care Spending Account helps you pay the cost of day care for your dependents so you and your spouse can work. Eligible dependents for this account must be claimed as dependents on your federal tax return and are either:

- Under age 13 or
- Mentally or physically unable to care for him/herself regardless of age (this may be a spouse or older relative)

If you are single or are jointly filing a tax return, you may contribute up to $5,000 each calendar year. If you are married and filing separately, you may contribute up to $2,550 per year. If you enroll, you must contribute a minimum of $500 per year.

Eligible dependent care expenses include: Licensed Day Care Facility (child or adult), Preschool or Nursery School (not Kindergarten), Before/After-School Programs, Care in Someone Else's Home, Housekeeper who performs dependent care duties, and Day Care Provided by a Non-Dependent Relative over the age of 19*.

** The non-dependent relative must claim this income on their tax return.*

Flexible Spending Account (FSA) Highlights *(continued)*

Important facts to consider about Flexible Spending Accounts

- IRS regulations impose a "use it or lose it" rule that requires you to forfeit any money not used by the end of the Plan Year. **BCPS can neither refund money, nor carry it forward from one Plan Year to the next.**
- You must re-enroll in FSAs each Plan Year, even if the amount of your contribution remains the same.
- You may participate in one or both of the Flexible Spending Accounts; but Health Care and Dependent Care Spending Accounts are treated separately. Money cannot be transferred from one account to the other.
- Employees who end employment with BCPS (i.e. termination, resignation, retirement) have 90 days from the last day worked to submit claims; however **only claims submitted for costs incurred prior to the employee's separation date will be paid.**
- The Internal Revenue Service (IRS) determines which expenses are eligible and which are ineligible. For a detailed list of examples, contact our Benefit Strategies visit their Web site at **www.benstrat.com**.
- New hires and enrollment changes due to a qualified life event, which occur after the beginning of the Plan Year, should determine the number of payroll deductions that remain. The elected amount will be deducted equally from the remaining pay periods in the academic year. Payroll deductions are taken from 20 pays between January 1 and December 31. No deductions for benefits are made in July and August.
- Please remember to save all paperwork and receipts for FSA card transactions in case Benefit Strategies would request documentation to support an expense.

FSA Grace Period (Health Care accounts only)

Grace period applies to Health Care accounts only. Not applicable for Dependent Care account. Expenses incurred during the Grace Period (January 1 through March 15), and approved for reimbursement, will first be paid from any remaining amount from the preceding Plan Year. Any expenses beyond the preceding Plan Year's balance will be reimbursed from the current Plan Year's election. Claims will be paid in the order in which they are approved. All Grace Period expenses must be submitted to Benefit Strategies by March 31. It is important to keep the extension in mind when you determine your new FSA contributions.

Amounts remaining in your account at the end of the Plan Year, that are not applied to pay expenses submitted on or before the March 31 deadline, will be forfeited.

Claim Substantiation

With each claim submitted or debit card transaction substantiation, you may be asked to submit an Explanation of Benefits (EOB), receipt or statement with the following information: Provider/Vendor Name, Date(s) of Service, Description of Service, and Your Portion of Cost. Please submit requested documentation within 30 days of the transaction.

Life Insurance

Basic Life Insurance

BCPS provides $15,000 of basic term life insurance coverage, at no cost, to all permanent full and part-time employees. Prudential is the insurer of the program.

Optional Life Insurance

All permanent full and part-time employees may request optional life insurance to supplement the basic life insurance coverage. Additional coverage can be purchased in increments of your annual salary, with a minimum of 1 times your salary and maximum of 10 times your annual salary, not to exceed $1,000,000.

Note: The multiple of your salary that you select for optional coverage will automatically result in an increase in insurance coverage whenever your salary increases. Similarly, the premium that you pay will be adjusted automatically as a result of changes to your salary or age.

Requesting Optional Life Insurance

Employees may increase, decrease, or cancel the amount of life insurance by completing an enrollment application. Employees increasing insurance must complete a short form health statement questionnaire. Requested increases are subject to approval by Prudential. Optional coverage of $35,000 or less, or the minimum annual salary increment above $35,000, may only be cancelled during open enrollment since this coverage is purchased pre-tax. Amounts over $35,000 may be cancelled at anytime.

Note: *Change amounts must be a multiple of salary.*

Requesting Optional Life Insurance as a New Hire

Employees electing optional life insurance coverage within 60 days of employment, may obtain coverage up to 3.0 times their annual base salary not to exceed $500,000 without providing proof of insurability. Simply select the multiple of salary that you wish to purchase on your Prudential/BCPS enrollment application.

Optional Life Insurance for Your Spouse & Children

You may purchase coverage for your spouse in $25,000 increments not to exceed the total amount of employee coverage to a maximum of $500,000. Eligible children may be insured for $10,000. Optional life insurance for a spouse or unmarried child(ren) may be requested or cancelled at any time. The beneficiary for this coverage is always the employee. Employees may purchase up to $50,000 of insurance for a spouse within 60 days of hire without evidence of insurability. Married children, regardless of age, are not eligible for optional term life insurance.

If you and your spouse are both employees of BCPS, you may not insure each other and only one of you may provide coverage for your children. See the Prudential enrollment packet for more information. Employees with dependent children who are BCPS employees are not eligible for dependent life insurance.

Requesting Additional Optional Life Insurance Due to a Change In Status

Employees may request a change in the amount of life insurance by completing an enrollment application within 30 days of the event. Requested increases are subject to approval by Prudential.

