

October 18, 2011

Dear AACPS Employee:

There is no question that the rising costs of healthcare have had an incredible impact on every individual, business, and government agency in our nation. In a climate of diminishing resources, Anne Arundel County Public Schools, like other entities, has had to address the issue in a manner that will ensure the continuance of high-level benefits employees receive while cutting costs to preserve jobs and stave off the types of large-scale reductions seen elsewhere.

AACPS and its four bargaining units recently convened a joint committee to study health care and examine ways not only to save money now, but to avoid some future costs. The negotiated agreements approved by the Board of Education on September 21, 2011, reflect the consensus of this collaborative partnership.

Changes in the healthcare plans for employees are expected to save approximately \$4 million in healthcare costs in 2012 and lay the groundwork for an additional \$26 million in projected cost avoidance over the next several years. Employees will continue to have access to high-quality healthcare through options that are more cost-effective for them and the school system.

The changes being enacted still permit AACPS to provide a comprehensive health care program for employees and their families. This guide and accompanying material highlight the standard, as well as voluntary, benefits available to you. Open Enrollment dates for your 2012 benefits are November 1-11, 2011. As you prepare for Open Enrollment, keep the following changes in mind:

- Medical Option availability will not include the CareFirst Traditional Plan or Aetna HMO plans beginning January 1, 2012. Members have been contacted about their options and action needed to enroll during Open Enrollment. Participants in these plans must make a new selection.
- New 2012 insurance premiums are detailed on pages 21-24 of this guide. Some changes have occurred in Board funding for medical, dental, and vision benefits. Please also note healthcare deductions are aligned with payroll frequency.
- Part-time employees who work a Full-Time Equivalency (FTE) between 0.46 and 0.749 will have premiums deducted in accordance with the rates which are detailed on pages 21-24 of this guide (Tier 2). The part-time rate structure for those below 0.46 FTE (tier 3) will remain the same.
- PPN participants are encouraged to review the benefits of the Triple Option program since PPN plan funding will be reduced for 2012. No new PPN enrollments will be permitted for January 1, 2012.
- CVS Caremark co-pays will change to a three-tier co-pay program effective January 1, 2012. Please review pages 17-18 in this guide for complete details. The first tier is generic, the second tier is preferred brand, and the third tier represents non-preferred brands.
- During Open Enrollment, you must go online to make changes to your healthcare coverage, including adding or removing an eligible dependent (please see Page 5 for additional information about adding dependents). We recommend that you also take the opportunity online to review your elections as well as information about Flexible Spending Account participation with HFS Benefits, our FSA administrator (annual election is required to participate each year).

Remember, that as an AACPS employee, you are automatically provided with group term life insurance at no cost to you. Please keep your beneficiary information updated through our HR/Benefits Office. You may elect to purchase additional supplemental life insurance during Open Enrollment.

A wide range of voluntary benefits are available, including long-term care insurance, the Maryland College Savings Plan (529), the Treasury Direct savings bond program, disability insurance, and FSAs. All permanent employees working over 500 hours per year are automatically enrolled in the Maryland State Retirement and Pension System. Note that your pension contribution increased from 5% to 7% effective July 1, 2011.

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AACPS also has an excellent 403(b)/457(b) Supplemental Retirement Program. Investment providers are ING, Lincoln, MetLife, and Valic. This program provides a wide range of investment opportunities along with low fees to participants. We encourage all employees to enjoy the benefits of pre-tax savings deferrals and retirement plan growth. Complete information is available at [www.aacps.org/HR/Employment/Benefits/Supplemental Retirement](http://www.aacps.org/HR/Employment/Benefits/Supplemental%20Retirement).

To learn about AACPS' many wellness resources, log onto the AACPS wellness page (www.aacps.org/wellness). Under *Health Promotion for Staff* you will find fitness center discounts, the wellness theme of the month, and programs offered by health partners.

I encourage you to review this guide carefully and take advantage of the benefits offered to you. AACPS is proud of the healthcare plans it offers to employees and we care about your well-being and that of your family. Questions may be directed to HR/Benefits at 410-222-5221/5219 or via e-mail to benefits@aacps.org.

Wishing you a healthy and successful 2012.

Sincerely,

A handwritten signature in dark ink, reading "Florence G. Bozzella". The signature is fluid and cursive, with the first letters of each word being capitalized and prominent.

Florence G. Bozzella
Director of Human Resources

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A Few Words About ...

...This Guide

This guide is intended to be a quick reference for enrollment purposes. It does not address every plan provision in detail. You should refer to each plan's individual benefit booklet for additional detail available on-line at www.aacps.org>*Human Resources/Employment>Benefits*.

For 2012, healthcare benefits will automatically continue if you do not make any changes to your benefits on-line.

Remember, you must go on-line if you wish to elect flexible spending accounts (FSAs) for 2012.

2011 Aetna and Traditional Healthcare participants may elect the CareFirst BlueChoice HMO or the CareFirst BlueChoice Triple Option Plan or waive coverage during Open Enrollment. *On-line action is required or your medical coverage will terminate December 31, 2011.*

If you currently do not have and do not want healthcare benefits through AACPS, no further action is required on your part; however, please review this 2012 benefits guide for a benefits overview.

You may print a personal Confirmation Statement of your benefit elections from the on-line system after you elect or review your 2012 benefits. Please review this statement carefully for accuracy and keep it as a record of your enrollment.

Remember, the 2012 Open Enrollment period is November 1-11, 2011, for benefits effective January 1, 2012.

...Materials available on-line

Please be sure to also review the following materials on-line:

- List of Open Enrollment fairs and informational meetings
- Benefits Open Enrollment On-line Instructions for 2012
- BlueChoice HMO Summary of Benefits
- BlueChoice Triple Option Plan Summary of Benefits
- Flexible Spending Account (FSA) summary information
- Voluntary Life Insurance Application
- Voluntary Life Evidence of Insurability (EOI) Form
- Long-Term Care Insurance Information and link to forms
- Preventive Guidelines

Note:

1. CareFirst BlueChoice HMO, CareFirst Triple Option, and CareFirst PPN benefit booklets, provider directories, and provider website information are available directly through the Benefits on-line enrollment system, and also on-line at www.aacps.org>*Human Resources/Employment>Benefits*. In addition, a limited supply of all provider directories will be available at work locations during Open Enrollment.
2. The Voluntary Life Insurance Application, Self-Administered Beneficiary Form, and the Medical Questionnaire Forms are available on-line as well as at each work location during Open Enrollment. Forms are due to HR/Benefits by November 11, 2011.

What's New for 2012

What's Open Enrollment?

Open Enrollment is the time of year when you may review your benefit elections, and make changes to your coverage, if you wish. This year's enrollment for benefits effective January 1, 2012 begins November 1, 2011 and ends November 11, 2011.

If you take no action at this time, your current healthcare elections will continue for 2012. You must go on-line to make changes to your coverages or to begin or renew participation in a flexible spending account (FSA) for 2012 or if you are currently an Aetna or CareFirst Traditional participant.

Note: if you wish to add an eligible dependent, you must do so on-line and furnish appropriate documentation as requested.

You may access the on-line enrollment system at home or work through the Anne Arundel County Public Schools (AACPS) website at www.aacps.org. Read the "Benefits Open Enrollment On-Line Instructions," on-line. You should also review "Updating/Electing Coverage for 2012" on page 4 of this guide.

