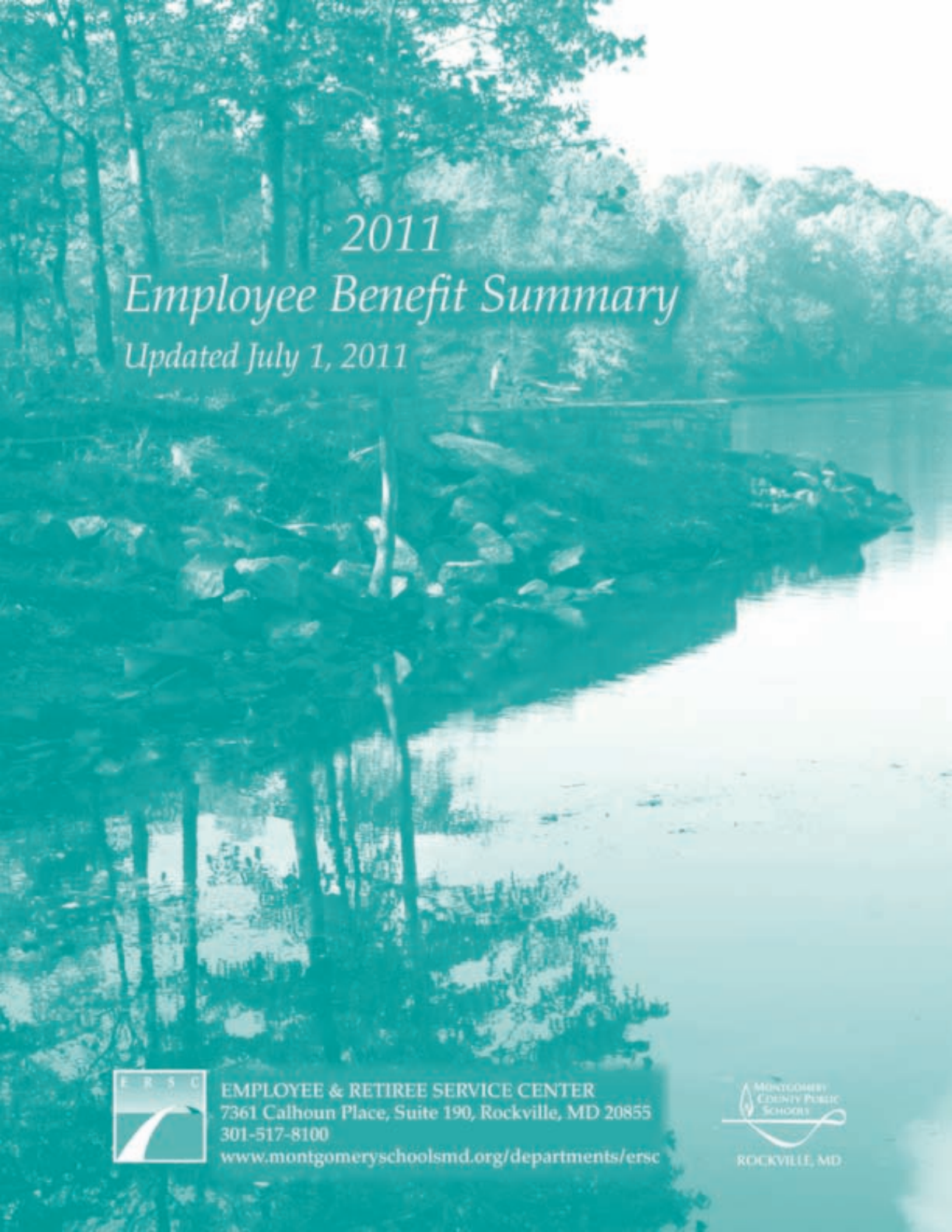

2011
Employee Benefit Summary

Updated July 1, 2011

EMPLOYEE & RETIREE SERVICE CENTER
7361 Calhoun Place, Suite 190, Rockville, MD 20855
301-517-8100
www.montgomeryschoolsmd.org/departments/ersc

Montgomery County Public Schools
ROCKVILLE, MD

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A high-quality education is the fundamental right of every child. All children will receive the respect, encouragement, and opportunities they need to build the knowledge, skills, and attitudes to be successful, contributing members of a global society.

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2011

Montgomery County Public Schools

2011 Employee Benefit Summary for Active Employees

Montgomery County Public Schools (MCPS) provides a comprehensive benefit plan for employees, retirees, and their eligible dependents. As an eligible MCPS employee, you have a variety of benefit options to choose from, including benefits to protect your health, your income, and your future.

The *Employee Benefit Summary* provides an overview of the benefits available to eligible active employees, effective January 1, 2011, and updated July 1, 2011. This summary includes information about eligibility for MCPS benefits, a list of benefit costs, important contact information, and instructions for accessing enrollment forms online.

Keep in mind that this is a summary of the MCPS benefit plan and is intended to help you understand and properly enroll in the plan. Full benefit plan details are available on the Employee and Retiree Service Center (ERSC) website at *www.montgomeryschoolsmd.org/departments/ersc*. Information available on the website includes summary plan and evidence of coverage documents. Provider handbooks are available from ERSC. ERSC staff members are available to assist you Monday through Friday. You may contact ERSC directly at:

Montgomery County Public Schools
Employee and Retiree Service Center
7361 Calhoun Place, Suite 190
Rockville, Maryland 20855
301-517-8100
ERSC@mcpsmd.org

Important Notice

You are not automatically enrolled in the MCPS employee benefit plan. New employees must enroll within 60 days following employment or wait for a future Open Enrollment, typically held in November, with coverage effective January 1 of the following year. You must complete MCPS Form 455-20: *Employee Benefit Plan Enrollment*, to join the employee benefit plan. This enrollment form also is used to make changes during the annual Open Enrollment for active employees, changes due to a qualifying event, and changes for employees returning from leave. This form also is used to designate and change beneficiaries for basic employee term life insurance.

2011

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About Your Benefits

WHO IS ELIGIBLE

You are eligible to enroll in the employee benefit plan if you are a permanent MCPS employee regularly scheduled to work 20 hours or more per week. If your spouse has health coverage through the MCPS employee benefit plan and you are a covered dependent, you may not enroll for coverage as an individual under the MCPS employee benefit plan.

If you are covered under your parent's MCPS employee benefit plan and are subsequently employed by MCPS in a benefits-eligible position, you cannot continue coverage as a dependent on your parent's benefit plan. If you fail to elect your own benefits coverage in the time allotted for new employees, MCPS will automatically unenroll you from your parent's benefits plan. MCPS will then enroll you in the same benefits coverage you previously held.

Eligible Dependents

You may choose to cover your eligible dependents under the MCPS employee benefit plan. Eligible covered dependents must be enrolled in the same coverage in which you are enrolled.

Eligible dependents include your—

- spouse,
- qualified same sex domestic partner, and
- eligible children meeting the following age requirements:
  - until the end of the month in which they turn 26 for medical and prescription coverage
  - until September 30 following their 23rd birthday for dental, vision, and life insurance coverage

The documentation you submit to show eligibility of a spouse, qualified same sex domestic partner, or child(ren) must include but is not limited to the following:

Spouse:

- Social Security number and
- marriage certificate or current joint tax return

Qualified Same Sex Domestic Partner:

- Social Security number and
- signed and notarized MCPS affidavit (available on ERSC website) plus additional documentation as required by the affidavit

Newborn or Biological Children:

- Social Security number and
  - birth certificate or birth registration

Children of same sex domestic partner:

- Social Security number and
- birth certificate or birth registration and one of the following—

- adoption documents
- shared or joint custody agreement

Stepchildren:

- Social Security number and
- birth certificate or birth registration and shared/joint custody agreement

Adopted Children, Foster Children, Children in Guardianship/Custodial Relationships:

- Social Security number and one of the following:
  - adoption documents
  - guardianship/custody documents
  - foster child documents

Continuation of Coverage for Disabled Dependents

Any disabled dependent child remains eligible for medical and prescription coverage until the end of the month in which he/she turns 26. A disabled dependent remains eligible for dental, vision, and life insurance coverage until September 30th following his/her 23rd birthday. However, your disabled dependent child(ren)'s medical and prescription coverage may be continued beyond age 26 if—

- he or she is permanently incapable of self-support because of mental retardation or physical handicap or became disabled, and
- the disability occurred before he or she reached age 19.

Coverage will continue as long as the disabled child is incapacitated and dependent unless coverage is otherwise terminated in accordance with the terms of the plan. You will be asked to provide the plan administrator with proof that the child's incapacity and dependency existed prior to age 19. Before the plan administrator agrees to the extension of coverage, the plan administrator may require that a physician chosen by your health plan provider examine the child. The plan administrator may ask for proof that the child continues to meet these conditions of incapacity and dependency. If you do not provide proof that the child's incapacity and dependency existed prior to age 19, as described above, coverage for that child will end September 30 following his/her 23rd birthday for dental, vision, and life insurance. Medical and prescription coverage will end at the end of the month in which he/she turns the age of 26.

If you change your medical plan, you may be required to submit new medical documentation to the new health plan provider.

It is your responsibility to notify MCPS of the child's incapacity and dependency to be considered for continuous medical and prescription coverage beyond age 26. Forms for incapacitated/disabled dependent children are available from ERSC. Coverage ends if you predecease your disabled dependent, except as provided under federal *Consolidated Omnibus Budget Reconciliation Act* (COBRA) legislation.

WHEN BENEFITS COVERAGE BEGINS

New employees must enroll within 60 days of initial employment or wait until a future open enrollment. Coverage begins on the first day of the month following the month that you enroll, provided ERSC receives your enrollment form by the 20th day of the month. If the 20th of the month falls on a weekend or holiday, the deadline to submit your enrollment form is the last business day before the 20th.

If ERSC receives your enrollment form after the 20th day of the month, your benefits coverage begins on the first day of the second month following receipt of your enrollment form. For example, let's assume you are hired on December 23. Refer to the chart below to see when your coverage would begin:

If you submit your enrollment form:	Your coverage will begin on:
On or before January 20	February 1
Between January 21 and February 18	March 1
On February 22	April 1

Special Rule for 10-Month Employees

If you are a 10-month employee reporting at the beginning of a school year, your coverage begins October 1 if ERSC receives your enrollment form by September 20. If ERSC receives your enrollment form between September 21and September 30, your coverage begins November 1. You must enroll within 60 days of initial employment.

ADDING NEW DEPENDENTS

Your new dependents are not automatically covered or enrolled under the benefit plan—you must take action to add new dependents to your plan. You also may add eligible dependents to your benefit plan when you have a qualifying life event.

Please note that you must enroll your new dependent through ERSC, not the benefit plan provider.

When you add a dependent to your coverage, you are required to complete MCPS Form 455-20: *Employee Benefit Plan Enrollment,* and to provide supporting documentation.

Refer to the chart below for information about important deadlines and documentation you are required to submit.

Qualifying Event	Forms Required	Deadline to Add
Newborn/adopted child	MCPS Form 455-20 Social Security number* Birth certificate/registration* or Legal court documentation	60 days from the date of birth or adoption
Legal guardianship/custody	MCPS Form 455-20 Social Security number* Legal court documentation	60 days from the court award of legal guardianship
Spouse	MCPS Form 455-20 Social Security number Marriage certificate	60 days from the date of marriage

** If you cannot provide a Social Security number and a birth certificate or birth registration within the 60-day timeframe, you may enroll your newborn with evidence that you have applied for a Social Security number and a birth certificate or birth registration. You must provide the Social Security number and birth certificate or birth registration to ERSC upon receipt. Failure to provide a Social Security number and birth certificate or birth registration in a timely manner will result in termination of coverage.*

If ERSC receives all required forms by the 20th of the month (or the last business day before the 20th of the month if the 20th falls on a weekend or holiday), coverage for your new dependent will begin on the first day of the following month. If ERSC receives the forms after the 20th of the month, coverage for your new dependent will start on the first day of the second month.