Cancelling or Reducing Optional Life Insurance

The first $35,000, or the lowest multiple that does not go below $35,000, of optional life insurance is paid on a pre-tax basis. Therefore, it may only be cancelled or reduced during open enrollment. Amounts over $35,000, or the lowest multiple that does not go below $35,000, may be cancelled at any time.

Examples:

Base Salary	Multiple of Salary Elected	Total Amount of Optional Life Insurance	Amount (or Multiple) that may be cancelled outside "Open Enrollment"
$16,000	3x	$48,000	May not be changed
$65,000	3x	$195,000	May reduce to 1x salary ($65,000)

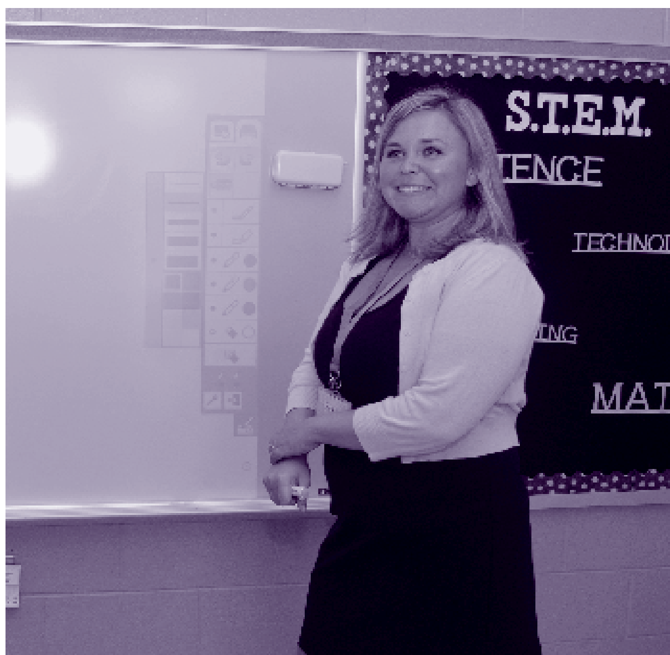
Effective Date of Life Insurance

Basic Life Insurance is effective the first day of the month after your hire date.

Optional Life Insurance that requires no medical underwriting is effective the first day of the month after you enroll.

Call the BCPS Office of Benefits, Leaves and Retirement at 443-809-8943 or e-mail benefits@bcps.org.
Certificates of Insurance are available at www.bcps.org/offices/benefits

Life Insurance



Optional Life Insurance that requires medical underwriting is effective the first day of the month after Prudential has approved the application.

Features of the Plan

- **Waiver of Life Insurance Premium Disability Benefit:** Prudential will waive each Life Insurance premium that becomes due for you under the Group Policy while you are totally disabled under certain conditions listed. When a premium is waived, the amount of Life Insurance equals the amount that would have been provided if you had not become totally disabled. That amount will reduce according to the Schedule of Benefits in effect on the date total disability begins. When a premium is waived it includes (basic and optional) Life Insurance, Accelerated Death Benefit, and Waiver of Premium. It does not include any other benefits as elected under this certificate which were effective at the time of disability.
- **Travel Assistance Services:** As part of the Basic Life insurance, Prudential offers a Travel Assistance Benefit to all permanent full- and part-time employees. This program, offered through the AXA Travel Assistance Program, is a travel assistance service provided to insureds and their dependents while traveling internationally or domestically over 100 miles from home. The program provides medical, travel, legal and financial assistance, 24 hours a day, 365 days a year, including the following services:
  - General travel information about visa, passport, inoculation requirements and local customs
  - Legal referrals
  - Assistance with pet friendly hotel accommodations, boarding facilities and travel home for pets
  - Lost document and luggage assistance
  - Emergency cash/bail assistance
  - 24-hour pre-departure information (weather, currency, holidays)
  - Urgent message transmission
  - Political evacuation
- The Repatriation Benefit is described below, but is only included for employees with optional PAI coverage (Personal Accident Insurance):

  Return of Remains (Repatriation) Benefit – If loss of life occurs outside a 100 mile radius from your home, the plan pays the lesser of the cost to return your remains or $5,000. Return of remains expenses include embalming, cremation, coffin, and transportation of remains.
- **Accelerated Death Benefit:** If you become terminally ill with less than 12 months to live, you may apply to receive up to 80% of your life insurance benefit to a maximum of $600,000. There are no restrictions on how this money can be spent, and no fees will be charged.
- **Portability:** If you terminate your employment, you may be able to "port" your provided coverage. You must complete an application to port your coverage within 31 days of the date that your coverage ends through BCPS.
- **Conversion:** If you are ineligible for the portability provision, then you have the option to convert your term life insurance policy to an individual whole-life level premium plan without having to provide evidence of insurability. You must complete a conversion application within 31 days of the date that your coverage ends through BCPS.

Call the BCPS Office of Benefits, Leaves and Retirement at **443-809-8943** or e-mail **benefits@bcps.org**.

Certificates of Insurance are available at **www.bcps.org/offices/benefits.**

Life Insurance

How Do I Change My Beneficiary Election?

You may designate or update your life insurance beneficiary information quickly and easily at **https://giselfservice.prudential.com**. If you have any questions about Prudential's Web site, your user profile or need additional assistance, contact Prudential's Customer Service at **800-778-3827**, Monday-Friday, 8am-8pm EST.