Open Enrollment is your opportunity to review on-line:

- 1. Your medical insurance options.**
(see 2012 Medical Comparison Chart and page 10 of this benefits guide).
- 2. Your dental insurance options.**
(see 2012 CareFirst Dental/Vision Options and page 19 of this benefits guide).
- 3. Your vision insurance options.**
(see 2012 CareFirst Dental/Vision Options and page 20 of this benefits guide).
- 4. Review and update eligible dependents as appropriate.**
(see information on page 5 as well as the Benefits Open Enrollment On-Line Instructions available at our website www.aacps.org).
- 5. Review new 2012 premium information.**
(see pages 21-24 of this benefits guide)

You may go to www.aacps.org, click on *Human Resources/Employment* and go to *Benefits*, then choose *Healthcare* for direct access to the AACPS healthcare vendor websites.

- 6. Start or renew participation in healthcare and/or dependent day care FSA(s).**
(see information on pages 25-28 of this benefits guide).
- 7. Enroll in, increase, or decrease voluntary life insurance benefits.**
(see information on page 30 of this benefits guide).
- 8. Enroll in, increase, or decrease long-term care insurance coverage.**
(see information on page 31 of this benefits guide).

All benefits are effective January 1, 2012. New payroll deductions will begin with the January 11, 2012 paycheck. Unit III employees, however, will have new 2012 deductions start with the January 25, 2012 paycheck.

What's New for benefits effective January 1, 2012

We've gone green! In addition to this Benefits Guide, you will have convenient on-line access to all other open enrollment materials and resources through www.aacps.org>Human Resources/Employment>Benefits.

This year's open enrollment is once again a "passive enrollment", that requires on-line action only if you want to change any of your coverages, update your dependents, or begin or renew participation in a flexible spending account (FSA).

1. New Insurance Premiums

New 2012 insurance premiums are detailed on pages 21-24 of this guide. Please note some changes have occurred in Board funding for medical, dental, and vision benefits. Effective January 1, 2012, the PPN plan will be funded at 75% for all units. BlueChoice HMO funding remains the same (95% for Units I, II, V, VI and 97% for Units III & IV). Triple Option funding remains the same (90% for Units I, II, V, VI and 92% for Units III & IV). All dental and vision options will be funded at 85% (from 90% funding).

2. Part-time Rate Structure effective January 1, 2012

Part-time employees who work an FTE of 0.46 to 0.749 will have premiums deducted in accordance with the rates which are detailed on pages 21-24

What's New for 2012

of this guide (Tier 2). The Board funds 95% of the monthly board share. The part-time rate structure for those below 0.46 FTE (Tier 3) will remain the same. The new part-time rate structure is effective with the first pay in 2012 for healthcare (medical, dental, and vision) benefit deductions.

3. The Aetna HMO will not be available effective January 1, 2012

Aetna HMO participants have been advised in a separate written communication that this medical plan option will not be available after December 31, 2011. Aetna members may select the CareFirst BlueChoice HMO or the CareFirst Triple Option Plan on-line from November 1-11. Participants must select a primary care physician (PCP) for themselves and their eligible dependents. **Aetna participants must elect/waive medical coverage or they will not have medical coverage for 2012.**

4. The CareFirst Traditional Medical Plan will not be available January 1, 2012

CareFirst Traditional Medical Plan participants have been advised in a separate written communication that this medical option will not be available after 12/31/2011. Traditional members may select the BlueChoice HMO or the CareFirst Triple Option Plan on-line from November 1-11. Participants must select a primary care physician (PCP) for themselves and their eligible dependents. **Traditional participants must elect/waive medical coverage or they will not have medical coverage for 2012.**

5. CareFirst PPN Plan participants are encouraged to review the benefits of the CareFirst Triple Option Plan.

PPN participants recently received a letter concerning the funding of this program. We encourage PPN participants to try out the Triple Option Plan for a year... if you are not happy with it, you may go back to the PPN in 2013.

6. CVS Caremark co-pays changed to a 3 Tier co-pay program effective January 1, 2012

Please review pages 17-18 in this guide for complete details. The first tier is generic, the second tier is preferred brand, and the third tier represents non-pre-

ferred brands. All of this is driven off CVS Caremark's formulary list (available at caremark.com). Participants may still access benefits at current pharmacies, mail-order, as well as maintenance medication availability at CVS retail stores.

7. Important Flexible Spending Account (FSA) reminder

You must take on-line action to enroll for a 2012 FSA (healthcare and/or dependent care spending account). Your 2011 deductions will not automatically continue. Please review pages 25-28 for the benefits of participating in a FSA program. If you had a healthcare FSA in 2011 and your card does not expire at the end of this year, you can continue to use the same debit card in 2012. If you did not have a healthcare FSA in 2011, or your card expires at the end of 2011, you will receive a new debit card.

Note: You may no longer use your healthcare spending account FSA debit account for most over-the-counter (OTC) expenses (unless they fall into certain categories) and are prescribed by a physician. This provision was eliminated by the Healthcare Reform Act (PPACA) for 2011.

8. Reminder...any dependent added during Open Enrollment will require proof of relationship to the employee before being approved (send to HR/Benefits by November 30, 2011).

Dependents or spouses currently covered, may be removed during Open Enrollment without proof.

9. New Insurance Card Information

New insurance cards will be issued only to employees electing coverage for the first time or making changes in coverage.

10. Same Sex Spouse Coverage

Same sex spouses that have been married in jurisdictions that legally recognize their marriage (for example the District of Columbia), are eligible to participate in the AACPS healthcare program. Employees with a same-sex spouse may enroll their spouse on-line. A copy of the marriage certificate will be requested at time of enrollment. Benefits coverage may be subject to imputed income resulting in higher Federal, State, Social Security, and Medicare taxes. Contact HR/Benefits for further information regarding tax implications.

Updating/Electing Coverage for 2012

Benefits Open Enrollment is November 1 – November 11, 2011

No action is required during Open Enrollment, unless you wish to:

1. **Change your medical, dental, or vision coverages.**
2. **Update or change your dependent information. Remember, if you are adding a child over 19 back to your healthcare plan, you must add them on-line and follow through with the documentation process to ensure coverage.**
3. **Begin or renew your participation in a flexible spending account (FSA) for 2012.**

You may complete your enrollment on-line, using the Benelogic system, which you may access via the Anne Arundel County Public Schools' website at www.aacps.org>**Human Resources/Employment>Benefits>On-line Benefits Enrollment**. If you do not have access to a computer at home, your technology support technician or other designated staff member at your work location can help you enroll at work. Or, you can access a computer in HR/Benefits (on Riva Road) or at your local library. If you need help enrolling, please plan to attend one of the Open Enrollment fairs/meetings listed in the Open Enrollment bulletin sent to all employees.

Before you enroll for the first time or make changes to your coverage:

Review this benefits guide to familiarize yourself with the different benefit options available. Have the following information on hand for yourself and your dependents:

- Social Security numbers of everyone to be enrolled
- Dates of birth of everyone to be enrolled

If you are enrolling in the CareFirst BlueChoice HMO, CareFirst BlueChoice Triple Option Plan, or the United Concordia dental plan, you will need to provide a primary care physician (PCP) code when you enroll. You may research this information either before or during on-line enrollment (see Benefits Open Enrollment On-line Instructions on-line).

When you are ready to enroll:

Be sure to have the Benefits Open Enrollment On-line Instructions sheet in front of you for help signing on and navigating the Benelogic website. Most of your personal data is already in the on-line system. The website also contains links to this guide, the insurance carriers sites (including provider directories), and forms.