If you do not enroll your new dependent within the 60-day time frame listed above, you must wait until a future Open Enrollment to enroll for coverage.

Coverage for your new dependent child(ren) will be retroactive to the date of birth, adoption, or

legal guardianship when forms are submitted within the 60-day timeframe.

CHANGES IN COVERAGE

In general, you are not permitted to make changes to your coverage during the plan year. Changes are only permitted during the annual Open Enrollment or if you experience a qualifying life or work event during the year.

Qualifying life or work events include:

- Marriage/Divorce
- Birth of child; adoption or legal guardianship
- Death
- Loss of health coverage other than from MCPS (must include evidence of coverage for previous 12 months)
- Change of work status (e.g., you are a .4 paraeducator, not benefits eligible, and your hours increase to .6—you are now benefits eligible)

Changes due to qualifying life events such as marriage, divorce, birth of a child, or loss of coverage, may be made during the plan year, as described in the section **Adding New Dependents**. If you experience a qualifying life event, you have 60 days from the date of the qualifying event to submit the necessary enrollment forms to ERSC. In addition, you have 60 days to enroll in benefits if you experience a change in your MCPS work status. You must use MCPS Form 455-20: *Employee Benefit Plan Enrollment,* to change your benefit plan enrollment, and you must attach all necessary documentation to the enrollment form at the time you submit your form. If you fail to submit all required information with MCPS Form 455-20, your form will be rejected and returned to you.

If you do not submit the form and necessary documentation within the 60-day period, you must wait until a future Open Enrollment to make any changes.

It is your responsibility to notify ERSC of all changes.

You may drop a dependent or cancel your entire coverage at any time by completing MCPS Form 455-20: *Employee Benefit Plan Enrollment*. However, you may not cancel individual components of your benefit plan. If you choose to cancel coverage, you must cancel the entire employee benefit plan (with the exception of life insurance coverage(s).

If ERSC receives all required forms by the 20th of the month (or the last business day before the 20th of the month if the 20th falls on a weekend or holiday), changes to your coverage will become effective on the first day of the following month. If ERSC receives the forms after the 20th of the month, changes to your coverage will become effective on the first day of the second month.

If you drop a dependent or cancel coverage, the change is effective the last day of the month ERSC receives your form. It is recommended that you notify ERSC promptly because removing a dependent could change your coverage level and reduce your cost.

PAYING FOR COVERAGE

You pay for your health plan coverage with premiums deducted from your paycheck on a pretax basis. Your premiums are deducted before income and payroll taxes are calculated, and your deductions are taken in equal amounts. The detailed cost is shown on your *e*Paystub.

- Ten-month employees have deductions taken from 20 paychecks during the school year.
- Twelve-month employees have deductions taken from 26 paychecks.

Refer to the rate chart at the end of this document for your health coverage costs for 2011.

WHEN BENEFITS COVERAGE ENDS

If you terminate employment with MCPS, benefits coverage for you and any covered dependents ends on the last day of the month you terminate employment.

Benefits coverage for a dependent child automatically ends at the end of the month in which he/she turns 26 for medical and prescription plans. Benefits coverage for a dependent child's dental, vision, and life insurance plans automatically ends on September 30 following the dependent child's 23rd birthday. You should complete MCPS Form 455-20: *Employee Benefit Plan Enrollment*, to remove your dependent from benefits coverage if your child—

- ceases to be your eligible dependent, or
- becomes benefit-eligible on his/her own with MCPS.

Special Rule for 10-month Employees

If you are a 10-month employee and you terminate employment with MCPS at the end of a school year, your coverage continues through September 30 because you have prepaid for benefits through the summer.

CONTINUATION OF BENEFITS

If your coverage ends, you and your dependents may be eligible to continue coverage as provided under COBRA.

You and/or your dependents may become eligible for coverage under COBRA if you terminate employment or you and/or your dependents become ineligible for coverage under the MCPS benefits plan. You may continue coverage by paying the full cost of coverage plus a 2 percent administrative fee for a period legally-mandated by COBRA regulations (generally 18-36 months).

MCPS does not share the cost of COBRA coverage. A COBRA rate chart can be found on the ERSC website. You will receive a qualifying event notice (QEN) from the MCPS third party administrator (SHPS | Carewise).

INSURANCE COVERAGE WHILE ON LEAVE

If you are on an approved leave of absence, you may elect to continue or terminate your coverage under the MCPS employee benefit plan. Depending on the type and duration of your leave of absence, you may be required to pay either the employee share or the full cost of coverage. For most unpaid leave categories, there is not an MCPS subsidy, and you are responsible for 100 percent of the cost of insurance while on leave. Should you have questions about leave of absence policies, contact ERSC at 301-517-8100.

You may elect to terminate coverage by indicating your choice in the appropriate box on MCPS Form 455-20: *Employee Benefit Plan Enrollment*. If you wish to continue coverage while on leave, no action is required.

You can continue life insurance coverage without continuing medical, dental, vision, or prescription coverage. If you elect to continue life insurance coverage, you will be billed by the Division of Controller. Failure to pay the required premium will result in cancellation of coverage.

Please be advised that if you terminate your coverage while on leave and return to work at a later date, you must contact ERSC and provide a completed MCPS Form 455-20: *Employee Benefit Plan Enrollment*, within 60 days of returning to active work status if you wish to re-enroll for benefits coverage. You must re-enroll in the same coverage you had prior to going on leave. If you marry, have a child, or adopt a child while on leave, they may be added to your

plan when you return from leave by completing MCPS Form 455-20: *Employee Benefit Plan Enrollment*, and providing the appropriate documentation.

You cannot continue your participation in the flexible spending accounts (FSAs) while on leave. Your FSAs are cancelled at the end of the month your leave begins, and you must re-enroll within 60 days of returning from leave. You can incur expenses up to the date your leave begins and have until April 30 following the plan year to submit claims for reimbursement.
Please note: Returning from leave is not a qualifying event to change your election amount.

If you fail to re-enroll in the employee benefit plan within 60 days of returning to active work status, you must wait until a future Open Enrollment. In order to re-enroll for basic employee life insurance or optional employee and optional dependent life insurance, you and any dependents age 19 or older must provide evidence of insurability and be approved by the Prudential Life Insurance Company. ERSC will initiate the evidence of insurability process after receiving your enrollment forms, which are available on the ERSC website.

If you are absent from work without approved leave, you still are required to pay health insurance premiums. If in any given pay period you do not have sufficient funds to cover the cost of your insurance premium, the premium will be withheld from your next paycheck. In the event of a longer unapproved absence from work, you will be billed the cost of the full premium rate. Please keep in mind that you could jeopardize your eligibility to continue health insurance coverage if you are absent without approved leave. Should you have questions about leave of absence policies, contact ERSC at 301-517-8100.

OUT-OF-AREA COVERAGE

If you are enrolled in the Kaiser Permanente Health Maintenance Organization (HMO) medical plan, any eligible dependents that reside or attend school outside the service area of the HMO will only be covered for urgent care or emergency services. Your dependents must contact the medical plan for authorization before receiving out-of-area medical care and the plan may deny out-of-area care. Refer to the applicable HMO summary plan document for details.

If you are enrolled in the CareFirst BlueChoice HMO, you have access to the Away From Home Care (AFHC) program that provides benefits for participants residing outside of the HMO home service area for 90 days or more. Some areas of the country do not participate in the AFHC program. Members must reapply to the program every year. To take advantage of the AFHC program or to reapply, you should contact CareFirst BlueChoice at 1-888-452-6403 for more information and enrollment procedures.

If you are enrolled in the CareFirst BlueChoice Open Point-of-Service (POS) plan, you have access to a regional network of doctors and facilities. In the event that you and/or your dependents seek care where CareFirst BlueChoice does not have participating doctors or facilities, the plan provides out-of-network benefits.

If you are enrolled in the UnitedHealthcare (UHC) Select Plus POS plans or the UHC Select HMO, you have access to a national network of doctors and facilities. In the event that you and/or your dependents seek care, the plans provide in-network benefits. Out-of-network benefits are available only to UnitedHealthcare (UHC) Select Plus POS plan members. Please consult the POS Plan chart for further details.

COORDINATION OF BENEFITS

If you or one of your dependents is covered by more than one insurance plan, there is an order of benefits determination established by the National Association of Insurance Commissioners. The primary plan will be the first to consider the medical services rendered for coverage. Any medical care not covered by

the primary plan in full will be considered for payment by the secondary plan.

Your employee plan is your primary coverage over any other plan that covers you as a dependent spouse.

Birthday Rule

If dependent children are enrolled for insurance coverage with both biological parents (one MCPS plan, one non-MCPS plan), the primary insurance plan for the children is determined by the birthday of the parents.

The plan of the parent with the birthday that comes first in the calendar year (month and day only) is primary for the child(ren). This order of benefits determination for dependent children is known as the birthday rule.

All medical plans offered by MCPS use the birthday rule for primary insurance plan determination. The birthday rule does not apply to stepchildren. Primary care for dependent stepchildren follows the biological parent.

ENROLLMENT IN MEDICARE

As an active MCPS employee, if you and/or your covered dependent(s) are eligible for Medicare due to age, illness, or disability, you may defer Medicare enrollment without penalty as long as you are covered by any active MCPS medical plan. Deferring Medicare enrollment will save you the cost of additional monthly Medicare Part B premiums while maintaining your MCPS medical coverage. Enrollment in Medicare Part B will not provide additional medical coverage beyond what is already included in all MCPS medical plans. Therefore, employees typically defer Medicare Part B enrollment until retirement when deferral is no longer permitted.

If you and/or your qualified dependent(s) defer Medicare enrollment, you will still be required to enroll in Medicare Parts A and B when you retire and are no longer covered by the active employee health plan. Enrollment in Medicare must coincide with your retirement date and is arranged by contacting the Social Security Administration at least three months prior to your retirement. At the time of your retirement, you must submit a copy of the Medicare card(s) to ERSC with your retirement papers. Conveying this information to ERSC will initiate the necessary process to update your benefit enrollment and notify the insurance carriers.

All retirees and dependents covered by any MCPS retiree medical plan are required to enroll in Medicare Parts A and B when first eligible to remain covered by the MCPS plan. Once enrolled, Medicare will be your primary insurance, and the MCPS medical plan provides secondary coverage as a supplement to Medicare.

If you and/or your dependent(s) become Medicare eligible at any time due to end-stage renal disease (ESRD), you must notify ERSC at 301-517-8100.

Detailed information about post-retirement health coverage and Medicare is provided during the Retirement Informational Sessions offered by ERSC and also is included in the *Retiree Benefit Summary*, which is available online at *www.montgomeryschoolsmd.org/uploadedFiles/retiree_benefit_summary_current.pdf.*

Accessing Benefits Forms

Forms to enroll in benefits, make changes, and file claims are available online. Most forms are available in Adobe Portable Document Format (PDF) and require Adobe Reader 8 or higher to open.

Employees can access benefits forms on the MCPS and ERSC websites by:

- Searching the MCPS website
- Searching the MCPS Forms Directory
- Using the ERSC Forms page
- Clicking on direct links

SEARCHING THE MCPS WEBSITE

The MCPS website offers a search box in the upper right corner of every MCPS Web page. Enter a form name, number, or appropriate keyword in this search box and you will see a list of results to match your search. Navigate to the form you need from the search results.

SEARCHING THE MCPS FORMS DIRECTORY

All MCPS forms are available on the MCPS forms directory Web page at *www.montgomeryschoolsmd.org/departments/forms/*. Enter a form name, number, or appropriate keyword in the search box on this page. You will then see a list of results that match your search. Navigate to the form you need from the search results.

USING THE ERSC FORMS WEB PAGE

Some benefits forms are provided courtesy of your insurance provider or other benefits vendor. For your convenience, ERSC maintains a Forms Web page where links to all benefits forms are compiled at *www.montgomeryschoolsmd.org/departments/ersc/employees/forms/*. You can browse for forms by benefit type. For example, a UnitedHealthcare claim form would be located in the "Health Benefits" section under "Medical Forms."