Your basic life insurance benefit plus your optional benefit (if elected) will be paid to the beneficiary(ies) named. You may select a person(s), your estate, or an organization, such as a charity, as your beneficiary(ies). You must designate a primary beneficiary and have the option of designating contingent beneficiaries. A primary beneficiary is the person(s) who will receive a benefit upon your death. If you name more than one primary beneficiary, then the benefit will be split equally among the surviving beneficiaries if no allocation was made. A contingent beneficiary is the person(s) who will receive a benefit in the event that all of the designated primary beneficiaries die before you.

It is very important that you update your beneficiary designations as your life situation changes (e.g., marriage, divorce, death, birth of a child, etc.) to ensure that your life insurance proceeds are paid to the appropriate person(s). ***A change in your life insurance beneficiary election does not change your pension beneficiary designation; they are separate elections and must be updated separately.***

Optional Life Calculation Worksheet	Your Calculation	Example (30 years old)
Step 1: Enter your annual basic salary (not including bonus or overtime).		**$21,209**
Step 2: Enter the new multiple of salary requested.		**2.00**
Step 3: Multiply the result of Step 1 & 2.		**$42,418**
Step 4: Round the result in Step 3 up or down to the nearest $1,000. This is your requested amount of optional insurance.		**$42,000**
Step 5: Divide by 1,000.		**42**
Step 6: Look on the table to the right for the rate for your age. Enter the rate.		**$.04**
Step 7: Multiply the result of Step 5 by the result in Step 6. This is your bi-weekly deduction.		**$1.68**

Bi-Weekly Insurance Rates

Benefit deductions will be taken from 20 pays.

Age	Rate*
Under 25	0.03
25-29	0.04
30-34	0.04
35-39	0.05
40-44	0.06
45-49	0.09
50-54	0.14
55-59	0.26
60-64	0.40
65-69	0.76
70+	0.96

*Rate changes on birth dates and is the rate per thousand dollars of coverage. The same rate table is used for your spouse/partner

Child Coverage

$10,000	$1.20 bi-weekly

Requested increases are subject to medical underwriting approval. Complete the Prudential Short Form Health Statement Questionnaire located in the back of this guide. Prudential will contact you directly if additional medical underwriting is required. Your payroll deduction and level of coverage will not change until your request is approved by Prudential.

Voluntary Whole Life Insurance

Who is Eligible?

All regular full-time employees and part-time employees working .5 FTE or more are eligible to participate.

What is Whole Life Insurance?

Whole Life Insurance gives you permanent life insurance with cash value that grows over time. You get tax-deferred cash accumulation (based on current tax laws). Benefit payments are reduced by proportionate amounts of any outstanding policy loan.

About the Plan

The voluntary Whole Life plan is insured by VOYA. You can choose to insure yourself, yourself and your eligible dependent children, and your dependent grandchildren.

In the Voluntary Whole Life Plan you can:

- Elect to purchase the greater of $5,000 or the amount that $5 per week will purchase, up to $500,000 for non tobacco users or $250,000 for tobacco users
- Cover your spouse for the greater of $5,000 or the amount that $5 per week will purchase, up to $500,000 for non tobacco users or $250,000 for tobacco users
- Cover your children for either $12,500, $15,000, $20,000 or $25,000 (Rules of dependent eligibility apply)

Requesting Whole Life Insurance as a new hire

Employees may only elect voluntary whole life insurance coverage during the Open Enrollment period. Employees may obtain coverage up to $50,000 without providing proof of insurability if they are between the ages of 15 and 55.

Features of the Plan

Several optional riders are available to enhance coverage:

- Long-Term Care Coverage Rider with restoration and extension of benefits: Long-term care benefits are paid through an acceleration of the life insurance death benefit. The duration and amount of long-term care benefits will vary based on the type of care required – long-term care, assisted living care, home health care, or adult day care. Each month a long-term care payment is made, the life insurance death benefit will be restored. The full insurance amount remains available after the long-term care benefit has been paid.
- Waiver of Premium Rider: If you become totally disabled for at least four consecutive months, your life insurance coverage and any riders will be continued without payment of further premiums while you remain totally disabled. This rider is available to employees who are under age 56.
- Accidental Death Benefit Rider: Coverage equal to the base policy face amount up to a maximum benefit of $150,000 is available for you and your spouse if between the ages of 15 and 60. Benefits are payable for death due to a covered accident (death due to certain causes is not covered).
- Children's Term Life Insurance Rider: If you are under age 61, you can add coverage from $2,000 to $10,000 in $1,000 increments for your eligible dependent children who are under age 24 for a modest premium amount. Once you add this rider, any newly eligible children are automatically covered from the age of 15 days, provided they are not hospitalized. You can also cover your grandchildren who are financially dependent on you and meet the policy's definition of a dependent child.

How to Learn More

For information regarding how to enroll in the voluntary Whole Life insurance thru the Voluntary Benefits Call Center, please either call **877-433-2384**, or e-mail **voluntarybenefits@lwarner.com**.

Benefit Specialists from The Warner Companies will be available Monday through Friday from 9 a.m. until 5 p.m. EST to enroll you. Please note that this number is only active during Open Enrollment.

For questions and service during the year, please either call **866-870-5093** or send an e-mail to **voluntarybenefits@lwarner.com**.

Please visit **www.lwarner.com/BCPS** for more information.

Voluntary Critical Illness Insurance

Who is Eligible?

All regular full-time employees and part-time employees working .5 FTE or more are eligible to participate.

What is Critical Illness Insurance?