Be sure to print, review, and keep your Confirmation Statement when you are finished enrolling. This statement confirms your elections and itemizes your payroll deductions for 2012. You may log back on at any time during the Open Enrollment period to review or change your elections.

You will also have the opportunity to elect a flexible savings account (FSA) during on-line enrollment. **Remember that FSA contributions must be re-elected each year, even if you are already participating.**

If you wish to change your coverage for 2012 or elect or renew an FSA, you must go on-line and enroll before midnight on November 11. The instructions sheet provides important contact information should you need assistance. If you are unable to successfully update your information on-line, ask the on-line enrollment expert at your work location for help, call Benelogic at 1-877-716-6612, or call HR/Benefits during business hours before the Open Enrollment period ends on November 11.

If you elect **new or additional Voluntary Life Insurance**, complete the Voluntary Life Insurance Application and the medical questionnaire which are available at the Benelogic website. Be sure to also complete the Self-Administered Beneficiary Designation form. Please note that Unit III employees are eligible for only up to \$100,000 in Voluntary Life Insurance benefits. Download and complete the forms, and send them to HR/Benefits before November 11.

Long-term care insurance benefits are also available during Open Enrollment. Go to the Benelogic website and link to the Unum enrollment site to download the required forms. Applications must be submitted to HR/Benefits by November 30, 2011.

Eligibility for Benefits

Eligible Employees

You are eligible to participate in the benefits offered during Open Enrollment if you are a:

- permanent active employee
- permanent employee on a leave of absence
- permanent employee on Family Medical Leave
- permanent employee on sabbatical
- former employee or dependent on COBRA

Who is considered an Eligible Dependent?

You may elect to cover any of your legal dependents under the healthcare plan. Your eligible dependents include:

- **Your spouse (opposite or same sex).** If you are adding a spouse during open enrollment, a copy of the marriage certificate must be furnished to HR/Benefits as soon as you execute your enrollment (by November 30, 2011).
Note: Marriage certificates for same sex spouses will only apply for states that recognize same sex marriages.
- **Your child, up to age 26.** The Patient Protection and Affordable Care Act (PPACA/Healthcare Reform) provides that children up to age 26 may be covered (coverage to the end of the month in which they turn age 26). Children may be added back to the plan based on the following:
 1. Children currently covered may continue to be covered without any student verification requirements up to age 26 (coverage terminates at the end of the month of his/her 26th birthday).
 2. Children do not have to be an IRS dependent for tax purposes or live with you.
 3. The eligible child may be married, but the spouse is not eligible to join the AACPS health plan nor are any of their children.
 4. AACPS requires proof of relationship for verification of the enrollment of the dependent (by November 30, 2011).

- **Your disabled child,** if your child becomes physically or mentally disabled while covered and the total disability begins prior to age 26. Proof of continuing disability may be required by the carrier.

Note that the term “children” includes:

- your natural children
- legally adopted children or children placed with you for adoption
- foster children
- your stepchildren, regardless of place of residence
- any child who lives with you, depends on you for support, and for whom you serve as legal guardian
- any child that you are responsible for as a result of a court-ordered custody arrangement

You may be required to provide documentation as proof of this legal relationship.

Who is not an Eligible Dependent?

- live-in partners
- children of live-in partners
- parents of employees
- married children, age 26 or over
- divorced spouses
- stepchildren following divorce from natural parent
- over-age dependents (not disabled or full-time student)

It is fraudulent to include dependents on the AACPS healthcare plan when they do not meet eligibility requirements. Claims paid for ineligible dependents will be recouped by the healthcare vendor from the provider, which could possibly cause you to be financially liable.

Social Security Number Requirements

Our medical plan carriers are required by law to provide the Centers for Medicare and Medicaid Services with the Social Security numbers of participants in our medical plans (including dependents). Please be sure you provide this information as requested for your eligible dependents.

Lifestyle Changes

After the annual Open Enrollment period ends, you may only make changes to your benefits during the year if you experience a qualifying lifestyle change. **Please download a lifestyle change form on-line at www.aacps.org/HR/Employment>Forms and submit it to HR/Benefits along with required documentation within 31 days of your lifestyle change to make any related changes to your benefit. You may contact HR/Benefits if you have questions.** The changes that you make must be *consistent* with the lifestyle change you have experienced (i.e., adding coverage for the addition of a child, or reducing coverage in the case of divorce).

The change in coverage will be effective the first of the month following the date of the qualifying event (except birth, which is effective the date of birth).

Qualifying lifestyle changes include:

- marriage
- divorce or annulment
(You may remove a spouse during Open Enrollment or within 31 days of a divorce. Supporting documentation will be requested)
- birth, adoption, placement for adoption, or appointment of legal guardianship of a child during the course of an adoption
- change in your or your spouse's employment status due to termination or commencement of employment, a strike or lockout, an unpaid leave of absence, or a change in worksite
- your death or the death of your dependent
- loss of dependent status due to a child reaching age 26 (may be covered through the end of the month in which they turn age 26)
- an unpaid leave of absence for you or your spouse under the Family and Medical Leave Act
- a change in your spouse's healthcare coverage – if your spouse elects new healthcare coverage, you may notify HR/Benefits to change your coverage prior to Open Enrollment within the normal 31-day notification timeframe
- your or your dependent's eligibility for COBRA, Medicare, or Medicaid
- moving into or out of an HMO's service area
- gain or loss of a dependent's coverage
- a change in your employment status that results in a gain or loss of eligibility (e.g., a switch between part-time and full-time status)

- a significant change in the coverage under a healthcare plan (does not apply to the healthcare FSA)
- an Open Enrollment for your spouse's benefit plans (changes must be consistent with the offerings in your spouse's benefit program. No changes can be made to the healthcare FSA)
- a mid-year plan enrollment offering through your spouse's employer (changes must be consistent with the offerings in your spouse's benefit program. No changes can be made to the healthcare FSA)
- a change in your or your dependent's residence or worksite
- a judgment, decree, or order which requires you to cover a dependent child (this does not include custody of grandchildren or relationships other than parent and child)
- a change in dependent day care fees (only affects the dependent day care FSA)
- your dependent child reaching age 13, and no longer qualifying for dependent day care reimbursement under your dependent day care FSA (only affects the dependent day care FSA)

Children's Health Insurance Program Reauthorization Act (CHIPRA)

If you, your spouse, or eligible dependent child loses coverage under Medicaid or a State Children's Health Insurance Program (S-CHIP) or becomes eligible for state-provided premium assistance, the affected individual(s) has 60 days from the date of the event to elect coverage in the AACPS Healthcare plans. Contact HR/Benefits for more information.

When a lifestyle change occurs, remember to update your Maryland State Retirement Agency (MSRA) beneficiaries, as well as your group life insurance designation. The Voluntary Life Insurance form and Self-Administered Beneficiary form are available at www.aacps.org>Human Resources/Employment>Forms and at work locations. The MSRA form is also available at www.aacps.org or by contacting the HR/Office of Retirement at 410-222-5224

Healthcare Consumerism & Wellness

Be an Informed Healthcare Consumer!

Most people are not accustomed to questioning their doctors about the insurance plans they accept, or the cost or medical necessity of treatment. Knowing what questions to ask and when to ask them makes the process much easier and less stressful. Asking questions of your healthcare providers helps maintain both the cost and quality of your healthcare. So it's important for everyone, regardless of the healthcare option elected, to ask about the medical necessity of any treatment and if there are alternatives to consider.