DIRECT LINKS

The following are direct links to your benefit enrollment forms. Additional forms can be found on the MCPS and ERSC websites using the search methods described.

- MCPS Form 455-20: *Employee Benefit Plan Enrollment: www.montgomeryschoolsmd.org/departments/forms/455-20.shtm*
- MCPS Form 450-3: *Flexible Spending Account Calendar Year 2011 Election www.montgomeryschoolsmd.org/departments/forms/450-3.shtm*
- MCPS Form 450-1: *Optional Employee Term Life Insurance: Enrollment/Cancellation www.montgomeryschoolsmd.org/departments/forms/450-1.shtm*
- MCPS Form 450-*2: Optional Dependent Life Insurance: Enrollment/Cancellation www.montgomeryschoolsmd.org/departments/forms/450-2.shtm*

SUBMITTING BENEFITS FORMS

All forms must be submitted to ERSC. Forms can be submitted in the following ways:

- Fax: 301-279-3651 or 301-279-3642
- Mail: 7361 Calhoun Place, Suite 190, Rockville, MD 20855
- Pony mail: ERSC at Metro North
- E-mail: ERSC@mcpsmd.org

If you choose to submit a form via e-mail, please note that you must submit an electronically signed Adobe PDF file. You also may scan a copy of your form with your original signature and attach it to an e-mail.

Your Benefits at a Glance

The chart below is a brief overview of your benefit options for 2011. For more information, refer to the appropriate section in this Benefits Summary.

Benefit	Your Options
Protecting Your Health	
Medical Point-of-Service (POS) Health Plans Health Maintenance Organizations (HMO) Health Plans	• CareFirst BlueChoice—Open POS Plan • UnitedHealthcare Select Plus—Open POS Plan • UnitedHealthcare Select Plus—Closed POS Plan (open to employees hired before January 1, 1994 only) • CareFirst BlueChoice HMO • Kaiser Permanente HMO • UnitedHealthcare Select HMO
Prescription Drug	• CVS/Caremark Prescription Drug (not available to Kaiser Permanente plan participants) • Kaiser Permanente Prescription Drug (only available to Kaiser Permanente plan participants)
Dental	• Aetna Dental Preferred Provider Organization (PPO) • Aetna Dental Maintenance Organization (DMO)
Vision	• National Vision Administrators, LLC
Protecting Your Income	
Flexible Spending Accounts	• Medical spending account (up to $4,000/year—MCPS matches the first $100 you contribute) • Dependent care account (up to $5,000/year or $2,500/year if married, filing separately)
Basic Term Life Insurance	• Employee (90% paid by MCPS)—2 times annual salary • Dependent (paid by MCPS)—$2,000/spouse, $1,000/each eligible dependent child
Optional Life Insurance	• Employee—1 times annual salary (paid by employee) • Dependent—$10,000/spouse or each eligible dependent child (paid by employee)
Long-Term Care Insurance	Elect coverage through Prudential Life Insurance Company of America (paid by employee)
Protecting Your Future	
Defined Contribution Plans 403(b) Tax Shelter Savings Plan 457(b) Deferred Compensation Plan	Elect a percentage or flat amount of your salary to contribute to each account, up to annual IRS limits (available at *www.mcps.yourplan.info*)
Defined Benefit Pension Plans	By completing the appropriate forms, you are enrolled in state and/or county-sponsored pension plans.

Medical Coverage

You may choose one of the following medical plan options:

Two Open Point-of-Service (POS) options:

- CareFirst BlueChoice POS Plan
- UnitedHealthcare Select Plus POS Plan
- UnitedHealthcare Select Plus Closed POS Plan **(available to employees hired before January 1, 1994, only)**

Three Health Maintenance Organization (HMO) options:

- CareFirst BlueChoice HMO
- Kaiser Permanente HMO
- UnitedHealthcare Select HMO

POINT-OF-SERVICE PLANS

A POS plan combines features of an HMO and an indemnity plan. You receive care in one of two ways. There is an in-network HMO-like component offering a full range of services provided or authorized by your primary care physician or by an in-network specialist. In addition, there is an out-of-network component similar to traditional indemnity insurance. The out-of-network benefit provides payment for treatments received from non-network physicians or specialists after the coinsurance and a yearly deductible are met. You also will be responsible for any above the usual, customary, and reasonable (UCR) charges determined by the plan.

The POS plans do not require you to obtain a referral to visit a participating in-network physician or specialist for medically necessary care.

CareFirst BlueChoice Open POS

MCPS offers this POS plan to employees and their eligible dependents through CareFirst BlueChoice.

When you enroll in the CareFirst BlueChoice Open POS plan, you must select a primary care physician (PCP) who will direct your care. You can contact CareFirst BlueChoice directly to select a PCP from a list of participating doctors in the BlueChoice provider directory by phone at 1-800-545-6199 or online at *www.carefirst.com*. You may change your PCP once you are enrolled in the plan by registering through the CareFirst BlueChoice website at *www.carefirst.com*.

This plan offers open access that allows you to see any in-network physician or specialist without a referral. If you receive care from an in-network specialist, benefits will be paid according to the in-network schedule of benefits outlined later in this document. If you choose to go out-of-network for medical care, you will receive benefits under the out-of-network schedule of benefits.

A percentage of out-of-network benefits are paid after you meet an annual deductible of $300 for individual coverage or $600 for family coverage. Benefits are generally paid at 80 percent of Allowed Benefit, depending on the type of service provided. The plan pays 100 percent of Allowed Benefit after you reach a $1,000 out-of-pocket maximum. The out-of-pocket maximum excludes the deductible and the cost of services above the Allowed Benefit. Some services, such as preventive care, are not covered out-of-network and are only covered when performed by an in-network physician.

You decide whether to stay in-network or use an out-of-network physician each time you receive medical care. Out-of-pocket expenses will vary depending on the types of services rendered. Away From Home Care* may be of interest to you or your covered family members out of the service area for an extended period of time.

Diabetic supplies are covered under your prescription drug benefit administered by CVS/ Caremark.

**Away From Home Care (AFHC) is an out-of-area program that provides benefits for CareFirst BlueChoice plan participants residing outside of their home network service area for 90 days or more. Some areas of the country do not participate in the AFHC program. Members must reapply to the program every year. To take advantage of the AFHC program or to reapply, members should contact CareFirst BlueChoice at 1-800-452-6403 for more information and enrollment procedures.*

UnitedHealthcare Select Plus—Open POS

MCPS offers this POS plan to employees and their eligible dependents through UnitedHealthcare (UHC).

When you enroll in the UHC Select Plus plan, you must select a primary care physician (PCP) who will direct your care. You can contact UHC directly to select a PCP or use the PCP UHC automatically assigns when you enroll in the plan. You may change your PCP once you are enrolled in the plan by registering through the UHC website at *www.myuhc.com* or by calling 1-888-607-5214.

This plan offers open access that allows you to see any in-network physician or specialist without a referral. If you receive care from an in-network specialist, benefits will be paid according to the in-network schedule of benefits outlined later in this document. If you choose to go out-of-network for medical care, you will receive benefits under the out-of-network schedule of benefits.

A percentage of out-of-network benefits are paid after you meet an annual deductible of $300 for individual coverage or $600 for family coverage. Benefits are generally paid at 80 percent of the UCR, depending on the type of service provided. The plan pays 100 percent of the UCR after you reach a $1,000 out-of-pocket maximum. The out-of-pocket maximum excludes the deductible and the cost of services above the UCR. Some services, such as preventive care, are not covered out-of-network and are covered only when performed by an in-network physician.

As a participant in this plan, you have access to UnitedHealthcare's national network of doctors and facilities. The availability of a national network allows access to in-network care for members wherever you are in the country, when traveling, and for dependent children when they are living out of the state.

You decide whether to stay in-network or use an out-of-network physician each time you receive medical care. Out-of-pocket expenses will vary depending on the types of services rendered.

Diabetic supplies are covered under the prescription drug benefit administered by CVS/Caremark.

Refer to the POS comparison chart later in this document for more details.

UnitedHealthcare Select Plus—Closed POS

This option is open to employees hired before January 1, 1994, only.

For more details about this plan, contact ERSC at 301-517-8100 or visit the ERSC website.

HEALTH MAINTENANCE ORGANIZATIONS

A health maintenance organization (HMO) plan offers a full range of services provided or authorized by your PCP or by an in-network specialist. You may only receive benefits for medical services and supplies received from a network provider, except in a true emergency. However, you do not have to meet a deductible before the plan pays benefits.

Refer to the HMO comparison chart outlined later in this document for further details.

CareFirst BlueChoice HMO

CareFirst BlueChoice is an individual practice HMO where you select a PCP from a list of participating doctors in the CareFirst BlueChoice provider directory or online at *www.carefirst.com*. Your PCP will provide medical care and may refer you to a network specialist, as necessary. However, the plan is an open access plan, and referrals are not necessary to see an in-network specialist. Referrals are necessary for certain coverage, such as laboratory and x-ray services. Each covered family member may select a different PCP. You must select your PCP prior to your first appointment by contacting CareFirst BlueChoice directly online or by phone at 1-800-545-6199.

Diabetic supplies are covered under the prescription drug benefit administered by CVS/Caremark. Specialty care benefits are covered as follows:

- Chiropractic Manipulation: 20 visits/year, $10 co-pay/visit
- Diabetic Education/Training: $10 co-pay (benefits are paid at 100 percent of the allowed amount)
- Physical, Speech, and Occupational Therapy: 30 visits/year, $10 co-pay/visit
- Away From Home Care*

**Away From Home Care (AFHC) is an out-of-area program that provides benefits for CareFirst BlueChoice plan participants residing outside of their home network service area for 90 days or more. Some areas of the country do not participate in the AFHC program. Members must reapply to the program every year. To take advantage of the AFHC program or to reapply, members should contact CareFirst BlueChoice at 1-800-452-6403 for more information and enrollment procedures.*

Kaiser Permanente HMO

Kaiser Permanente is a center-based HMO with approximately 30 Medical Centers in the MCPS service area. You may receive information about locations at *www.kp.org* or from the provider directory. Medical Centers are staffed by doctors, nurses, and specialists and offer a wide range of services such as pharmacy, laboratory, x-ray, ambulatory surgery, and health education. We encourage you to select a center and PCP that best meets your needs when you enroll in the plan. If you do not choose a center, Kaiser will automatically assign a center nearest to your residence of record.

When scheduling an appointment, be sure to ask for your PCP. You may call and change your PCP or Medical Center location at any time. Each of your covered family members may select a center and PCP of their choice. Your PCP is responsible for coordinating all health needs including hospital and specialty care if needed. If you enroll in the Kaiser Permanente HMO, your prescription drug benefits and diabetic supplies are provided under this plan.

As a participant in the Kaiser Permanente HMO, you also may receive complementary medicine discounts via the American Specialty Health Network (ASHN). You can get discounts and preferred rates through ASHN on the following services:

- Chiropractic care, acupuncture, and massage therapy
- Fitness club memberships
- Health tools and health products

To select a provider, join a fitness club, or learn more about the services offered, visit *www.kp.org/healthyroads* or call the ASHN toll-free customer service line at 1-877-335-2746.

Kaiser Permanente covers diabetic supplies and provides certain discount specialty services.

UnitedHealthcare Select HMO

UnitedHealthcare Select HMO is an individual practice HMO where you select a PCP from a list of participating doctors. When you enroll in the UHC Select HMO plan, you must select a PCP who will direct your care. You can contact UHC directly to select a PCP or use the PCP UHC automatically assigns when you enroll in the plan. Each covered family member may select a different PCP. You may change your PCP once you are enrolled in the plan by registering through the UHC website at *www.myuhc.com* or by calling UHC directly at 1-800-638-1103. Your PCP will provide medical care and may refer you to network specialists, as necessary. However, referrals are not necessary to see an in-network specialist. Referrals are necessary for certain coverage, such as laboratory and x-ray services.