Critical Illness Insurance can help relieve the financial impact of a sudden, life-threatening event by helping to pay the direct and indirect costs of the illness. The policy provides a lump-sum cash benefit upon the initial positive diagnosis for the first ever occurrence of a covered critical illness after the policy effective date (Covered critical illnesses are limited to the specific definitions found in the policy.)

About the Plan

The voluntary Critical Illness plan is insured by Transamerica Life Insurance Company, Cedar Rapids, Iowa. You can choose to insure yourself, yourself and your children, or your entire family.

In the Voluntary Critical Illness Plan you can:

- Elect to purchase from $5,000 to $50,000 of coverage
- Cover your spouse for 50% of your benefit amount
- Cover your children for 50% of your benefit amount (Rules of dependent eligibility apply)

Requesting Voluntary Critical Illness Insurance as a New Hire

Employees may only elect voluntary critical illness insurance coverage during the Open Enrollment period. Employees may obtain coverage up to $20,000 without providing proof of insurability.

Schedule of Benefits

The voluntary Critical Illness plan pays a lump sum benefit equal to the Benefit Election multiplied by the applicable percentage shown in the chart below upon the first diagnosis within each category.

If the benefit payment is less than 100% of the selected benefit amount. Transamerica will pay a lump sum benefit amount upon the diagnosis of a different type of critical illness within the same category.

Covered Illness or Event	Transamerica will pay this % of the benefit amount
Category 1	
Heart	100%
Stroke	100%
Heart Transplant Surgery	100%
Coronary Bypass Surgery	25%
Angioplasty/Stent	5%
Category 2	
Major Organ Transplant	100%
Surgery (excluding heart)	
End-Stage Renal Failure	100%
Paralysis Not due to Stroke – all 4 limbs	100%; 50% if fewer than 4 limbs
Burns (3rd degree of 50% coverage)	100%
Category 3	
Invasive Cancer	100%
Carcinoma	25%
Prostate Cancer with TNM	25%
Classification of T1	
Skin Cancer	5%
Cancer Screening Benefit	$50 per calendar year

How to Learn More

For information regarding how to enroll in the voluntary Critical Illness insurance through the Voluntary Benefits Call Center, please either call **877-433-2384**, or e-mail **voluntarybenefits@lwarner.com**.

Benefit Specialists from The Warner Companies will be available Monday through Friday from 9am until 5pm EST to enroll you. Please note that this number is only active during Open Enrollment.

For questions and service during the year, please either call **866-870-5093** or send an e-mail to **voluntarybenefits@lwarner.com**.

Please visit **www.lwarner.com/BCPS** for more information.

Personal Accident Insurance (PAI)

Who Is Eligible?

All permanent full and part-time employees are eligible to participate. If you and your spouse are both employees of BCPS, you may not insure each other and only one of you may provide coverage for your children. Employees with dependent children who are BCPS employees are not eligible for dependent PAI Insurance. Married children of BCPS employees are not eligible for PAI regardless of their age.

About the Plan

The voluntary PAI plan is insured by Prudential. You can choose to insure yourself and your family members against the risk of death or dismemberment from accidental causes.

In the PAI Plan You Can:

- Elect to purchase from $25,000 to $500,000 of coverage if less than 10 times your salary
- Cover your spouse for the same benefit amount that you have elected (up to $500,000) or cover your spouse for half your amount
- Cover your children for 10% of your benefit amount (Rules of dependent eligibility apply)

Beneficiary Information

When you elect PAI, you do not need to designate a beneficiary. The policy will pay based on the life insurance beneficiary designation on file at Prudential.

Prudential will pay the full benefit amount for accidental loss of life occurring within 365 days of a covered accident. To help survivors of severe accidents adjust to new living circumstances, Prudential will pay benefits for paralysis, dismemberment and loss of eyesight, speech, or hearing according to the chart provided.

If within 365 days of a covered accident, bodily injuries result in:	Prudential will pay this % of the benefit amount	
	For you or your spouse:	For your children:
Loss of life	100%	100%
Quadriplegia; Loss of any two: hand, foot or eyesight; Loss of speech and hearing in both ears	100%	200%
Hemiplegia and Paraplegia; Loss of one eye, hand or foot; Loss of speech or loss of hearing in both ears	50%	100%
Loss of thumb and index finger of the same hand	25%	50%
Coma Benefit	1% of the principal sum for up to 11 months and full principal sum after the 12th month	1% of the principal sum for up to 11 months and full principal sum after the 12th month
Child Care Benefit	5% to $5,000 per year up to 4 years	N/A
Spouse Retraining Benefit	Lesser of 5% of the principal sum or $5,000 per year.	N/A

Changing from the Group Plan to Individual Coverage

If, this group coverage ends for any reason except non-payment of premium, you may be able to “port” your coverage. No medical certification is needed. To continue coverage, you must complete an application for portability within 31 days after your group coverage ends. Call Prudential at **800-778-3827**.

Personal Accident Insurance (PAI)

Cost Per 20 Pay Periods

The following chart illustrates examples of the benefit amount and related pay period cost for several plan options. Add the individual costs together to determine your total bi-weekly cost.