Here are some tips to help you become a good healthcare consumer:

- Ask your provider or his/her business office if they accept the AACPS healthcare plans. If they do, evaluate what plan is best for you.
- Make notes in advance of your office visit about the things you want to ask your doctor. Keep a list of any symptoms you have had or are currently experiencing. Keep a list of the medications you take, whether prescriptions or over the counter. Share the list with all healthcare providers.
- Bring a spouse or friend along with you...chances are if you don't recall something that was said, he or she will!
- Bring a pad and pencil to the doctor's office; don't rely on your memory for everything!
- If your doctor uses a term that you do not understand, ask what it means and ask that it be spelled. Then, write it down and do some more research once you leave the office.
- Get a copy of any test results.
- If your doctor writes a prescription for you, ask your doctor and pharmacist about interactions with other drugs you may be taking or about side effects that you may experience. Remember, if you are taking any maintenance medications, request one prescription for a 30-day supply from a retail pharmacy and another prescription for mail-order through CVS Caremark or the Maintenance Choice program through your local CVS pharmacy (for up to a 90-day supply, plus up to three refills).

- If you have access to the Internet, use it to learn about your medications or illnesses. The Internet has excellent information on many health-related subjects. One respected resource is www.webmd.com. Ask your physician which websites they believe are valuable. Be sure to let your physician know your findings.
- Visit www.aacps.org > **Human Resources/ Employment > Benefits** to link to our healthcare vendors' websites for more resources. See the front left pocket of this guide for vendor website information.
- Check the vendor websites for details on providers and other useful information. For example, the CVS Caremark website allows you to order medications and access other important information about the program.

Wellness

AACPS is concerned about your health and wellness. We encourage you to visit www.aacps.org/wellness to review valuable information about fitness center discounts for employees, health themes of the month, and other useful information and links. AACPS is working with the Anne Arundel County Government in a coordinated Wellness Connection Program.



***Living a Healthy Life...
one of your most important
benefits!***

Your most important choice is caring for your health! It is your responsibility to make lifestyle changes that promote good health, and to become an informed healthcare consumer. AACPS is committed to helping you and your dependents by offering a comprehensive and affordable healthcare package. Take time to evaluate your lifestyle habits and see if they promote your optimum health.

Healthcare Consumerism & Wellness

Lifestyle Changes to Improve Your Health (adapted from www.heart.org)

Here are eleven suggestions to improve your health

- 1 Add produce, whole grains, beans, nuts, fish and fiber to your diet. Eat main dishes that are full of vegetables and fruit.
- 2 Avoid fried foods, full-fat dairy products, and refined carbohydrates such as white bread, white rice, desserts, potato chips and soft drinks. Reduce salt intake.
- 3 Reduce portion size (e.g., a serving of meat should be no larger than a deck of cards).
- 4 If you drink alcohol, drink moderately (no more than one drink per day).
- 5 Do at least 30 minutes of moderate-intensity activity (e.g., brisk walking) five days per week. The 30 minutes do not have to be consecutive.
- 6 Wear your seatbelt.
- 7 Wear sunscreen.
- 8 Quit smoking.
- 9 Take steps to reduce stress (e.g., enroll in a yoga class, exercise more, practice relaxation techniques).
- 10 Get at least seven hours of sleep a night.
- 11 Schedule appropriate preventive checkups/screenings (e.g., mammograms).

***Don't let the list overwhelm you!
You will see and feel improvement
if you just try one or two suggestions.***

Also, be sure to take advantage of CareFirst's wellness discounts. Review their website or their "More to Feed Good About" booklet for further wellness information.

Helping to Control the Cost of Healthcare and Promote your Well-Being

Almost daily, the rising cost of healthcare is in the news. Advances in medical technology, expensive prescription drugs, consumer demand, and an aging population are just a few factors that impact healthcare costs. While there are some factors beyond the control of the consumer, there are some things you can do to help keep healthcare costs down – both for you and for AACPS. Below are a few tips to help you become a wiser consumer of healthcare:

- Get a regular annual checkup and/or physical exam, which can uncover early warning signs of potential health problems, and can also help you build a good relationship with your doctor. **There are no wellness-related office visit co-pays.**
- Save the emergency room for emergencies. Emergency room visits are two to three times more expensive than a visit to the doctor's office or an urgent care center. These ER visits are not only costly, but they can be unnecessarily stressful and time-consuming for you and your family if what you need is routine care. Urgent care facilities are available in the area and may be used for a variety of urgent health problems for a lower co-pay than the ER.
- Get regular dental and vision examinations.
- Get regular screenings (eg., mammograms) as recommended by your carrier and national organizations, such as the American Cancer Society. Refer to the Preventive Guidelines on the wellness website for more information.
- When you need a prescription, ask your doctor to prescribe a generic, if one is available. Generics have the same chemical equivalency as brand-name drugs, and are held to the same standards by the Food and Drug Administration, but they cost less than brand-name drugs.

Healthcare Information

Special Enrollment Rights Through HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides you with certain special enrollment rights regarding your healthcare coverage.

If you decline enrollment for yourself or your dependents (including your spouse) because you have other healthcare insurance coverage (such as coverage through your spouse's employer), but then you lose that coverage, you may in the future be able to enroll yourself or your dependents in AACPS' healthcare coverage. In this case, you must request enrollment in writing within 31 days after the other coverage ends. You must also provide evidence of your prior coverage.*

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment (in writing) within 31 days of the marriage, birth, adoption, or placement for adoption.

HIPAA also gives you certain other rights regarding the privacy of your medical information. A complete description of your rights under HIPAA can be found in the Plan's privacy notice, available in this guide. See page 42 for the AACPS HIPAA Notice of Privacy Practices.

* This special enrollment provision does not apply if you lost coverage under the other plan because you did not make required contributions or you lost coverage for cause (such as submitting a fraudulent claim).

TEFRA

(Tax Equity and Fiscal Responsibility Act of 1982)

Any active employee and/or their spouse over the age of 65, or under age 65 who is Medicare disabled who wishes to maintain their AACPS medical coverage must decline Medicare Part B benefits until no longer covered or retirement or resignation. If Medicare Part B is selected at time of eligibility, the participant should disenroll from the AACPS healthcare program. The employee/spouse must confirm this information on a form maintained in HR/Benefits (call 410-222-5219/5221 for more information). The HR/Benefits Office recommends that AACPS healthcare is selected as the primary insurance until retirement.

Healthcare Information

Healthcare Options for 2012

One of your most important and most utilized benefits is probably healthcare. This guide provides you with information to help you select the healthcare options that are best for you and your eligible dependents.

For 2012, there are three medical options available for employees. All of these plans provide comprehensive medical care, including CVS Caremark prescription benefits:

- CareFirst BlueChoice HMO (*see page 11*)
- CareFirst BlueChoice Triple Option Plan – (*see pages 12-14*)
- CareFirst BlueCross BlueShield of MD – Preferred Provider Network (PPN) (*see page 14*) (*Available only to currently enrolled PPN participants. New enrollments are not accepted.*)

In addition, all medical plans include mental health benefits. CareFirst BlueChoice HMO, BlueChoice Triple Option, and PPN participants have access to Magellan Behavioral Health to provide direction/assistance on the provider network.