As a participant in this plan, you have access to UnitedHealthcare's national network of doctors and facilities. The availability of a national network allows access to in-network care for members wherever you are in the country, when traveling, and for dependent children when they are living out of state.

Diabetic supplies are covered under the prescription drug benefit administered by CVS/Caremark.

Refer to the HMO comparison chart for more information about the HMO plans.

PREVENTIVE CARE SERVICES

As a result of the *Affordable Care Act,* certain preventive care procedures will no longer have co-pays when they are provided by in-network providers, regardless of your medical plan choice. The specific procedures provided for adults and children are listed separately in the following charts. Preventive care procedures not listed specifically will be covered by in-network providers with co-pays outlined in the HMO and POS comparison charts on the following pages. Out-of-network coverage remains unchanged, and co-pays are listed in the POS comparison chart later in this document.

Preventive Services Covered with Zero Co-Pay for Adults	
Preventive Service Covered	**Who is Eligible, Additional Details**
Abdominal Aortic Aneurysm Screening	one-time screening for men of specified ages who have ever smoked
Alcohol Misuse Screening and Counseling	all adults
Aspirin Use	men and women of certain ages
Blood Pressure Screening	all adults
Cholesterol Screening	adults of certain ages or at higher risk
Colorectal Cancer Screening	adults over 50
Depression Screening	all adults
Type 2 Diabetes Screening	adults with high blood pressure
Diet Counseling	adults at higher risk for chronic disease
HIV Screening	all adults at higher risk
Immunizations for: • Hepatitis A • Hepatitis B • Herpes Zoster • Human Papillomavirus • Influenza • Measles, Mumps, Rubella • Meningococcal • Pneumococcal • Tetanus, Diphtheria, Pertussis • Varicella	doses, recommended ages, and recommended populations vary
Obesity Screening and Counseling	all adults
Sexually Transmitted Infection (STI) Prevention Counseling	adults at higher risk
Tobacco Use Screening	all adults and cessation interventions for tobacco users, expanded counseling for pregnant tobacco users
Syphilis Screening	all pregnant women, all adults at higher risk
Anemia Screening	pregnant women, on a routine basis
Bacteriuria Urinary Tract or Other Infection Screening	pregnant women
BRCA Counseling about Genetic Testing	women at higher risk
Breast Cancer Mammography Screenings	women over 40, every 1 to 2 years
Breast Cancer Chemoprevention Counseling	women at higher risk
Breast Feeding Interventions	women, to support and promote breast feeding
Cervical Cancer Screening	sexually active women
Chlamydia Infection Screening	younger women and other women at higher risk
Folic Acid Supplements	women who may become pregnant
Gonorrhea Screening	all women at higher risk
Hepatitis B Screening	pregnant women at their first prenatal visit
Osteoporosis Screening	women over age 60 depending on risk factors
Rh Incompatibility Screening	all pregnant women and follow-up testing for women at higher risk

Preventive Services Covered with Zero Co-Pay for Children	
Service	Who is Eligible, Additional Details
Alcohol and Drug Use Assessments	adolescents
Autism Screening	children at 18 and 24 months
Behavioral Assessments	children of all ages
Cervical Dysplasia Screening	sexually active females
Congenital Hypothyroidism Screening	newborns
Developmental Screening	children under age 3, and surveillance throughout childhood
Dyslipidemia Screening	children at higher risk of lipid disorders
Fluoride Chemoprevention Supplements	children without fluoride in their water source
Gonorrhea Preventive Medication for the Eyes	all newborns
Hearing Screening	all newborns
Height, Weight and Body Mass Index Measurements	children of all ages
Hematocrit or Hemoglobin Screening	children of all ages
Hemoglobinopathies or Sickle Cell Screening	newborns
HIV Screening	adolescents at higher risk
Immunization Vaccines for: • Diphtheria, Tetanus, Pertussis • Haemophilus Influenzae Type B • Hepatitis A • Hepatitis B • Human Papillomavirus • Inactivated Poliovirus • Influenza • Measles, Mumps, Rubella • Meningococcal • Pneumococcal • Rotavirus • Varicella	children from birth to age 18; doses, recommended ages, and recommended populations vary
Iron Supplements	children ages 6 to 12 months at risk for anemia
Lead Screening	children at risk of exposure
Medical History	all children, available throughout development
Obesity Screening and Counseling	children of all ages
Oral Health Risk Assessment	young children
Phenylketonuria (PKU) Screening for Genetic Disorder	newborns
Sexually Transmitted Infection (STI) Prevention Counseling	adolescents at higher risk
Tuberculin Testing	children at higher risk of tuberculosis
Vision Screening	children of all ages

Health Maintenance Organization (HMO) Plans	Kaiser Permanente HMO	UnitedHealthcare Select HMO	CareFirst BlueChoice HMO
Annual Deductible	None	None	None
Preventive Care			
Routine Physical Exam	Covered in full	$5 co-pay*	$5 co-pay*
Well Baby/Child Care	Covered in full (under age 5)	$5 co-pay*	$5 co-pay*
Childhood Immunizations	Covered in full (under age 5)	$5 co-pay*	$5 co-pay*
Physician Services			
Physician Office Visit	$5 co-pay	$5 co-pay	$5 co-pay
Specialist Office Visit	$5 co-pay	$5 co-pay	$10 co-pay
Lab Work and X-rays	Covered in full	Covered in full	Covered in full
Allergy Shots	$5 co-pay	$5 co-pay	$5 co-pay ($10 co-pay for specialist)
Maternity Care			
Prenatal and Postnatal Care	$5 co-pay, no charge once pregnancy is confirmed*	$5 co-pay first visit; covered in full thereafter per pregnancy*	$10 co-pay per visit; $100 max co-pay per pregnancy*
Physician Services	Covered in full	Covered in full	Covered in full
Hospital Services	Covered in full	Covered in full	Covered in full
Emergency Services (when medically necessary)			
Urgent Care Centers	$5 co-pay	$15 co-pay	$10 co-pay
Emergency Room	$100 co-pay (waived if admitted)	$100 co-pay (waived if admitted)	$100 co-pay (waived if admitted)
Emergency Physician Services	Covered in full	Covered in full	Covered in full
Emergency Ambulance	Covered in full if authorized	Covered in full	Covered in full
Hospital Services—Inpatient			
Semi-Private Room	Covered in full	Covered in full	Covered in full
Professional Services	Covered in full	Covered in full	Covered in full
Surgical Procedures	Covered in full	Covered in full	Covered in full
Specialty Care/ Consultation	Covered in full	Covered in full	Covered in full
Anesthesia	Covered in full	Covered in full	Covered in full
Radiology and Drugs	Covered in full	Covered in full	Covered in full
Intensive Care	Covered in full	Covered in full	Covered in full
Coronary Care	Covered in full	Covered in full	Covered in full
Hospital Services—Outpatient			
Surgical Procedures	$5 co-pay	$25 co-pay	Covered in full
Professional Fees	Covered in full	Covered in full	Covered in full
Mental Health/Substance Abuse Services			
Inpatient Days	Covered in full	Covered in full	Covered in full
Outpatient Visits	$5 co-pay	$5 co-pay	$5 co-pay
Other Services			
Catastrophic Illness	Covered in full	Covered in full	Covered in full
Durable Medical Equipment	Covered in full	You pay 25%**	You pay 25%*
Home Health Care	Covered in full	Covered in full up to 60 visits	Covered in full
Hospice Care	Covered in full	Covered in full	Covered in full
Skilled Nursing Care	Covered in full up to 100 days	Covered in full up to 60 days	Covered in full

*Applies to services not specifically listed in the previous preventive care charts.
**Does not include diabetic supplies such as lancets, glucose strips, etc. See CVS/Caremark Prescription for details.

Open Point of Service (POS) Plans	CareFirst BlueChoice POS		UnitedHealthcare Select Plus POS	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible	None	$300 individual, $600 family	None	$300 individual, $600 family
Preventive Care				
Routine Physical Exam	$10 co-pay*	Not covered	$10 co-pay*	Not covered
Well Baby/Child Care	$10 co-pay*	80%, no deductible	$10 co-pay*	80%, no deductible
Childhood Immunizations	Covered in full	80%, no deductible	Covered in full	80%, no deductible
Physician Services				
Physician Office Visit	$10 co-pay	80% after deductible	$10 co-pay	80% after deductible
Specialist Office Visit	$10 co-pay	80% after deductible	$10 co-pay	80% after deductible
Lab Work and X-rays	Covered in full	Diagnostic: 80% after deductible Routine: not covered	Covered in full	Diagnostic: 80% after deductible Routine: not covered
Allergy Evaluations	$10 co-pay each visit	80% after deductible	$10 co-pay each visit	80% after deductible
Allergy Shots	Covered in full	80% after deductible	Covered in full	80% after deductible
Maternity Care				
Prenatal and Postnatal Care	$10 co-pay first visit, covered in full after*	80% after deductible	$10 co-pay first visit, covered in full after*	80% after deductible
Physician Services	Covered in full	80% after deductible	Covered in full	80% after deductible
Hospital Services	Covered in full	80% after deductible	Covered in full	80% after deductible
Emergency Services (when medically necessary)				
Urgent Care Centers	$10 co-pay	80% no deductible	$10 co-pay	80% no deductible
Emergency Room	$100 co-pay, waived if admitted	$100 co-pay, waived if admitted	$100 co-pay, waived if admitted	$100 co-pay, waived if admitted
Emergency Physician Services	Covered in full	Covered in full	Covered in full	Covered in full
Emergency Ambulance	Covered in full	Covered in full	Covered in full	Covered in full
Hospital Services—Inpatient				
Semi-Private Room	Covered in full	80% after deductible up to 180 days	Covered in full	80% after deductible up to 180 days
Professional Services	Covered in full	80% after deductible	Covered in full	80% after deductible
Surgical Procedures	Covered in full	80% after deductible	Covered in full	80% after deductible
Specialty Care/ Consultation	Covered in full	80% after deductible	Covered in full	80% after deductible
Anesthesia	Covered in full	80% after deductible	Covered in full	80% after deductible
Radiology and Drugs	Covered in full	80% after deductible	Covered in full	80% after deductible
Intensive Care	Covered in full	80% after deductible	Covered in full	80% after deductible
Coronary Care	Covered in full	80% after deductible	Covered in full	80% after deductible
Hospital Services – Outpatient				
Surgical Procedures	$10 co-pay	80% after deductible	$10 co-pay	80% after deductible
Professional Fees	Covered in full	80% after deductible	Covered in full	80% after deductible
Mental Health/Substance Abuse Services				
Inpatient Days	Covered in full	80% after deductible (up to 180 days)	Covered in full	80% after deductible (up to 180 days)
Outpatient Visits	$10 co-pay	80% after deductible	$10 co-pay	80% after deductible
Other Services				
Catastrophic Illness	Covered in full	Covered in full after $1,000 out-of-pocket expenses (excludes deductible)	Covered in full	Covered in full after $1,000 out-of-pocket expenses (excludes deductible)
Durable Medical Equip.**	Covered in full	80% after deductible	Covered in full	80% after deductible
Home Health Care/ Skilled Nursing Care	Covered in full	80% after deductible	Covered in full	80% after deductible
	(up to 60 visits in- and out-of-network)		(up to 60 visits in- and out-of-network)	
Hospice Care	Covered in full	80% after deductible	Covered in full	80% after deductible

*Applies to services not listed in the previous preventive care charts.

**Does not include diabetic supplies such as lancets, glucose strips, etc. See CVS/Caremark Prescription for details.

Please Note: All percentages shown for out-of-network service are up to the usual, customary, and reasonable (UCR) charge, as determined by UnitedHealthcare Select Plus, or allowed benefit, as determined by CareFirst BlueChoice. The description of benefits and services is only a summary. For complete information, please refer to the evidence of coverage on the ERSC website.

Other Benefit Plan Coverage

In addition to medical coverage, you also may choose dental, vision, and prescription drug coverage when you enroll (refer to the appropriate section in this document for additional information). Rates for the 2011 plan year are included in this document.