		Pay Period Cost For:			
Your Benefit Amount	**Rate Per $1,000**	**You**	**Your Spouse at 100%**	**Your Spouse at 50%**	**Your Children at 10%**
$500,000*	$0.012	$3.60	$3.60	$1.80	$0.36
$400,000*	$0.012	$2.88	$2.88	$1.44	$0.29
$300,000*	$0.012	$2.16	$2.16	$1.08	$0.22
$200,000	$0.012	$1.44	$1.44	$0.72	$0.14
$100,000	$0.012	$0.72	$0.72	$0.36	$0.07
$75,000	$0.012	$0.54	$0.54	$0.27	$0.05
$50,000	$0.012	$0.36	$0.36	$0.18	$0.04
$25,000	$0.012	$0.18	$0.18	$0.09	$0.02

**Benefit amounts over $250,000 cannot be greater than 10 times your annual earnings.*

Example:		
	Benefit Amount	**Cost**
Yourself	$200,000 $1.44	= $1.44
Your Spouse (100%)	$200,000 $1.44	= $1.44
Your Children (10%)	$20,000	= $ 0.14
	Total Pay Period Cost	**$3.02**

Personal Accident Insurance (PAI) *(continued)*

	For You and Your Spouse	For Your Children
Seat Belt Benefit	10% to $25,000	✔
Air Bag Benefit	5% to $5,000	✔
Common Disaster	Spouse Benefit: 100% to $600,000 combined with employee benefit	
Special Education Benefit	10% to $10,000 per chid per year up to 4 years; $1,000 if no dependents qualify	
Spouse Retraining	5% to $5,000	
Increased Dependent Child Benefit	200% to $60,000; if death occurs within 90 days, 100% to $30,000	✔
Child Care Benefit	5% to $5,000 per year up to 4 years (age 13 maximum)	
Coma Benefit	1% up to 11 months, then 100% after 12th month	✔
Monthly Medical Premium Benefit	1% to $200 per month, no more than 12 months while not working	
Felonious Assault Benefit	10% to $10,000 for a physical attack considered a felony or misdemeanor	
Emergency Disaster Response Team Benefit	10% to $10,000 if on BCPS's emergency response team	
Exposure and Disappearance	Disappearance will be considered as loss of life after one year, and Exposure will be treated as an accidental injury	✔
Repatriation	Up to $5,000	✔
Travel Assistance Services	Included	✔

Long-term Disability Insurance (LTD)

How Do I Enroll?

Make the selection for LTD on the Flexible Benefits Enrollment/Change Application Form in the back of this guide.

Who Is Eligible?

Any regular employee over age 18, actively at work whose full-time equivalency equals .5 or more is eligible to join the Voluntary Long-term Disability (LTD) plan insured by Sunlife underwritten by Union Security Insurance Company. Employees can enroll or cancel at any time. (Your union may also offer a members-only LTD Plan. **You cannot participate in both.**)

Pre-Existing Condition Limitation

Proof of good health is not required. Instead, this plan pays no benefit for any injury or sickness, which begins in the first 12 months of your coverage, if the disability results from a pre-existing condition. A pre-existing condition is one for which you have seen a medical practitioner or taken medication in the 3 months before your coverage effective date, and for which you did not go "treatment-free" for 3 months before your disability began.

Plan Highlights

LTD provides continuing income and protection if you become disabled due to an injury, accident, or sickness. If you are qualified as disabled for 180 days, you will be eligible for benefits. The plan pays 66⅔% of your base monthly salary up to a maximum of $10,000 each month while you are disabled. This 66⅔% of your salary is offset by any income from Social Security, workers compensation, or retirement plan(s) if any of these benefits are being received.

Plan Features	Plan Coverage
Payments to You	66⅔% less applicable offset
Benefits Start	After 180 days of disability or once sick leave is exhausted, whichever is later
Combined Benefits	Guarantees total Combined Benefits Payments when this plan is added to Social Security, Workers' Compensation, and Sick Leave Benefits
Duration of Benefits	Maximum benefit period: • Under 60 – the day before retirement age • 60–65 – 36 months • 65–68 – 24 months • 68–70 – 18 months • 70–72 – 15 months • 72 or over – 12 months

How Much Will My Coverage Cost?

You can determine how much your coverage will cost by following the four steps below:

Four Steps:	Calculation	Example (30 yr. old Non-SLB member)
Step 1. Enter your gross or pre-tax pay (not including bonus or overtime)	$	$35,000
Step 2. Enter your rate based on your age and Sick Leave Bank eligibility from the table below	$	.00146
Step 3. Multiply Step 1 by Step 2	$	$51.10
Step 4. Divide Step 3 by 20 to determine the amount of premium that will be deducted from each paycheck	$	$2.55

Rate Chart — Rates Change on Birth Dates

If you are between these ages:	For Sick Leave Bank* Participants:	For Non-Sick Leave Bank Participants:
18 to 24	.00063	.00085
25 to 29	.00077	.00103
30 to 34	.00111	.00146
35 to 39	.00155	.00207
40 to 44	.00299	.00401
45 to 49	.00488	.00650
50 to 54	.00633	.00843
55 to 59	.00704	.00939
60+	.00640	.00852

**For information regarding the Sick Leave Bank, TABCO Members contact TABCO; others contact the Office of Payroll.*

Where To Get More Details About This Plan

For a full description of the plan benefits, limitations, and exclusions please refer to the Long-term Disability Income Plan Booklet available online at **www.bcps.org/offices/benefits** and click on Plan Documents. For specific benefit questions, you may also contact Crawford Advisors, LLC at **888-943-8447**.

Savings and Retirement Benefits

Baltimore County Public Schools offers you several ways to begin saving money through payroll deductions.