For 2012, your Dental Options are:

- CareFirst BlueCross BlueShield Dental PPO Plan (*see page 19*)
- CareFirst BlueCross BlueShield Traditional Dental Plan (*see page 19*)
- United Concordia Dental POS Plan (*see page 20*)

For 2012, your Vision Care Benefit options are*:

- CareFirst Vision – Option 1 (eye exam benefit every 24 months) (*see page 20*)
- CareFirst Vision – Option 2 (annual eye exam every 12 months) (*see page 20*)

* Remember, if you are enrolled in BlueChoice HMO, you may see a participating provider within their network for an eye exam according to the permitted schedule. BlueChoice HMO participants pay a \$10 co-pay at Davis Vision providers. Davis Vision offers discounts on glasses and contact lenses to BlueChoice members.

Address and Phone Number Changes

Please remember to notify HR/Benefits to change your address if you move. It is essential that medical carriers have an up-to-date address from AACPS to send Explanations of Benefits (EOBs), reimbursements, etc. If you have an incorrect address in the Human Resources database, you will not receive important communications from AACPS.

Keeping your phone number current is important, too, in case you need to be contacted at home, and for Connect-Ed messages.

For these changes, as well as name changes, complete a Change of Personnel Records Form available on-line at www.aacps.org>HR/Employment>Forms, and submit to HR/Benefits.

Medical Options

IMPORTANT – You must enroll on-line for 2012 benefits if you:

- **are a CareFirst Traditional or Aetna participant;**
- **wish to change your coverage; or**
- **wish to begin or renew participation in a flexible spending account**

Otherwise, your 2011 benefit elections will remain in place for the 2012 plan year or terminate if currently participating in Aetna or CareFirst Traditional (except for FSAs, which must be elected each year). The Benelogic on-line enrollment system is open from November 1-11, 2011. Please follow the “Benefits Open Enrollment On-line Instructions” (available on-line) for more information.

Health Maintenance Organizations (HMOs)

HMOs are healthcare plans that provide comprehensive services for a fixed fee. The BlueChoice HMO has affordable premiums and low office visit co-payments. Your choice of healthcare providers is limited to the physicians, hospitals, and diagnostic facilities affiliated with BlueChoice HMO.

Remember, if you choose the BlueChoice HMO, there is no coverage provided outside the HMO network, except in the case of a medical emergency. Please remember to contact your primary care physician (PCP) within 24 hours to report any emergency care you receive. If you are traveling out of state and require routine care, be sure to check with BlueChoice on “Away from Home Care” benefits.

Prescription drug benefits for all of the medical plan options are provided through CVS Caremark. See page 17 of this guide for more information.

CareFirst BlueChoice HMO

The CareFirst BlueChoice HMO is available to all employees who live in the Maryland, Washington D.C., and Northern Virginia service area. The BlueChoice network includes over 18,000 PCPs in Maryland. You must select a PCP from the BlueChoice HMO network for yourself and each of your eligible dependents. Referrals are required in the BlueChoice HMO; however, your PCP has the flexibility to refer you to any specialist within the broad BlueChoice network. To find out if your physician is a BlueChoice HMO network provider, visit www.carefirst.com or check the BlueChoice HMO provider directory.

With the BlueChoice HMO, the office visit co-payment is \$5 for a PCP visit and \$10 for a specialist visit. The emergency room co-payment is \$50, but it is waived if you are admitted directly to the hospital. Urgent care co-payments are \$10.

Chiropractic benefits are available with a referral from your PCP for 20 visits per condition per calendar year (\$10 co-pay). Acupuncture and massage therapy discounted services are available through the CareFirst Options program.

BlueChoice HMO Vision Benefits

With the BlueChoice HMO, you may receive an annual eye exam at Davis Vision providers for a \$10 co-pay (no referral required). You must use participating optometrists or ophthalmologists, which include Sears Optical, JC Penney’s, and many other providers. A discount is also available for glasses, frames, and contact lenses. Visit www.carefirst.com or call 1-800-783-5602 for more information. If you are enrolled in a CareFirst vision plan, you can coordinate benefits between these two plans.

Emergency and Urgent Care

As a CareFirst BlueChoice member, your benefits include the BlueCard® program for out-of-area emergency and urgent care situations. The BlueCard® program is a benefit because when you see an out-of-area participating BlueCross and BlueShield physician or hospital for emergency or urgent care, you will only be responsible for paying out-of-pocket expenses (copayment) and your benefits will be paid at the in-network level. This relieves you of the hassle and worry of paying for the entire visit up-front and then filing a claim form later. The participating BlueCross and BlueShield physician or hospital will file the claim directly to their local BlueCross and BlueShield plan. In turn, the participating provider will be reimbursed directly on your behalf.

Medical Options

To use the BlueCard® program for out-of-area emergency and urgent care, please call (800) 810-BLUE (2583) to locate the nearest BlueCross and BlueShield physicians and hospitals. At the time of service, present your member ID card. If your physician or hospital does not bill its local BlueCross BlueShield plan for out-of-area emergency or urgent care, the physician or hospital should bill CareFirst BlueChoice directly. However, if an up-front payment is requested, obtain itemized receipts and contact Member Services when you return to obtain a claim form for consideration and reimbursement of charges.

You should always follow-up with your Primary Care Physician to make them aware of the emergency or urgent care situation.

Away From Home Care® Program

The Away From Home Care® program allows BlueChoice members and their dependents to receive care when they are away from home for at least 90 days. The care can be provided by an affiliated BlueCross and BlueShield HMO outside of the CareFirst BlueChoice service area (MD, DC, No. VA). Whether it is extended out-of-town business or travel, college students out of state or families living apart, with the Away From Home Care® program, members can enjoy a full range of benefits. This includes, but is not limited to routine and preventive care. Your copay and benefits will be those of the affiliated HMO in the area where you are visiting.

If you would like more information or to enroll in the Away From Home Care® program, please the Member Services number on your ID card and ask to be transferred to the Away From Home Care® Coordinator.

CareFirst BlueChoice Triple Option Plan

The CareFirst BlueChoice Triple Option Plan is available to all employees who live in the Maryland, District of Columbia, or Northern Virginia service area.

The CareFirst BlueChoice Triple Option Plan is actually three plans in one, for one low monthly premium. You always have the flexibility to determine the level of care you want.

When you enroll, you must designate a primary care physician (PCP) from the BlueChoice HMO network. Your PCP will direct your care and refer you to a BlueChoice HMO network specialist when you need specialty care. With the Triple Option Plan, you also have the freedom to see a provider without a referral from your PCP; however, different co-payments and deductibles apply.

Level 1 – BlueChoice HMO

When you receive care from a BlueChoice HMO provider, there is no annual deductible and you receive the highest level of benefits for the lowest co-payment. Co-payments are \$10 for PCP visits and specialist visits. Currently, over 95% of services our employees receive are provided by doctors in the BlueChoice HMO network. This means your provider may be a Level 1 provider — therefore, you will be able to enjoy the lower co-pays in Level 1. See “How to Locate a Provider” to check if your provider is in the BlueChoice HMO network.

TIP: Save Money With Level 1 Providers

The CareFirst BlueChoice Triple Option Plan gives you the freedom to decide which level of care you want when you need care. However, you’ll save the most if you receive your care from a Level 1 BlueChoice HMO network provider. Level 1 co-pays are just \$10 for primary care and specialist visits. Many providers participate in the BlueChoice HMO network; ask your doctor if he or she participates, or visit www.carefirst.com and click on “Find a Doctor”.