You are responsible for updating beneficiary designations for your life insurance plans, the state and county pension plans, and the defined contribution plans [403(b) and 457(b)]. Forms are available on the ERSC website. To change your defined contribution plan beneficiaries, contact your vendor directly.

Important Notice

New employees eligible for benefits are automatically enrolled in the basic term life insurance plan. You will need to designate a beneficiary for basic life insurance using MCPS Form 455-20: *Employee Benefit Plan Enrollment*. If you wish to decline basic term life insurance coverage, you must complete Section V of MCPS Form 455-20, and elect "decline" life insurance coverage. See the Life Insurance section of this document for additional details on this benefit, as well as Optional Employee Life and Optional Dependent Life Insurance. You may update your life insurance beneficiaries at any time. It is important that you update beneficiary designations as your circumstances change.

Dental Coverage

If you are eligible for benefits, you may choose from two dental plans:

- Aetna Dental Preferred Provider Organization (PPO) or
- Aetna Dental Maintenance Organization (DMO).

You may change dental plans only during Open Enrollment.

DENTAL PREFERRED PROVIDER ORGANIZATION (PPO)

If you enroll in the Aetna Dental PPO, you have the freedom to select the dentist of your choice. You can access provider information by calling 1-800-282-0555 or visiting Aetna's website at *www.aetna.com/docfind*. Generally, you receive a higher level of benefits if you receive dental services from a participating (in-network) PPO dentist. If you receive dental services from a non-participating (out-of-network) dentist, you receive a less generous level of benefits. Reimbursement is based on the schedule of dental benefits and is subject to deductibles, co-pays, and reasonable and customary charges. Prophylaxis, including scaling and polishing, is covered up to two times per calendar year.

Orthodontic benefits are available to dependent children of active employees only if they were enrolled in the MCPS plan and younger than age 20 when the treatment began. There is no orthodontic coverage for retirees or their dependents. The in-network orthodontic benefit is 50 percent of the allowed charge, and the out-of-network orthodontic benefit is 30 percent of the allowed charge. There is a maximum lifetime orthodontic benefit of $1,000 per child (in- or out-of-network.)

You must submit an Aetna dental claim form for reimbursement for PPO claims incurred with a non-participating provider. The claim form is available on the ERSC website. The annual maximum benefit per covered participant is $2,000.

Refer to the dental benefits chart for more information about your dental benefits.

DENTAL MAINTENANCE ORGANIZATION (DMO)

If you wish to enroll in the Aetna DMO plan, you should contact Aetna directly to verify that you reside in the DMO service area. As a DMO participant, you must select a primary dentist from a list of participating DMO dentists and be on the dentist's roster before your first appointment. To obtain information and select a participating DMO provider, visit Aetna's website at *www.aetna.com/docfind* or call 1-800-843-3661.

The Aetna DMO does not require you to meet an annual deductible before benefits are paid, and there is no maximum annual benefit limitation. However, benefits are paid only if you receive care from a dentist who is part of the DMO network. Benefits are paid at a certain percentage (100 percent for preventive or basic or 75 percent for major).

Orthodontic benefits are available to dependent children of active employees only if they were enrolled in the MCPS plan and younger than age 20 when the treatment began. There is no orthodontic coverage for retirees or their dependents. The orthodontic benefit is 50 percent of the scheduled fee, limited to one full treatment per eligible child. There is no lifetime maximum.

Refer to the following chart for more information about your dental options.

Dental Benefits	Aetna PPO		Aetna DMO
	In-Network Plan pays:	Out-of-Network Plan pays:	In-Network Only Plan pays:
Maximum Annual Benefit	$2,000	$2,000	None
Annual Deductible Class I Class II Class III	 None $50 $50	 None $100 $100	 None None None
Diagnostic (Class I) Routine exams X-rays Prophylaxis (includes scaling and polishing) Fluoride (one treatment per year up to age 18) Sealants (one treatment every three years on permanent molars only under age 16) Oral Hygiene Instruction	100% Oral Hygiene Instruction not covered	80% Oral Hygiene Instruction not covered	100%
Basic (Class II) Amalgam Composite Filling (anterior tooth only) Pulp Capping Root Canal Therapy with X-rays and Cultures (other than molar root canal) Scaling and Root Planing	100%	80%	100%
Basic (Class II) Space Maintainers Molar Root Canal Therapy Osseous Surgery (periodontal surgery) General Anesthesia	100%	80%	75%
Major (Class III) Inlays, Onlays, and Crowns Full and Partial Dentures Bridge Pontics, and Abutments	50%	40% Maximum eligible charge per service: $400	75%
Major (Class III) Surgical Removal of Impacted Teeth	100%	80% Maximum eligible charge per service: $400	75%
Orthodontics (Class IV) Orthodontic Appliances and Treatment (one lifetime treatment per covered dependent child only if treatment begins prior to age 20 while covered under the MCPS plan)	50%, up to $1,000 lifetime maximum	30%, up to $1,000 lifetime maximum	50%, no lifetime maximum

Vision Coverage

If you are eligible for benefits, you may choose to enroll for vision coverage offered through the National Vision Administrators, L.L.C. (NVA).

As a participant in the plan, you may use any licensed doctor, optometrist, or ophthalmologist for vision services and file a claim for a partial reimbursement with NVA. You will be reimbursed as follows:

Service	Maximum Benefit	Limits
Exams: Optometrist Ophthalmologist	 $25 $33	One exam during any consecutive 18-month period
Frames: Frames only	 $20	One set of frames during any consecutive 18-month period (In lieu of contact lenses)
Lenses only, per pair: Single vision Bifocal Trifocal Lenticular Contact Lenses: Medically Necessary** Standard or Disposable	 $20 $35 $45 $120 $230 $40	Two lenses during any consecutive 18-month period (in lieu of contact lenses) In lieu of lenses & frames

**Contact lenses are covered up to $230 only if they are prescribed after cataract surgery or when needed to restore the visual acuity of the person's healthier eye to 20/70 or better, and if this cannot be accomplished with regular glasses. Otherwise, they are covered at $40 in lieu of glasses.

This coverage does not provide benefits for the following:

- More than one eye examination, including refraction, and two lenses per person during any consecutive 18-month period.
- More than one set of frames per person during any consecutive 18-month period.
- Services and materials in connection with special procedures, such as orthoptics and vision training, or in connection with medical or surgical treatment of the eye.
- Sunglasses, plain or prescription.
- Replacement of lost, stolen, or broken lenses or frames furnished under this benefit.
- Eye examinations required by an employer as a condition of employment, where the employer is required to provide by virtue of a labor agreement or a government body.
- Any eye care to the extent that benefits are payable for the service or supply under any other coverage of the plan, such as infections of the eye and eye surgery that are covered under your medical plan.

OPTI-VISION PROGRAM

MCPS also has selected NVA to offer a discount vision care program that includes eye examinations, eyeglasses, and supplies at discount prices under the Opti-Vision program. This extended discount benefit is available throughout the plan year when you need additional coverage for benefits that are limited to the 18-month reimbursement period.

The discount vision plan enables participants to purchase glasses, standard or disposable contact lenses, frames, and related services at discount prices. The plan also provides discount LASIK surgery at more than 100 locations across the United States. Vision plan participants can schedule a complimentary evaluation.

For additional information on LASIK surgery, please call 1-877-295-8599 or visit *www.e-nva.com.* Your out-of-pocket expenses are reduced when using an NVA network provider. In addition, there is a mail order program available to plan participants where you can obtain contact lenses, including disposable lenses, at a discounted rate. A list of participating providers is available at *www.e-nva.com*.

When you enroll in the plan, you will receive a vision plan ID card, a plan description, a provider directory, and claim forms. Please review the specific information on the ERSC website for details of the NVA Opti-Vision discount program.

Prescription Drug Coverage

Two prescription drug plans are offered to MCPS employees. Eligibility for a plan depends on which medical plan you choose. If you enroll in a UnitedHealthcare or CareFirst BlueChoice medical plan, or if you decline medical coverage, you are eligible to enroll in the CVS/Caremark prescription drug plan.

If you enroll in the Kaiser Permanente HMO, you must enroll in the Kaiser Permanente prescription drug plan to receive a prescription drug benefit.

CVS/CAREMARK PRESCRIPTION PLAN

The CVS/Caremark prescription plan provides benefits for short-term medications to be filled at participating retail pharmacies using the CVS/Caremark prescription drug card. Short-term medications are medicines prescribed for short-term illnesses, such as a cold, flu, or infection, generally requiring no more than a 30-day supply.

CVS/Caremark provides two options for filling long-term maintenance medications. You may fill your 90-day supply of long-term medication at any CVS pharmacy, or you may receive your 90-day supply of maintenance medication through the CVS/Caremark Mail Service pharmacy. After an initial fill and one refill at a participating retail pharmacy, you must fill your long-term maintenance medications either at any CVS pharmacy or through CVS/Caremark's Mail Service pharmacy to avoid penalty fees.

Long-term maintenance medications are generally used to treat long-term chronic conditions, such as high blood pressure, arthritis, coronary artery disease, and diabetes.

The plan has a three-tier co-pay structure and provides financial incentives for using generic drugs, using preferred brand name drugs, and purchasing maintenance medications through CVS/Caremark's Mail Service pharmacy.

Refer to the chart below for more information:

	Retail (up to 30-day supply)	CVS/Caremark Mail Service Pharmacy or CVS retail pharmacy (up to 90-day supply)
Generic	$5 co-pay 1 refill allowed for maintenance medications	$0 co-pay
Preferred Brand Name (no generic equivalent)*	$10 co-pay 1 refill allowed for maintenance medications	$10 co-pay
Non-Preferred Brand Name**	$25 co-pay 1 refill allowed for maintenance medications	$25 co-pay***

*Detailed information is available on the CVS/Caremark website.
**If you purchase a brand name drug when a generic equivalent exists, you pay the generic drug co-pay plus the difference between the non-preferred brand name drug and generic drug cost. Example: Generic drug cost is $100, Non-Preferred Brand Name drug cost is $200, and your co-pay is $105.
***There is no penalty for purchasing a brand name drug that has a generic equivalent if a letter of medical necessity is filed. See details below.

Please Note

You can purchase your 90-day supply of maintenance medication at a CVS pharmacy for the same co-pay as the CVS/Caremark Mail Service pharmacy.

If you choose *not* to purchase a maintenance medication at a CVS pharmacy or through CVS/Caremark Mail Service after two fills at another retail pharmacy, you will pay the corresponding co-pay, plus the difference between the mail order and retail prescription cost.

To take advantage of the lowest co-pay, choose generic drugs when available. Plan participants who choose to purchase a brand name drug when a generic equivalent exists will be required to pay the generic drug co-pay plus the difference between the cost of the brand name drug and its generic equivalent.

When your doctor certifies in a letter (along with your prescription) that it is medically necessary to prescribe a brand name drug and not its generic equivalent, if it meets the FDA approved diagnosis criteria, you will be charged the brand name co-pay, without penalty, for mail order only.

The letter of medical necessity must be written on the doctor's official letterhead (not written on the prescription) and must contain details of the medical reason accompanied by the prescription. Simply stating that in his/her medical opinion brand name drugs are better than generic drugs is not sufficient medical documentation. CVS/Caremark will require yearly updates of medical necessity.

The letter of medical necessity and prescription should be sent to:

CVS/Caremark, Inc.
Department of Appeals, MC109
P.O. Box 52084
Phoenix, AZ 85072-2084

CVS/Caremark also can be reached by fax at 1-866-689-3092.