- Defined Benefit Pension Plan
- Tax Sheltered Annuities and Custodial Accounts

Defined Benefit Pension Plan

Did you know that the average person needs to replace 60% to 80% of his final income in order to afford retirement? When it comes to retirement planning, it's never too soon to start. Your retirement income will come from more than one source. However, the principal sources of income when you retire are personal savings, Social Security, and your pension from one of the systems in which Baltimore County Public Schools participates. It is important to understand which retirement plan you are eligible for and the benefits your plan will provide at retirement.

Which Retirement Plan am I Eligible For?

Depending on your job classification and the date you were employed, you may be eligible for one of the retirement programs listed below:

	Maryland State Teachers' Pension System (SRA)	Baltimore County Employees' Retirement System (BCERS)
Eligibility provision	Automatic membership after 1980 for eligible employees as defined by Code of Maryland Regulations (COMAR).	Employees in job classifications ineligible for the State Teacher's pension system are eligible for BCERS. Participation is voluntary, subject to the 60 day enrollment window.

Savings and Retirement Benefits *(continued)*

403(b), 403(b)(7), and 457(b) Plans

Tax-Deferred Annuity Plans and Custodial Accounts

You may save for retirement and reduce your current taxes by participating in a Tax-Deferred Annuity Plan or Custodial Account and/or a Deferral Compensation Plan. Sections 403(b), 403(b)(7) and 457(b) of the Internal Revenue Code authorize a tax-deferred retirement savings program for employees of public schools. The account shelters your money from taxes in two ways:

- Pre-tax investing – Investments are made through payroll deductions before federal and state taxes are calculated on your income. FICA tax is also withheld which lowers your current taxable income.
- Tax-deferred compounding – Your contributions and investment earnings accumulate tax-free while in your 403(b) account. You pay taxes only when you withdraw the money.

Important facts to consider about 403(b) and 457(b) plans

- All employees are eligible to participate in the 403(b)/(b)(7) plan and the 457(b) plan.
- Employees do not have to wait until Open Enrollment to begin saving in a plan. You may enroll or disenroll at any time.
- Participation is 100% voluntary. Baltimore County Public Schools does not contribute to your account.
- Deductions are taken from 24 paychecks per calendar year for 12-month employees and from 20 paychecks per calendar year for 10-month employees.

- IRS regulations permit you to set aside up to $18,000 for calendar year 2017. An additional contribution can be made if you are age 50 or older by the end of the calendar year. Contact your approved vendor to assist you in determining your personal annual maximum.
- You may obtain the current listing of authorized providers or other information on the web at: www.bcps.org/offices/benefits. There are currently five 403(b)/(b)(7) providers. Nationwide is the only 457(b) provider.
- Your savings in these accounts are generally not available until age 59½ unless you have a financial hardship, as defined by the IRS. If you meet the hardship requirements, you may be able to borrow or withdraw money from your account before 59½.
- Distributions from a 457(b) plan are not subject to the 10% “early withdrawal” penalty that applies to the 403(b) plans.

Retirement savings options such as 403(b) and 457(b) accounts are intended to provide funds after an individual has reached age 59½. Employees who have to take distributions early should consider contributing to a savings account through our credit union, FFFCU, to avoid incurring tax penalties if funds are needed urgently.

For more information about 403(b) and 457(b) plans:

If you would like more information about participating in one of these plans, please visit our Web site at **www. bcps. org/offices/benefits** and click on “Consider the Benefits.” Or you may also call the Office of Benefits, Leaves and Retirement at **443-809-8943** to obtain a copy of the booklet entitled “Consider the Benefits!”

Savings and Retirement Benefits

Retiree Insurance Benefits

Your retiree insurance benefits are provided by Baltimore County Public Schools regardless of the retirement plan from which you are receiving your pension. Please note that the insurance benefits and the Board's contribution percentages are subject to change in the future depending upon the agreements reached by the Board, its bargaining units, and its funding authorities.

While you may be vested in your pension plan, your ability to participate in the retirement insurance plans of BCPS may be limited. In order to be eligible to participate in retiree benefits now or in the future, you must begin to receive a monthly pension directly following active employment with Baltimore County Public Schools. **An employee who does not qualify to receive a pension currently or who elects to defer pension benefits is ineligible for future participation in the Board's benefit plans.**

Important facts to consider about Retiree Benefits

- Employees planning to retire should visit the Office of Benefits Leaves and Retirement Web site at www.bcps.org/offices/benefits to review the pre-retirement checklist appropriate for their retirement system.
- Upon retirement, you are not required to enroll in a health insurance plan of Baltimore County Public Schools in order to preserve your right to enroll at a later date. As a retiring employee of Baltimore County Public Schools, you may enroll in a health plan and/or change your enrollment selection in the future.
- The cost of your health insurance is paid by you and Baltimore County Public Schools. The Board contributes a specified percentage of the total cost of your health insurance based upon your years of service to BCPS and the specific health insurance plan in which you and your dependents, if applicable, choose to enroll.
- **For purposes of calculating the Board's contribution, only years of service to Baltimore County Public Schools and military service up to 5 years are credited.** Time on unpaid leaves of absence or time worked in a temporary, substitute, or contractual capacity is not credited. No distinction is made between part-time and full-time service.
- The same plans available to active employees are available to retirees who are ineligible for Medicare. Upon reaching eligibility for Medicare (usually at age 65 or if eligible due to disability) retiree's and/or their spouses must enroll in Medicare Parts A & B in order to continue participation in the Board's health insurance plans, and they must then enroll in a different health plan which coordinates with Medicare. Please note that each of the medical plans offered by Baltimore County Public Schools includes coverage for prescription drugs.

What is Creditable Coverage?