Level 2 – BluePreferred (PPO) **(like the PPN benefit plan)**

If you seek care from a BluePreferred (PPO) provider (without a referral from your PCP) you will pay a \$15 co-payment. A \$15 co-pay also applies for in-network lab and diagnostic services. Hospital and out-patient facilities are subject to deductibles and co-insurance. See “How to Locate a Provider” for information on BluePreferred (PPO) providers.

Level 3 – Par/Non-Par

(like the PPN out-of-network plan)

Level 3 coverage allows you to seek care from both participating CareFirst providers and non-participating providers. Level 3 coverage is subject to higher deductible and co-insurance amounts.

	Triple Option Plan		
	Level 1 BlueChoice HMO	Level 2 BluePreferred PPO	Level 3 Par/Non-Par
Annual Deductible (does not include co-payments)			
Individual	N/A	\$200	\$300
Family	N/A	\$400	\$600
Annual Out-of-Pocket Maximum			
Individual	N/A	\$500	\$1,000
Family	N/A	\$1,000	\$2,000
Lifetime Maximum			
	Unlimited	Unlimited	Unlimited
Co-payments			
Primary	\$10	\$15	N/A
Specialist	\$10	\$15	N/A
Co-Insurance			
	N/A	You pay 10% after deductible	You pay 20% after deductible

How to Locate a Provider:

1. Go to www.carefirst.com
2. Select “Find a doctor or other provider in your plan”
3. Click on “Find a Doctor”
4. You can Search by Plan:
 - For a Level 1 BlueChoice HMO PCP or Specialist select “BlueChoice – All Other BlueChoice Plans”.
 - For a Level 2 Provider in the area select “PPO – Within MD/DC/Northern VA”.
 - For a Level 2 Provider outside the area select “PPO Outside MD/DC/Northern VA”.
 - For a Level 3 Provider select “Traditional/ Indemnity”.
5. On the next two screens that follow you can refine your search further.

You can also Search by Provider Name

For more information on how to find a doctor, select “More” from the Home page under “Find a Doctor”.

You can also check directly with your current providers to verify their participation.

Co-payments, Deductibles, and Co-Insurances

Level 2 co-pays, like in the PPN, do not apply toward satisfying your annual deductible; however, they do accumulate toward meeting your annual out-of-pocket maximum. The deductibles and co-insurance in Levels 2 and 3 apply toward meeting your annual out-of-pocket maximum. Also, all charges that apply toward meeting the Level 2 out-of-pocket also apply toward meeting the Level 3 annual out-of-pocket maximum, and vice versa.

Specialist Referral

To receive Level 1 benefits and pay a \$10 co-payment for specialist care, your PCP must refer you to a specialist in the BlueChoice HMO network. If you receive services in Level 2 (no referral required), the co-payment is \$15. If you do not receive a referral and use a non-network provider, services are subject to the deductible and co-insurances as stipulated for Level 3 (see the CareFirst BlueChoice Triple Option Plan summary for more information).

Emergency Room Coverage

When an emergency occurs, seek the care you need and contact your PCP within 24 hours.

Chiropractic & Physical Therapy Benefits

If you wish to receive Level 1 benefits and pay a \$10 co-payment per visit, your PCP must refer you for care. Your PCP may specify an appropriate number of visits on one referral. For Level 2 benefits (\$15 co-payment), no referrals are required.

Lab Benefits

If you wish to receive Level 1 benefits (100% coverage), you must have a referral from your Level 1 PCP or specialist and use a Lab Corp lab. You may use Quest Diagnostics in Level 2 and pay a \$15 co-payment.

Medical Options

BlueChoice Triple Option Plan

Vision Benefits

With the CareFirst BlueChoice Triple Option Plan, you may receive an annual eye exam at Davis Vision providers for a \$10 co-pay (no referral required). You must use participating optometrists or ophthalmologists, which include Sears and JC Penney's Optical as well as many individual providers. There is also a discount available for glasses, frames, and contact lenses. Visit www.carefirst.com or call 1-800-783-5602 for more information. If you are enrolled in a CareFirst Vision plan, you can coordinate benefits between these two plans.

Emergency and Urgent Care

As a CareFirst BlueChoice member, your benefits include the BlueCard® program for out-of-area emergency and urgent care situations. The BlueCard® program is a benefit because when you see an out-of-area participating BlueCross and BlueShield physician or hospital for emergency or urgent care, you will only be responsible for paying out-of-pocket expenses (copayment) and your benefits will be paid at the in-network level. This relieves you of the hassle and worry of paying for the entire visit up-front and then filing a claim form later. The participating BlueCross and BlueShield physician or hospital will file the claim directly to their local BlueCross and BlueShield plan. In turn, the participating provider will be reimbursed directly on your behalf.

To use the BlueCard® program for out-of-area emergency and urgent care, please call (800) 810-BLUE (2583) to locate the nearest BlueCross and BlueShield physicians and hospitals. At the time of service, present your member ID card. If your physician or hospital does not bill its local BlueCross BlueShield plan for out-of-area emergency or urgent care, the physician or hospital should bill CareFirst BlueChoice directly. However, if an up-front payment is requested, obtain itemized receipts and contact Member Services when you return to obtain a claim form for consideration and reimbursement of charges.

You should always follow-up with your Primary Care Physician to make them aware of the emergency or urgent care situation.

Away From Home Care® Program

The Away From Home Care® program allows BlueChoice members and their dependents to receive care when they are away from home for at least 90 days. The care can be provided by an affiliated BlueCross and BlueShield HMO outside of the CareFirst BlueChoice service area (MD, DC, No. VA). Whether it is extended out-of-town business or travel, college students out of state or families living apart, with the Away From Home Care® program, members can enjoy a full range of benefits. This includes, but is not limited to routine and preventive care. Your copay and benefits will be those of the affiliated HMO in the area where you are visiting.

If you would like more information or to enroll in the Away From Home Care® program, please the Member Services number on your ID card and ask to be transferred to the Away From Home Care® Coordinator.

CareFirst BlueCross BlueShield Preferred Provider Network (PPN)

This plan is only available to participants who are enrolled as of December 31, 2011. New enrollments are not accepted for 2012.

This managed care plan coordinates with over 35,000 network providers (doctors, hospitals, diagnostic centers, etc.) throughout Maryland. Log onto www.carefirst.com for the most up-to-date provider information (which you may access from www.aacps.org>*Human Resources/Employment>Benefits*).

The PPN gives you the flexibility to see any provider within the CareFirst BCBS PPN network, including specialists, and you are not required to designate a PCP. If you travel out of state and need healthcare, call the toll-free number on the back of your ID card and you will be referred to the closest participating provider. There are over 900,000 PPN providers nationwide.

- **In-network:** In-network office visits are only \$15 and there is no paperwork to complete, as long as you use a network provider. If you are hospitalized, you are covered at 100%.

Medical Options

- **Out-of-network:** When you use a provider who does not participate in the PPN network, benefits are paid at a lower level. You must first satisfy a \$200 individual annual deductible, and then benefits are paid at 80% of the plans' allowed benefit. The maximum out-of-pocket annual expense for out-of-network providers is \$1,200 per year (individual), after which the plan pays benefits at 100%. There are no lifetime benefit maximums for in- or out-of-network benefits.

Disease Management Resources

Disease management programs provide resources for those with certain chronic health conditions, such as asthma or diabetes. If you suffer from one of the identified conditions, you may be contacted by Healthways (CareFirst BlueCross BlueShield's disease management partner). The goal of this program is to help employees better manage their health conditions and provide information and resources to improve their care. Please consider agreeing to work with a health advisor when they contact you.