The plan provides two options for the purchase of brand name drugs that do not have a generic equivalent:

- $10 co-pay for any preferred brand name drug that appears on CVS/Caremark's Primary Drug list (updated quarterly) or
- $25 co-pay for non-preferred brand name drugs that do not appear on CVS/Caremark's Primary Drug list

The Primary Drug list is a list of preferred brand name medications that have been carefully reviewed and selected by the CVS/Caremark National Pharmacy and Therapeutics Committee of practicing doctors and clinical pharmacists for their safety, quality, and effectiveness. You can help control the amount you pay for prescriptions by asking your doctor to prescribe medications on the Primary Drug list. The medicines on the Primary Drug list are not equivalents of non-preferred brand name medicines, but are medicines in the same therapeutic category used to treat the same condition.

For example, there are several drugs on the market for lowering cholesterol. Familiar names include Lipitor and Vytorin. Lipitor is on CVS/Caremark's Primary Drug list and would be available at the $10 co-pay. Vytorin is not on the Primary Drug list and would be available at the $25 co-pay. Please note, not every drug listed on the Primary Drug list is covered by MCPS. CVS/Caremark updates the Primary Drug list quarterly. The complete list is available on the CVS/Caremark website at *www.caremark.com*.

CVS Retail Pharmacy or CVS/Caremark Mail Service Pharmacy

If you are taking a maintenance medication, you are allowed an initial fill and one refill up to a 30-day supply at a retail pharmacy at the applicable co-pay. Thereafter, you must either use the CVS/Caremark Mail Service Pharmacy or fill your maintenance medication prescription at any CVS pharmacy. If you choose to purchase a maintenance medication at a retail pharmacy other than a CVS pharmacy after a second fill, you will be required to pay the retail co-pay plus the difference between the mail order and retail cost of the drug. When utilizing a CVS pharmacy or the CVS/Caremark Mail Service pharmacy, you can obtain up to a 90-day supply

of medication for the same co-pay needed to purchase up to a 30-day supply at a retail pharmacy. There is no co-pay when purchasing generic drugs at any CVS pharmacy or through the CVS/Caremark Mail Service Pharmacy.

To receive a 90-day supply of medication at a CVS pharmacy, ask your doctor for a prescription for up to a 90-day supply of medication, plus refills as appropriate (three refills maximum), and submit directly to the CVS pharmacist.

To participate in the CVS/Caremark Mail Service pharmacy, ask your doctor for a prescription for up to a 90-day supply of medication, plus refills as appropriate (three refills maximum). Complete a Patient Profile/Order Form, available from ERSC and on the ERSC website, and mail the form, along with the original prescription, to CVS/Caremark. Keep a copy of the prescription for your records and allow a minimum of 10 to 14 business days for delivery. You can also order medications online at *www.caremark.com*.

If you wish to change your current long-term prescription from CVS/Caremark Mail Service to a CVS pharmacy, you must call Customer Care at 1-800-378-7558.

Coverage for over-the-counter drugs, cosmetic drugs, experimental drugs, and vitamins is excluded under the MCPS plan. While not all drugs are covered, those that are not may be filled at 100 percent of the discounted cost.

The following medications have prior authorization requirements, corresponding programs, or quantity limits:

- Anabolic steroids, some treatments for acne, botox, growth hormones, and medication to treat fungal infections all require prior authorization.
- Smoking cessation drugs and weight loss medications require corresponding programs.
- Drugs for erectile dysfunction have a quantity limit of six doses per month.

Your doctor will need to contact the prior authorization staff with your diagnosis. If you meet the criteria, your prescription will be approved. The prior authorization phone number is 1-800-626-3046. The prior authorization will be valid through the life of the prescription (maximum of one year).

CVS/Caremark's website provides information on how to use the mail order benefit, forms you can download (mail order claim, etc.), and a feature to request refills once you are registered. You also may obtain forms from ERSC and on the ERSC website. You also may refill your prescriptions using CVS/Caremark's automated telephone service at 1-800-378-7558.

If you fill a prescription at a nonparticipating pharmacy, you must pay the full cost of the prescription and may file a paper claim for partial reimbursement. Reimbursement is limited to the network price (an amount that is normally less than the retail price) of the drug minus the appropriate co-pay. Most major pharmacies participate in the CVS/Caremark network.

Please ask your pharmacist or refer to CVS/Caremark's website to determine if your pharmacy participates with CVS/Caremark.

Diabetic Supplies

CVS/Caremark will cover diabetic supplies, including test strips, lancets, swabs, and meters. The medical plans will cover Insulin Pumps and supplies associated with the pumps under durable medical equipment provisions. Supplies are limited up to the following:

- 200 strips every 30 days
  200 lancets every 30 days
  200 alcohol swabs every 30 days
  Lancet device limit of 1 per 180 days

You can receive up to 600 strips, swabs, and lancets every 90 days through the

CVS/Caremark Mail Service pharmacy. Diabetic supplies are considered a maintenance drug and, therefore, follow maintenance drug requirements.

KAISER PRESCRIPTION PLAN

If you are enrolled in the Kaiser Permanente HMO and elect to receive prescription drug coverage, you will receive your coverage through Kaiser.

The Kaiser plan pays for prescriptions you fill at either Kaiser Medical Center pharmacies, participating Kaiser network pharmacies, or through Kaiser mail order pharmacy.

Short-term medications are those prescribed for illnesses such as colds, flu, and ear/sinus infections. You can obtain up to a 60-day supply at a Kaiser Medical Center pharmacy or a Kaiser participating network pharmacy.

Long-term maintenance medications and prescriptions taken for chronic illnesses may be obtained up to a 90-day supply via Kaiser's mail order program. Long-term maintenance medications are those prescribed for high blood pressure, arthritis, heart conditions, and diabetes.

The Kaiser plan does not pay benefits for over-the-counter cosmetics, experimental drugs, or vitamins. Prescriptions written by a dentist will be covered when written either for antibiotics or pain medications. For prescriptions that do not meet these conditions, you must contact your Kaiser physician; otherwise, you will not receive benefits for these prescriptions.

Refer to the chart below for more information about your costs for prescriptions under the plan.

	Kaiser Medical Center Pharmacy (up to 60-day supply)	Kaiser Network Pharmacy (up to 60-day supply)	Mail Order (up to 90-day supply)
Kaiser Generic	$5 co-pay	$10 co-pay	$5 co-pay
Kaiser Brand Name (only when no generic equivalent is available)	$5 co-pay	$10 co-pay	$5 co-pay

Retail Pharmacy

You can receive benefits for prescriptions you fill at any participating Kaiser Medical Center Pharmacy or any participating Kaiser network pharmacy. Simply present your Kaiser member ID card when you fill your prescription. When you fill your prescription at a Kaiser Medical Center Pharmacy, you pay the $5 co-pay for up to a 60-day supply for a generic or brand name drugs when there is not a generic available. When you fill your prescription at a participating Kaiser network pharmacy, you pay the $10 co-pay and receive up to a 60-day supply for generic or brand name drugs when there is not a generic available.

Major and independent pharmacies participate with Kaiser. Please visit Kaiser's website at *www.kp.org* for a complete list. The quantity limitation for medications obtained on the retail level is up to a 60-day supply.

Mail Order Service

You can use the mail order program to fill up to a 90-day supply of maintenance medications with the $5 co-pay. To participate in the mail order program, ask your doctor for a written prescription for up to a 90-day supply of medication, plus refills as appropriate. You should fill new maintenance prescriptions at

your Kaiser Medical Center Pharmacy for the first fill so that you have the opportunity to consult with a pharmacist. Allow seven business days for delivery.

Insulin is covered the same as other prescription medications.

Life Insurance

New employees who are eligible for benefits automatically receive basic employee term life insurance effective the first day of the month following their hire date.* Employee cost for life insurance coverage is outlined in the life insurance rate chart which appears later in this document. If you are enrolled in basic term life insurance, you automatically receive dependent life insurance coverage for your spouse and any eligible dependent children at no additional cost.

**For 10-month employees reporting for the school year in August, coverage begins October 1.*

Please Note
Same sex domestic partners are excluded by state law from participating in basic dependent life and optional dependent life insurance.

If you do not wish to participate in the basic term life insurance program, you must decline life insurance coverage using MCPS Form 455-20: *Employee Benefit Plan Enrollment*. Once you decline coverage, you may enroll only during the annual Open Enrollment by providing evidence of insurability and receiving approval from the insurer. ERSC will initiate the process of providing evidence of insurability upon receipt of your enrollment forms.

BASIC TERM LIFE INSURANCE

The amount of basic life insurance you receive is determined by rounding your annual salary to the next lowest thousand dollars and multiplying by two. Overtime, stipends, and non-guaranteed supplemental earnings are not included in this calculation.

For Example
An employee with a salary of $52,300 would have $104,000 of employee basic term life insurance coverage (2 times $52,000).

You and MCPS share the cost of your life insurance coverage. You pay 10 percent of the cost for coverage and MCPS pays 90 percent. MCPS pays 100 percent of the cost for basic dependent life insurance.

Please remember to update your beneficiary information as your personal situations change. You can make beneficiary updates by completing the MCPS Form 455-20: *Employee Benefit Plan Enrollment*. (Note: The enrollment form does not update your beneficiaries for retirement/pension plans, 403(b) or 457(b) defined contribution plans.)

BASIC DEPENDENT LIFE INSURANCE

If you are enrolled in basic employee life insurance, you automatically receive basic dependent life insurance as follows:

- $2,000 for your eligible spouse and
- $1,000 for each eligible dependent child(ren).

If you are covered by MCPS life insurance, you must designate one or more beneficiaries for your life insurance. However, you are always the beneficiary for dependent life insurance.

Under IRS regulations, you are taxed on the value of the employer-paid portion of premiums for all coverage in excess of $50,000. This taxable imputed income appears on your *e*Paystub as EXS Life.

OPTIONAL EMPLOYEE LIFE INSURANCE

If you are enrolled for basic life insurance, you also may choose to purchase additional life insurance equal to one times your annual salary (rounded down to the nearest thousand).

The cost of optional employee life insurance is based on your age, and you pay the full cost of coverage through payroll deduction. New employees are not required to submit evidence of insurability when selecting coverage, provided they enroll within 60 days of employment by completing the MCPS Form 450-1: *Optional Employee Term Life Insurance Enrollment/Cancellation*.

If you did not elect coverage during your initial period of eligibility, you are required to provide evidence of insurability and be approved for coverage by the insurer when you enroll during the next annual open enrollment. ERSC will initiate the process of providing evidence of insurability after receiving your enrollment form.

OPTIONAL DEPENDENT LIFE INSURANCE

If you are enrolled for basic life insurance, you may choose to purchase additional dependent life insurance in the amount of $10,000 for each eligible dependent. The cost of coverage is based on a flat rate, regardless of the number of dependents you enroll. You pay for the full cost of this coverage.

This coverage includes your spouse and any eligible dependent child(ren). Your dependents are not automatically covered. You must enroll dependents when first eligible. You have 60 days following your hire date to complete MCPS Form 450-2: *Optional Dependent Term Life Insurance Enrollment/Cancellation*, and submit to ERSC.

Otherwise, you must wait until the next annual open enrollment to enroll your dependents.

Dependents age 19 or older will be required to provide evidence of insurability and be approved for coverage by the insurer. ERSC will initiate the process of providing evidence of insurability after receiving your enrollment form.

If you have a qualifying event, such as marriage or birth of a child, you must complete MCPS Form 450-2: *Optional Employee Term Life Insurance Enrollment/Cancellation* within 60 days of the event to enroll your dependents in optional dependent life. This also is a good time to update all of your beneficiary information.

Flexible Spending Accounts

Flexible Spending Accounts (FSAs) provide you with a tax-saving opportunity. The *plan year* begins January 1 of the current year and continues through March 15 of the following year. The *plan year* determines the period of time you may incur expenses. The *calendar year* begins January 1 of the current year and continues through December 31 of the current year. The *calendar year* determines the period of time you make contributions. Under the FSA plan, you may set aside a portion of your salary before taxes are deducted to pay for anticipated, qualifying expenses, such as day care for a child under age 13 or medical expenses not covered by an insurance plan. You have two FSA plan options:

- Dependent Care Account—Set aside up to a combined family maximum of $5,000/year or $2,500/year if married filing separately from your salary to pay for qualified dependent care expenses. Qualified dependent care expenses are expenses incurred for the care of children under age 13 or disabled dependents while you are working, disabled, or attending school. Qualified expenses include day care, nursery school, summer day camps, and in-home care.