Beginning January 1, 2006, Medicare beneficiaries will have the opportunity to receive subsidized prescription drug coverage through the new Medicare Part D program. Beneficiaries who choose not to sign up at the first opportunity may have to pay more if they wait to enter the program later after the open enrollment period.

Beneficiaries who have other sources of drug coverage through a current or former employer or union, may stay in that plan and choose not to enroll in the Medicare drug plan. If their other coverage is at least as good as the new Medicare drug benefit, it is considered "creditable coverage", then the beneficiary can continue to get the high quality care they have now as well as avoid higher payments if they sign up for the Medicare drug benefit.

Under Section 423.56(a) of the final regulation, coverage is creditable if the actuarial value of the coverage equals or exceeds the actuarial value of standard prescription drug coverage under Medicare Part D, as demonstrated through the use of generally accepted actuarial principles and in accordance with CMS actuarial guidelines. In general, the actuarial equivalence test measures whether the expected amount of paid claims under the entity's prescription drug coverage is at least as much as the expected amount of paid claims under the standard Part D benefit.

Required Disclosures to Medicare Beneficiaries

Baltimore County Public Schools must provide a notice of creditable prescription drug coverage to Medicare beneficiaries who are covered by, or who apply for, prescription drug coverage under any of the Baltimore County Public Schools plans.

For a copy of this notice, please visit our Web site at: **www. bcps.org/offices/benefits/benefits_enrollment/** or **www. bcps.org/offices/benefits/retiree_ben/**.

Frequently Asked Questions (FAQs)

Can I Change My Elections During the Year?
IRS regulations require you to keep your elections through December 31 unless you have a Qualified Life Event. Changes must be requested within 30 days of the Qualified Life Event. Plans cannot be changed, only level of coverage depending on the life event.

If I am Enrolled in a Medical Plan and My Doctor Leaves the Network, Can I Change My Election?
No. This is not considered a qualified life change.

How Do I Add A New Child To My Insurance Coverage?
Please see page 11 for information on how to add your new child. You have 30 days from the child's birth date/adoption date to add him/her to your health plans. Coverage will take effect retroactively to the child's date of birth/date of adoption. If you miss this 30-day period, the next opportunity to add would be during the open enrollment period held annually. The bi-weekly cost of your health plan will change according to your new level of coverage.

If an HMO Participant's Family Member Moves to Another Location, Such as a Dependent Child Starts and Resides at School, Do I Need to Change the PCP Elected?
Yes. It is also possible that the dependent child may not be able to continue with a network doctor because there may not be a network doctor available in the new location. No coverage will be available except for life threatening situations. Therefore, you may want to enroll in the Cigna Open Access Plus In-Network (OAPIN) or Cigna OAP Plan.

How is my Coverage Continued While on an Approved Leave of Absence?
If you are on an approved leave of absence from BCPS, your health plan contributions will continue to be deducted from your paycheck as long as you have paid leave (i.e. sick leave, vacation, holiday, etc.) available. When your accrued leave is exhausted or when you cease to be paid by BCPS, you must contact the Office of Benefits, Leaves and Retirement to make arrangements to continue payment of your health plan contributions to ensure continued coverage.

When Does Coverage End?
If your employment ends following the close of the school year, then your medical, dental and vision benefits terminate as of August 31. If your employment ends during the school year, benefits terminate on the last day of the month in which you are in active pay status.

If Medicare Eligible at the time of retirement or employment ending, you must enroll in Medicare Plans Part A and B.

Coverage continues for a child until the end of the month in which the child turns 26. For example, a child whose 26th birthday is on October 11 can be covered until October 31.

How Does BCPS define a Domestic Partner?
A Domestic Partner is defined as an adult 18 years or older, who is of the same or opposite gender of the employee, who is not related by blood, who shares financial obligations with the employee, who has resided with the employee continuously for at least 12 months, who has agreed to be jointly responsible for the welfare of the employee, and who is not legally married to or in a domestic partnership with anyone else.

My Spouse or Domestic Partner is also an employee of BCPS. Can we cover each other for benefits?
If you and your spouse (or domestic partner) are both employees of BCPS, you may each enroll as an individual or one of you can elect two-person or family health care coverage. If you elect coverage separately, you cannot claims each other as a dependent. Your eligible dependent child(ren) may only be covered by one of you.

BALTIMORE COUNTY PUBLIC SCHOOLS • FLEXIBLE BENEFITS ENROLLMENT/CHANGE APPLICATION
JANUARY 1, 2017 — DECEMBER 31, 2017
ACTIVE EMPLOYEES (Please print)*

RETURN COMPLETED FORM TO: **Baltimore County Public Schools, Office of Employee Benefits, Leaves and Retirement 6901 N. Charles Street, Building B, Towson, MD 21204 • Phone: (443) 809-8943 • Fax: (410) 887-8950**

SCAN AND E-MAIL FORM TO: benefits@bcps.org

1. TYPE OF REQUEST- This application is for one of the following:

☐ New hire (Effective ___/___/___) ☐ Open Enrollment ☐ Change in status (Check below) (Effective ___/___/___)

If you have experienced a change in status outside of Open Enrollment, complete this section

Add Dependent(s)**:	Date of event:	Remove dependent(s)**:	Reason for termination:	Date of event:
☐ Marriage	___/___/___	☐ Spouse	☐ Death	___/___/___
☐ Birth of child	___/___/___	☐ Child/children	☐ Divorce	___/___/___
☐ Adoption of child	___/___/___		☐ Child reached age limit	___/___/___
☐ Other (explain) ____________________	___/___/___		☐ Other (explain) ______________	___/___/___