For all medical plans:
No co-payments are required for annual physicals, well-baby visits, routine gynecological visits, and childhood preventive care visits.

Mental Health Benefits

All CareFirst Plans

Participants enrolled in the CareFirst medical plans may use Magellan's Behavioral Health Plan for guidance and referrals to mental health providers. No pre-authorization for care is required for outpatient visits (but is required for inpatient hospitalization). Participants may contact Magellan at 1-800-245-7013 to access care within the Magellan network or they may visit www.magellanassist.com for more information.

A Magellan representative will help you access care within the Magellan network. Visit www.magellanassist.com for more information on accessing care and providers, as well as wellness topics and self-assessment tools and resources.

To register on-line for the first time, type in the Magellan phone number, 1-800-245-7013 (from the back of your ID card), select "AACPS HMO," "PPN," or "Triple Option Plan," and create a user name and password. To read the contents of the monthly Magellan "Your Source" newsletter, look for "In the Spotlight – Topic of the Month".

All information discussed and shared with Magellan remains confidential. No information is disclosed to AACPS. Participants are encouraged to review the "Living Healthy Working Well" brochure, which is available at all work locations, at www.aacps.org>HR/Employment>Benefits>Healthcare>Magellan Brochure, or by contacting HR/Benefits.

Mental Health Costs

The Mental Health Parity Act (MHPA) controls participants' co-payments, co-insurances and deductibles. The Act requires that annual or lifetime dollar limits on mental health benefits be no lower than any such dollar limits for medical and surgical benefits offered by a group health plan. As long as services are rendered in-network, specialist co-payments apply (except for BlueChoice HMO which would be a \$5 co-payment). Out-of-network benefits would be subject to deductibles and co-insurance for the CareFirst PPN and BlueChoice Triple Option Plan. No out-of-network benefits are available for BlueChoice HMO members.

There are no limits on the number of visits for outpatient mental health services and no length-of-stay limits on inpatient care (which still must be pre-authorized).

Note that these guidelines are subject to change.

**Detailed Plan Benefit Guides are on-line
for easy access by employees.**

**To view details of the AACPS healthcare plans,
you may go to www.aacps.org and click on Human
Resources/Employment>Benefits>Healthcare.**

Medical Options

AACPS Medical Plans follow these federal guidelines:

Mastectomy Services

Federal law requires a group health plan to provide coverage for the following services to an individual receiving plan benefits in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

The group health plan must determine the manner of coverage in consultation with the attending physician and patient. Coverage for breast reconstruction and related services will be subject to deductibles and co-insurance amounts that are consistent with those that apply to other benefits under the plan.

Maternity and Newborn Length Of Stay

Under federal law, group health plans and health coverage issuers offering group coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to:

- Less than 48 hours following a normal vaginal delivery.
- Less than 96 hours following a cesarean section.

They may also not require that a provider obtain authorization from the plan or coverage issuer for prescribing a length of stay not in excess of those periods. The law generally does not prohibit an attending provider of the mother or newborn (in consultation with the mother) from discharging the mother or newborn earlier than 48 hours or 96 hours, as applicable.

Prescription Drug Program

CVS Caremark Prescription Drug Program

New 3-tier co-pay structure across all medical plans effective January 1, 2012.

The CVS Caremark Prescription Drug Program is a 3-tiered managed generic benefit program for AACPS employees and eligible dependents who are covered by the AACPS medical plans. **Retail and mail-order co-payments will change to a 3-tier co-payment structure for 2012.**

Please refer to the table below for co-pays effective January 1, 2012.

Starting January 1, 2012, your co-pay will depend on whether your doctor prescribes a generic, preferred brand, or non-preferred brand-name drug.

Tier	Medication Type	Retail (up to 30-day supply)	CVS/Caremark Mail Order or CVS retail pharmacy/Maintenance Choice (up to 90-day supply)
1	Generic	\$5	\$10
2	Preferred Brand (no generic equivalent)	\$15	\$20
3	Non-Preferred Brand	\$25	\$40

Obtain a copy of the CVS Caremark Primary/Preferred Drug List from www.caremark.com and discuss generic/preferred brand options with your physician.

www.caremark.com

You may access www.caremark.com to place and track your prescription mail orders and refills. Refills are often received within a few days of the order placement.

To use www.caremark.com, you must register and establish a password. Through www.caremark.com, you may review your benefit plan coverage, track out-of-pocket costs, read about the latest drug information, and receive on-line health newsletters.

You may also direct your prescription questions to a CVS Caremark pharmacist.

Waiver of Generic Co-Pay

You may be eligible to receive a free first fill for a generic alternative for a brand medicine you are currently taking. You may switch from a brand medication to generic at your local CVS retail pharmacy (90-day supply) or through mail-order. Yes, you may receive a 90-day supply at no cost! Your doctor is best qualified to decide whether a generic alternative is right for you.

Obtain a copy of CVS Caremark's Primary/Preferred Drug List from www.caremark.com and discuss generic alternatives with your physician.

Prescription Drug Program

Obtaining Your Prescriptions

Retail

CVS Caremark's retail pharmacy network is extensive and includes over 98% of pharmacies nationwide. You may fill short-term prescriptions for up to a 30-day supply, plus one refill, at any participating pharmacy.

Maintenance Medications

All medications that you take on a long-term basis for over 60 days (i.e., maintenance medications) may be filled through CVS Caremark's Pittsburgh, Pennsylvania mail-order service. To best utilize your mail-order benefit, you should ask your physician to write two prescriptions: one for your immediate needs (a 30-day supply through a retail pharmacy) and one that you will send to CVS Caremark's mail-order for up to a 90-day supply, plus up to three refills. First-time mail-order requests generally take 14 days for home deliveries.

After you receive your prescription from the mail-order service, refills are easy to order. Refills are processed quickly through the CVS Caremark system and may be ordered three ways.

1. **On-line** — Log on to www.caremark.com and click on "Refills." Have your prescription order number (on your prescription) and credit card information ready. The on-line refill service is very user friendly and is the quickest delivery method. You will receive a confirmation e-mail that your medication has been shipped.
2. **By phone** — Simply dial 1-800-344-8075; have your prescription order number (on your prescription), Social Security number, and credit card information ready.
3. **By mail** — Attach the refill label provided by CVS Caremark on a mail-order form (usually included with your original prescription when you receive it from CVS Caremark) and include your payment.

For more information about the benefits of your CVS Caremark prescription program, such as benefits or medication coverage: contact CVS Caremark directly at 1-800-841-5550 and identify yourself as a participant with Anne Arundel County Public Schools.

Maintenance Choice

You may choose to receive your 90-day supply of medications through CVS Caremark Mail Service or at a CVS Pharmacy. The co-pay is the same either way.

If you would like to switch a current 90-day prescription with remaining refills from mail service to a CVS pharmacy:

- Contact CVS Caremark at 1-800-824-6349, or
- Go to a CVS pharmacy to request the 90-day prescription (CVS will check with CVS Caremark that a prescription is on file), or
- Go to a CVS pharmacy with a new 90-day prescription.

If you are filling a maintenance medication for the first time and want to use a CVS Pharmacy:

- Bring the 90-day prescription to a CVS pharmacy, or
- Bring a 30-day prescription to a CVS pharmacy; CVS will contact the prescriber after the last allowable fill to get a 90-day prescription.