- Medical Spending Account—Set aside up to $4,000 from your salary per calendar year to pay for qualified medical expenses. Qualified expenses include deductibles, co-payments, expenses in excess of plan limits, and qualified costs not covered by any benefit plan. Cosmetic procedures are not qualified expenses under a medical spending account. Please note that beginning January 1, 2011, over-the-counter drugs will no longer be eligible for reimbursement from your medical FSA. Please consult the flexible spending summary plan document available on the ERSC website for additional information.

Visit the SHPS | Carewise (SHPS) website at *www.shps.net* for a complete listing of eligible expenses for dependent care and medical spending accounts.

Important
MCPS will match the first $100 contribution to the medical spending account for any employee who enrolls. For instance, if you set aside $1,300 for qualified medical expenses, MCPS will add an additional $100 to your medical spending account. As a result, you will have $1,400 to apply toward qualified medical expenses.

You are eligible to enroll in the FSA plan if you are a permanent employee working at least 20 hours a week, even if you do not participate in health coverage through MCPS.

When you are newly hired, you have 60 days from your date of hire to enroll in the FSA plan, using MCPS Form 450-3: *Flexible Spending Account Calendar Year 2011 Election*. After that time, you may only enroll for the FSA plan during the annual Open Enrollment, unless you have a qualifying event. If you experience a qualifying event, you have 60 days from the date of the event to enroll in the FSA plan. Qualifying events include marriage or divorce, addition or loss of a dependent, your spouse becomes eligible for or loses medical coverage, or your spouse loses full-time employment.

You may enroll in one or both accounts subject to a $100 annual minimum per account. Elections are made one year at a time and do not carry forward from year-to-year. If you wish to participate, you must make a new FSA election each year during Open Enrollment.

You decide how much to contribute to your FSA plan on a calendar year basis. The amount you specify will be withheld from your paycheck in equal amounts on a pre-tax basis. When you incur a qualified expense for dependent care, you file a claim for reimbursement from your FSA plan through the plan administrator, SHPS. Then, you are reimbursed from your FSA plan with pretax dollars.

When you elect to contribute to the Medical FSA, you will receive a Visa debit card that is good for three consecutive years if you re-enroll each calendar year. Using the Visa debit card can provide immediate access to the funds in your FSA. You can use the debit card to cover the costs of certain eligible health care services at the time of payment, so you don't have to file a claim for reimbursement.

Important Reminder to Visa Debit Card Users:
All expenditures are subject to audit. It is important to retain all receipts.

An envelope for retaining receipts is provided in the Visa debit card mailing. You are not required to use the Visa debit card for reimbursement of eligible expenses. If you prefer, you can submit a paper claim along with receipts for eligible expense directly to SHPS for reimbursement.

IRS regulations impose a "use or lose" rule due to the tax advantages of the FSA plan. This rule requires that any money not used by the end of

the plan year is forfeited. In addition, you are not permitted to transfer funds from one account to the other. It is very important to fully understand the program and carefully estimate qualifying expenses before enrolling.

An IRS regulation provides plan participants enrolled in the Medical and Dependent Care FSA with an additional two and one-half months to incur claims for the plan year. Qualifying medical and/or dependent care expenses incurred from January 1, 2011, through March 15, 2012, may be reimbursed from funds set aside for the 2011 calendar year.

Qualifying expenses incurred between January 1, 2011, and March 15, 2012, may be reimbursed from the 2011 plan year account. If there is a balance in the 2011 plan year account, claims incurred between January 1, 2012, and March 15, 2012, may be reimbursed from either the 2011 or 2012 plan year account (but not from both plan years). All claim requests for reimbursement of expenses incurred during the previous calendar year must be submitted and received by SHPS no later than April 30, 2012.

There are separate reimbursement forms for the medical and dependent care accounts. Reimbursement forms are available on the ERSC website. IRS regulations do not permit FSA election changes during the year unless a qualifying event such as marriage, divorce, addition or loss of a dependent, or change of employment status occurs.

Employees who begin leave, terminate employment, or retire will be reimbursed for qualified expenses incurred prior to beginning leave and/or separation of employment with MCPS, and must submit claim receipts for reimbursement by April 30 following the plan year. Expenses incurred after you begin leave, terminate employment, or retire are not qualified expenses.

Additional information, estimation worksheets, and reimbursement forms are available on the ERSC website.

Long-Term Care

MCPS offers you the opportunity to purchase long-term care insurance at group rates through Prudential Life Insurance Company of America. You enroll directly through Prudential for this coverage.

To request an enrollment kit and/or ask questions about the program, contact the Prudential Customer Service line at 1-800-732-0416.

You also can visit Prudential's website at *www.prudential.com* to review detailed descriptions of plan options and eligibility features, as well as online enrollment at *www.prudential.com/gltc/mca.html*. When accessing the website, you will be prompted to enter a group name and password. Enter the following:

- Group name: MCPS
- Password: mcpsltc

Please note

Long-term coverage is offered, without proof of insurability, to benefit-eligible employees within the first 60 days after hire. If you enroll after the 60-day period, you will be required to meet Prudential's underwriting standards. Long-term care coverage also is offered to certain family members (your spouse, parents, grandparents, parents-in-laws, and domestic partners) at the same group rates. Family members who wish to apply for this coverage must meet Prudential's underwriting standards regardless of the enrollment date.

403(b) Tax Shelter Savings and 457(b) Deferred Compensation Plans (Defined Contribution Plans)

MCPS offers two defined contribution plans to all employees as follows:

- 403(b) Tax Sheltered Savings Plan
- 457(b) Deferred Compensation Plan

You can contribute to one or both plans up to the annual IRS limit. The plans offer a means to supplement retirement savings while reducing current taxable income. Participation in the plans is through voluntary contributions available to all MCPS employees.

Important
MCPS maintains a website that provides detailed information regarding the two plans including approved providers, contribution limits, and the necessary forms and instructions to begin contributions and/or withdrawal of funds. The Web address is *http://mcps.yourplan.info*.

To participate, you decide how much of your salary to contribute and how it will be invested. Your investments are made on a pretax basis through the convenience of payroll deduction. Current federal, state, or local income taxes are not withheld on money invested for retirement. Any earnings on your investments within the accounts also are tax deferred. Therefore, your account value grows faster than it would in a taxable investment. You pay income taxes on your contributions and any earnings when you withdraw money from the account.

MCPS employees may begin participating in one or both of the plans at any time. To begin, you must first submit an enrollment application to one of the approved providers to open an MCPS account. Then, send a completed 403(b) salary reduction agreement and/or 457(b) salary deferral agreement to ERSC. If you do not open an MCPS account with one of the approved providers before you send the salary reduction agreement form to ERSC, all forms will be returned. You retain the right to stop your contributions at any time. If you need to make any adjustments, you must complete and return the signed form to ERSC. E-mails are not accepted.

The agreement(s) authorize(s) MCPS to withhold a specific amount of money from each pay and to forward the funds to your 403(b) and/or 457(b) carrier for your individual account. ERSC must receive your salary reduction agreement well in advance of the pay date of the paycheck from which you wish to have funds withheld. A list of applicable dates for deductions, approved providers, and frequently asked questions are available on the ERSC website. For additional details, please contact one of the approved providers.

Withdrawals are limited to those permitted by the plan as described in the plan document available on the MCPS defined contributions website at *http://mcps.yourplan.info*. If you choose to participate, you should recognize that you are investing for retirement and may not have free access to the funds until you meet one of the withdrawal requirements, such as age or separation of service.

Retirement Benefits

SOCIAL SECURITY

As an MCPS employee, you pay Social Security and Medicare taxes on your earnings and are

eligible to qualify for benefits under the Social Security program. If you earn 40 credits (10 years of work) under the program, you will qualify for a future Social Security retirement benefit.

"Understanding Social Security (Publication No. 05-10024)" provides a summary of the Social Security program and includes instructions on estimating your Social Security retirement benefit. The summary is available free of charge from the Social Security Administration by calling 1-800-772-1213 or by visiting their website at *www.ssa.gov*.

PENSION PLANS

Membership

As a benefits-eligible MCPS employee, you are a member of either the Maryland State Teachers Pension Plan or the MCPS Pension Plan for your core benefit, depending on your job classification. The difference between the State and MCPS systems is administrative—both systems have similar features and provide retirement benefits. In addition, MCPS provides a supplemental retirement benefit to all eligible employees.

Enrollment

Enrollment in a pension system is mandatory and a condition of your employment. You must complete enrollment forms for the State (if eligible) and MCPS pension systems, including the application for membership and beneficiary forms. You also need to provide a copy of your birth certificate or valid driver's license at the time of enrollment.

Contribution Rates

Effective July 1, 2011, employees contribute 7 percent of their salary to the core benefit and an additional .5 percent to the supplemental benefit. Contributions are made on a pretax basis and are deducted from paychecks from September through June.

Pension Changes

Due to changes in 2011, pension benefits are different for employees hired on or after July 1, 2011. The following pension information differs for those employees hired prior to July 1, 2011, and those employees hired after July 1, 2011. Find your applicable section to learn more about your pension benefits.

PENSION BENEFITS FOR EMPLOYEES HIRED PRIOR TO JULY 1, 2011

Eligibility to Retire

Pension system members are eligible to retire as follows:

Age at Retirement	Minimum Eligibility Service
62	5 years
63	4 years
64	3 years
65	2 years
Any age	30 years

Normal Retirement

You are eligible for normal retirement once you attain 30 years of eligibility service, with no age requirement. A year of eligibility service is defined by a specified number of scheduled hours worked from July 1 to June 30 each year. Prior to July 1, 1998, 700 hours were required to earn one year of eligibility service. Effective July 1, 1998, the requirement was changed to 500 hours. If you are scheduled to work less than 500 hours in a fiscal year, your eligibility service is prorated based on the number of scheduled hours worked divided by 500 hours.

Early Retirement

Early retirement plan provisions allow you to retire prior to your normal retirement date. You must be at least age 55 and have 15 years of eligibility service. Retiring early will result in a reduced retirement benefit. The reduction for early retirement is 6 percent per year or .5 percent per month for the number of months prior to age 62, in both the state and MCPS plans.

Benefit Amount

The amount of pension benefit you receive is based on the following:

- Credited Service—Credited service is used in the calculation of your retirement benefit. You earn credited service based on your scheduled hours. For example, if you are scheduled to work 80 hours biweekly from September to June, you will earn 10 months of credited service. Ten months equals one year. If you are scheduled to work less than 80 hours, your credited service will be prorated based on your scheduled hours. Credited service also may include purchased service, prior active duty military service, and any service that has been transferred to your current account.
- Average Final Salary—Average final salary for the pension system is the average of the highest three consecutive years of salary during your career and is used to calculate the benefit. For most employees, the final three years are the highest.
- Benefit Formula—The amount of your benefit is based on a defined formula that uses both your credited service and average final salary. For all employees, the benefit formula was enhanced retroactive to July 1, 1998. For employees who have service prior to July 1, 1998, the formula is as follows:

Benefit Formula for Employees with Service Prior to July 1, 1998

Core Benefit

1.2% x average final salary x credited service before 7/1/98
Plus
1.8% x average final salary x credited service after 7/1/98

Supplemental Benefit

.08% x SSIL x credited service before 7/1/98
Plus
.15% x earnings above SSIL x credited service before 7/1/98
Plus
.2% x average final salary x credited service after 7/1/98

Please Note: SSIL is the Social Security Integration Level and is an average of the Social Security wage base over a 35-year period prior to retirement. The SSIL changes each calendar year, as determined by the Social Security Administration. The projected SSIL is $59,300 for 2011.

Employees who entered the system between July 1, 1998, and June 30, 2011, will receive a core benefit of 1.8 percent multiplied by average final salary multiplied by credited service. They also will receive a supplemental benefit of .2 percent multiplied by average final salary multiplied by credited service.