****Must submit request within 30 days of event and attach supporting documentation**

2. SUBSCRIBER INFORMATION

LAST NAME	FIRST NAME	M.I.	MAIDEN/FORMER NAME (If Applicable)	SOCIAL SECURITY NUMBER
				___ ___ ___ / ___ ___ /___ ___ ___ ___

STREET ADDRESS	APT. NO.	DATE OF HIRE (New Hire Only)
		___ ___ /___ ___ /___ ___

CITY	STATE	ZIP

SEX	DATE OF BIRTH	PHONE NO.	MARITAL STATUS	Date of Event
☐ M ☐ F			☐ Single ☐ Married ☐ Partner	___ ___ /___ ___ / ___ ___

3. ELECTION OF BENEFITS - Refer to the Benefits Enrollment and Reference Guide for Details.

MEDICAL PLAN OPTIONS:
Check a plan and a level of coverage
☐ Kaiser Permanente HMO
☐ Cigna OAPIN (in-network only)
☐ Cigna OAP (in/out of network)

☐ Individual
☐ Parent & Child (children for Kaiser only)
☐ Two Adults
☐ Family
☐ I cancel/waive medical coverage

PERSONAL ACCIDENT INSURANCE:
☐ Employee Benefit Amount $_____,000
☐ Spouse (circle one): 50% or 100%
☐ Children: 10%
☐ I cancel/waive PAI insurance

VISION INSURANCE:
CareFirst Davis Plan - Employee coverage is free if your FTE is .500 or greater
☐ Individual
☐ Family
☐ I cancel/waive family vision insurance

LONG-TERM DISABILITY:
☐ I elect LTD coverage
☐ I cancel/waive LTD insurance

CANCER & INTENSIVE CARE INSURANCE
☐ I cancel cancer insurance

OPTIONAL LIFE INSURANCE:
☐ I cancel/waive optional life insurance

DENTAL PLAN OPTIONS:
Check a plan and level of coverage
☐ CareFirst BlueCross BlueShield Regional Dental PPO
☐ CareFirst BlueCross BlueShield Regional Dental Traditional
☐ Cigna Dental DHMO – You must select a Cigna dentist in section 4 below.

☐ Individual
☐ Parent & Child (children for Cigna only)
☐ Two Adults
☐ Family
☐ I cancel/waive dental coverage

4. COVERED EMPLOYEE AND DEPENDENT(S) INFORMATION

PLEASE LIST ALL MEMBERS TO BE COVERED. If you are adding or removing coverage for a dependent, please check the appropriate box below and complete all of the information. **If Kaiser indicate primary care physician or medical center and I.D. #.**

LAST NAME FIRST M.I.	RELATIONSHIP	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER	PRIMARY CARE / FACILITY # PHYSICIAN INFO – KAISER ONLY
	EMPLOYEE/ APPLICANT				NAME:
	SPOUSE/ PARTNER ☐ ADD ☐ REMOVE				NAME:
	CHILD ☐ ADD ☐ REMOVE				NAME:
	CHILD ☐ ADD ☐ REMOVE				NAME:
	CHILD ☐ ADD ☐ REMOVE				NAME:
	CHILD ☐ ADD ☐ REMOVE				NAME:

If you have any questions concerning the benefits and services that are provided by or excluded under the agreement, please contact the applicable plan's membership services representative before signing the application form.
I hereby apply for myself and any dependents listed on this application for the coverage indicated and authorize my employer to deduct from my earnings the amount required to participate in the elected plans. I understand that the elections that I make on this form will remain in effect for the entire Plan Year, unless I am permitted to change them during the Plan Year under special rules contained in the plan that apply only in very limited situations. If I do not complete and file a new enrollment form during the next annual enrollment period, the elections I make on this form will continue in effect indefinitely until changed by me during an annual enrollment period or in connection with the special rules discussed above. I also understand that the elections I make on this form are subject to modification by the Employer to insure that the Plan complies with applicable laws or to reflect increases in the cost of the elected coverage(s) that occur during the Plan Year. I hereby consent, for myself and for all individuals covered by the Plan through me, to any investigations or inquiries into medical condition that are deemed necessary or appropriate by the Plan Administrator and to any disclosures of medical records by anyone deemed necessary or appropriate by the Plan Administrator. I have carefully read this application and agree to its terms. The statements are true and complete and are representations made to induce the issuance of the subscription agreement(s) for which I have applied.

EMPLOYEE'S SIGNATURE DATE

RETAIN A COPY FOR YOUR RECORDS

New Employee Orientation meetings are typically held on the Greenwood campus. Days and hours vary. Confirm with the Office of Staffing at 443-809-4191 for teacher personnel or 443-809-7870 for support service personnel.

Greenwood Campus – Building B and E, 6901 North Charles Street, Towson, Maryland, 21204

- From I-695, take Exit 25 to Charles Street – from the West turn right onto Charles Street. From the East – turn left on Bellona Avenue and left on Charles Street.
- Continue on Charles Street approximately 1 mile to Greenwood Road.
- Turn left on Greenwood Road.
- Proceed approximately .2 miles to entrance to parking lot on the right.
- Building E is on your left.
- New hire orientation is typically held on the first floor of Building E.

The Department of Human Resources

Office of Benefits, Leaves and Retirement

6901 N. Charles Street, Building B,
Towson, MD 21204

www.bcps.org

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