Benefit Formula for Employees Hired Between July 1, 1998, and June 30, 2011

Core Benefit

1.8% x average final salary x credited service

Supplemental Benefit

.2% x average final salary x credited service

PENSION BENEFITS FOR EMPLOYEES HIRED ON OR AFTER JULY 1, 2011

Eligibility to Retire: Normal Retirement

Pension system members are eligible for normal retirement as follows:

- Age 65 with at least 10 years of eligibility service or
- Age + Years of Eligibility Service = 90

A year of eligibility service is defined as working at least 500 scheduled hours from July 1 to June 30 each year. If you are scheduled to work less than 500 hours in a fiscal year, your eligibility service is prorated based on the number of scheduled hours worked divided by 500 hours.

Early Retirement

Early retirement plan provisions allow you to retire prior to your normal retirement date. You must be at least age 60 and have 15 years of eligibility service. Retiring early will result in a reduced retirement benefit. The reduction for early retirement is 6 percent per year or .5 percent per month for the number of months prior to age 65, in both the state and MCPS plans.

Benefit Amount

The amount of pension benefit you receive is based on the following:

- Credited Service—Credited service is used in the calculation of your retirement benefit. You earn credited service based on your scheduled hours. For example, if you are scheduled to work 80 hours biweekly from September to June, you will earn 10 months of credited service. Ten months equal one year. If you are scheduled to work less than 80 hours, your credited service will be prorated based on your scheduled hours. Credited service also may include purchased service, prior active duty military service, and any service that has been transferred to your current account.
- Average Final Salary—Average final salary for the pension system is the average of the highest five consecutive years of salary during your career and is used to calculate the benefit. For most employees, the final five years are the highest.
- Benefit Formula—The amount of your benefit is based on a defined formula that uses both your credited service and average final salary. New employees entering the system on or after July 1, 2011, will receive a core benefit of 1.5 percent multiplied by average final salary multiplied by credited service. They also will receive a supplemental benefit of .2 percent multiplied by average final salary multiplied by credited service.

Benefit Formula for Employees Hired On or After July 1, 2011
Core Benefit 1.5% x average final salary x credited service
Supplemental Benefit .2% x average final salary x credited service

To Learn More about Retirement

Additional information about retirement is available on the ERSC website. This information includes the document *Understanding Your Retirement*, which explains the fundamentals of retirement, the timeline for retirement, the payment options, required forms, and frequently asked questions. Employees who are within one year of retirement may request an estimate of their MCPS retirement benefit. MCPS Form 455-2a: *Request for Estimate of Retirement Benefits*, is available on the ERSC website.

Employees who are enrolled in the state pension plan can visit the Maryland State Retirement Agency (SRA) website at *sra.state.md.us*. You also may contact SRA by telephone at 1-800-492-5909.

Active Employee Cost - Calendar Year 2011

Healthcare Costs

Effective January 1, 2011

Medical Plans	Coverage Level	Employee Percentage	Biweekly 10-Month Employee	Biweekly 12-Month Employee
Open Point Of Service Plans				
CareFirst BlueChoice	Individual	10%	25.11	19.31
	2 Party	10%	50.22	38.63
	Family	10%	68.33	52.56
UnitedHealthcare Select Plus	Individual	10%	26.41	20.31
	2 Party	10%	52.81	40.63
	Family	10%	71.86	55.28
Health Maintenance Organization Plans				
CareFirst BlueChoice	Individual	5%	8.80	6.77
	2 Party	5%	16.53	12.72
	Family	5%	27.09	20.84
Kaiser Permanente	Individual	5%	11.80	9.08
	2 Party	5%	23.55	18.11
	Family	5%	34.12	26.24
UnitedHealthcare Select	Individual	5%	11.55	8.89
	2 Party	5%	21.71	16.70
	Family	5%	35.57	27.36

Supplemental Plans	Coverage Level	Employee Percentage	Biweekly 10-Month Employee	Biweekly 12-Month Employee
Caremark Prescription	Individual	10%	8.42	6.48
	2 Party	10%	16.83	12.95
	Family	10%	20.77	15.98
Kaiser Prescription	Individual	10%	3.68	2.83
	2 Party	10%	7.34	5.65
	Family	10%	10.64	8.18
Aetna Dental Preferred Provider Organization	Individual	10%	1.93	1.49
	2 Party	10%	3.87	2.98
	Family	10%	5.69	4.37
Aetna Dental Maintenance Organization	Individual	10%	1.42	1.09
	2 Party	10%	2.83	2.18
	Family	10%	4.16	3.20
Vision	Individual	10%	0.06	0.05
	2 Party	10%	0.11	0.08
	Family	10%	0.14	0.11

Closed Point Of Service Plan UnitedHealthcare Select Plus Open to employees hired ***before*** January 1, 1994 only	Coverage Level	Employee Percentage	Biweekly 10-Month Employee	Biweekly 12-Month Employee
MCEA Employees	Individual	15%	62.82	48.32
	2 Party	15%	125.64	96.64
	Family	15%	170.93	131.48
SEIU Local 500 and MCAASP Employees	Individual	20%	83.76	64.43
	2 Party	20%	167.52	128.86
	Family	20%	227.90	175.31

Employee Life Insurance 100% Rate = $.093 Per Thousand Of Insurance Per Month
Based on two times current salary rounded to the nearest $1,000

LEAVE RATE SCHEDULE

Healthcare costs for employees on leave

100% ACTIVE EMPLOYEE RATE

Effective January 1, 2011

		Component Cost	
		MONTHLY	ANNUAL
CareFirst BlueChoice POS	IND	418.49	5,021.88
	2	836.95	10,043.40
	FAM	1,138.78	13,665.36
UnitedHealthcare Select Plus Open POS	IND	440.13	5,281.56
	2	880.23	10,562.76
	FAM	1,197.68	14,372.16
UnitedHealthcare Select Plus Closed POS	IND	697.98	8,375.76
	2	1,395.96	16,751.52
	FAM	1,899.18	22,790.16
CareFirst BlueChoice HMO	IND	293.24	3,518.88
	2	551.14	6,613.68
	FAM	902.95	10,835.40
Kaiser HMO	IND	393.30	4,719.60
	2	784.86	9,418.32
	FAM	1,137.25	13,647.00
UnitedHealthcare Select HMO	IND	385.03	4,620.36
	2	723.69	8,684.28
	FAM	1,185.64	14,227.68
Caremark Prescription	IND	140.40	1,684.80
	2	280.50	3,366.00
	FAM	346.15	4,153.80
Kaiser Prescription	IND	61.26	735.12
	2	122.31	1,467.72
	FAM	177.25	2,127.00
Aetna PPO Dental	IND	32.23	386.76
	2	64.50	774.00
	FAM	94.75	1,137.00
Aetna HMO Dental	IND	23.59	283.08
	2	47.21	566.52
	FAM	69.38	832.56
NVA Vision	IND	1.00	12.00
	2	1.84	22.08
	FAM	2.33	27.96

Optional Term Life Insurance
2011 Rates

Optional Employee Term Life Insurance

Eligible employees enrolled for basic term life insurance are entitled to purchase an additional one times their salary (rounded down to the nearest thousand) in life insurance. The cost of optional life insurance is based on age and is paid entirely by the employee through payroll deductions.

AGE BRACKET	BI-WEEKLY EMPLOYEE DEDUCTIONS (per thousand of coverage)	
	10-month	12-month
Under 25	0.020	0.016
25 - 29	0.025	0.019
30 - 34	0.033	0.025
35 - 39	0.037	0.028
40 - 44	0.041	0.032
45 - 49	0.062	0.048
50 - 54	0.095	0.073
55 - 59	0.178	0.137
60 - 64	0.272	0.210
65 - 69	0.524	0.403
70 and over	0.852	0.655

SAMPLE CALCULATION: Optional Term Life Insurance Coverage rates for a 37 year-old, 10-month employee who earns $46,000 a year.	
Coverage Amount (one times the annual salary)	$46,000.00
Thousands of Coverage	46
Bi-weekly Cost = 46 X .037	$1.70

Optional Dependent Term Life Insurance

You must be enrolled in Basic Employee Term Life coverage to elect Optional Dependent Term Life coverage. Coverage for qualified dependent children will continue until September 30 following their 23rd birthday.

Coverage Amount for each qualified dependent spouse and/or dependent child(ren)	$10,000.00
Bi-weekly payroll deduction for 12-month employees	$1.04
Bi-weekly payroll deduction for 10-month employees	$1.35

Montgomery County Public Schools
Vendor List for the
§403(b) Tax Sheltered Savings (TSA) and
§457(b) Deferred Compensation Plans
http://mcps.yourplan.info/

Currently, there are 9 Board-approved providers:

Fidelity Investments	**800-343-0860**	**www.fidelity.com/atwork**
Hendershot Financial Group (Lincoln Investment Planning)	**301-987-7211**	**www.lincolninvestment.com**
ING	**800 525 2765**	**www.ingretirementplans.com**
Lincoln Financial Group	**800-234-3500**	**www.lincolnalliance.com**
MetLife Resources	**800 842 9406**	**www.mlr.metlife.com**
Morgan Stanley Smith Barney (Diversified Investment Advisors)	**301-556-2360**	**www.divinvest.com**
TIAA-CREF	**800-842-2008**	**enroll.tiaa-cref.org/mcps**
T. Rowe Price	**800-922-9945**	**rps.troweprice.com/mcps**
VALIC	**410-859-2164**	**www.valic.com**

MCPS does not review, approve or endorse any of the investment options that may be offered by any vendor in connection with the plan. As a plan participant, you are solely responsible for the review and selection of any and all plan investment options. Not all investment options that may be offered by vendors may be appropriate or suitable for plan investments. You must review the mcarefully before making any investment decisions. Neither MCPS nor any of its employees has any liability or responsibility for investment options that you select**.**

Frequently Requested Websites and Phone Numbers

Employee and Retiree Service Center **www.montgomeryschoolsmd.org/departments/ersc**	**301-517-8100**
Office of Human Resources **www.montgomeryschoolsmd.org/departments/personnel**	**301-279-3270**
Aetna Dental Plan **www.aetna.com**	
DMO	**800-843-3661**
PPO	**800-282-0555**
Carefirst BlueChoice HMO Plan **www.carefirst.com**	**800-545-6199**
CVS/Caremark Prescription Plan **www.caremark.com**	**800-378-7558**
COBRA (Continuous Coverage)	**800-284-8638**
Kaiser Permanente HMO and Prescription Plans **www.kp.org**	**800-777-7902**
Maryland State Retirement Agency **www.sra.state.md.us**	**800-492-5909**
MCAASP (Administrators Union)	**301-762-8174**
MCBOA (Non-Certified Supervisors Union)	**301-762-8174**
MCEA (Teachers Union) **www.mcea.nea.org**	**301-294-6232**
National Vision Administrators Plan **www.e-nva.com**	**800-672-7723**
Prudential Long Term Care **www.prudential.com/gltc**	**800-732-0416**
SEIU Local 500 **www.seiu500.org**	**301-740-7100**
Social Security Administration **www.ssa.gov**	**800-772-1213**
SHPS **www.shps.net**	**800-678-6684**
UnitedHealthcare Select Plus Point of Service Plans **www.myuhc.com**	**888-607-5214**
United Health Care Select HMO **www.myuhc.com**	**800-638-1103**

This document is available in an alternate format, upon request, under the Americans with Disabilities Act, by contacting the Public Information Office, at 850 Hungerford Drive, Room 112, Rockville, MD 20850, or by phone at 301-279-3391 or via the Maryland Relay at 1-800-735-2258.

Individuals who need sign language interpretation or cued speech transliteration in communicating with Montgomery County Public Schools (MCPS) may contact Interpreting Services in the Deaf and Hard of Hearing Program at 301-517-5539.

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MONTGOMERY COUNTY PUBLIC SCHOOLS
ROCKVILLE, MD

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