Coverage for Medicare Eligible Individuals

Individuals who are eligible for Medicare may enroll in a Medicare prescription drug plan, known as Medicare Part D, if you meet certain income requirements. If you enroll in such a plan, you must disenroll from the AACPS prescription drug plan. These Medicare prescription drug plans are offered through a number of private insurance carriers. If you are eligible for Medicare, you will be receiving additional information from CMS/Medicare about this benefit and how it may affect you.

If You Are Eligible For Medicare

If you have Medicare or will become eligible for Medicare in the next 12 months, you may be eligible for prescription drug benefits through Medicare. Please refer to the special notice at the end of this guide for important information about Medicare prescription drug coverage.

Dental & Vision Options

CareFirst BlueCross BlueShield

Dental Preferred Provider Organization

Benefits are available on an in- and out-of-network basis. You may visit www.carefirst.com to access provider network information. The PPO plan provides a higher level of coverage when using a preferred provider. When a non-preferred provider is used, reimbursement is lower. There is no in-network deductible for services; however, an out-of-network deductible of \$50 per member (no more than \$150 per family) applies. The annual benefit per covered member is \$1,500.

- Routine examinations (cleanings) received in-network are covered at 100% of the approved benefit amount.
- Fillings, extractions, and root canals are covered at 80% of the approved benefit amount.
- Other services, such as crowns, bridgework, implants, and periodontics, are covered at 80% of the approved benefit amount.
- Orthodontic benefits are covered for children and adults at 50% of the approved benefit, up to a lifetime orthodontia maximum of \$1,500.

If you have questions about the PPO Dental Plan, call CareFirst BCBS at 1-866-891-2802.

Traditional Dental Plan

The Traditional Dental Plan is slightly more expensive than the Dental PPO, but offers richer benefits for more routine services.

You may see any dentist with the Traditional Dental Plan. The yearly benefit maximum per person is \$1,500, after you satisfy the yearly deductible of \$25 per member (maximum \$50 family). This deductible does not apply to routine cleanings.

- Preventive maintenance services, including oral examinations and routine cleanings, are covered once every six months at 100% of the BCBS approved benefit.
- Other services, such as fillings, root canals, and extractions, are covered at 100% of the approved benefit.
- Crowns and oral surgery are covered at 80% of the approved benefit.
- Benefits for bridges, dentures, and implants are covered at 50% of the approved benefit.
- Orthodontic benefits are covered at 50% of the approved benefit for dependents and adults, up to the \$1,500 lifetime orthodontia maximum.

If you have questions about the Traditional Dental Plan, call CareFirst BCBS at 1-866-891-2802.

You may also refer to the CareFirst Dental and Vision Options Summary at the end of this guide for more information. The CareFirst PPO Dental Plan benefit summary and the CareFirst Traditional Dental Plan benefit summary are available on-line at www.aacps.org > HR/Employment > Benefits > Healthcare.



Dental & Vision Options

United Concordia

Dental POS

The United Concordia Dental Plan is a Point-of-Service (POS) plan that gives members greater flexibility to access dental care.

You may enroll in the United Concordia Dental Plan if you live in the plan's service area of MD, DC, Northern VA, and PA (network providers may be limited in some areas). Call United Concordia at 1-866-357-3304 if you have questions about the network.

With the United Concordia Dental Plan, you must select a primary care dentist. To find a participating dental provider, visit United Concordia's website at www.unitedconcordia.com or refer to a provider directory.

The United Concordia Dental Plan provides comprehensive dental coverage with no annual deductible and no annual maximum benefit for in-network services. United Concordia will reimburse up to a maximum of \$1,000 per family member per contract year for out-of-network services.

The orthodontic lifetime maximum is \$2,900. **There is no out-of-network coverage for orthodontic benefits under this plan.**

If you have questions about the United Concordia Dental Plan, call United Concordia at 1-866-357-3304.

CareFirst BlueCross BlueShield

Low Option & High Option Vision Plans

AACPS has two vision plans with CareFirst BCBS.

- **Vision Option 1** provides benefits for an eye examination every 24 months.
- **Vision Option 2** provides benefits for an eye examination every 12 months.*

Both options allow you to use optometrists, ophthalmologists, or retail outlets. Eye exams are covered up to 100% of the CareFirst BCBS approved benefit under both plans. Reimbursements for lenses and frames, and contacts are made at the same reimbursement schedule for both Vision Options 1 and 2.

Please refer to the CareFirst Dental and Vision Options Summary, at the end of this guide, to compare the two vision plans' benefits, or contact BCBS at 1-800-342-7287.

* For example, if you have Vision Option 2 and you have an eye exam on May 15, 2012, you may not have another covered eye exam until May 16, 2013. The same logic applies for Vision Option 1 (every 24 months).

Remember: if you are enrolled in the BlueChoice HMO, or BlueChoice Triple Option plans, these plans include vision care discounts.

Be sure to review the vision benefit provided through each of these medical options. If you are enrolled in one of these medical plans, you may use these discount benefits with certain providers to supplement benefits provided through your CareFirst vision program.

AACPS' Healthcare Costs for 2012

Units I, II, V & VI (Full-Time) – Tier 1

Effective January 1, 2012

				Your Bi-Weekly Payroll Deduction	
	Healthcare Options	Total Monthly Premium*	Board's Monthly Share	26 Pays	22 Pays
Medical Options					
CareFirst BlueChoice HMO	Individual	\$ 432.61	\$ 410.98	\$ 9.98	\$ 11.80
	Parent & Child	676.10	642.30	15.60	18.44
	Employee & Spouse	1,041.87	989.78	24.04	28.41
	Family	1,249.62	1,187.14	28.84	34.08
CareFirst BlueCross BlueShield Triple Option	Individual	\$ 536.15	\$ 482.54	\$ 24.74	\$ 29.24
	Parent & Child	983.00	884.70	45.37	53.62
	Employee & Spouse	1,280.29	1,152.26	59.09	69.83
	Family	1,535.74	1,382.17	70.88	83.77
CareFirst BlueCross BlueShield ** PPN	Individual	\$ 567.74	\$ 425.81	\$ 65.51	\$ 77.42
	Parent & Child	1,044.37	783.28	120.50	142.41
	Employee & Spouse	1,359.58	1,019.69	156.87	185.39
	Family	1,626.24	1,219.68	187.64	221.76
Dental Options					
CareFirst BlueCross BlueShield Traditional Dental	Individual	\$ 33.89	\$ 28.80	\$ 2.35	\$ 2.77
	Parent & Child	55.57	47.23	3.85	4.55
	Employee & Spouse	70.16	59.63	4.86	5.74
	Family	106.09	90.17	7.34	8.68
CareFirst BlueCross BlueShield PPO Dental	Individual	\$ 31.68	\$ 26.93	\$ 2.19	\$ 2.59
	Parent & Child	51.94	44.15	3.60	4.25
	Employee & Spouse	65.54	55.71	4.54	5.36
	Family	99.13	84.26	6.86	8.11
United Concordia Dental POS	Individual	\$ 16.18	\$ 13.75	\$ 1.12	\$ 1.32
	Parent & Child	26.97	22.92	1.87	2.21
	Employee & Spouse	32.36	27.51	2.24	2.65
	Family	43.15	36.68	2.99	3.53
Vision Options					
CareFirst BlueCross BlueShield Option 1—Low Level	Individual	\$ 3.24	\$ 2.75	\$ 0.22	\$ 0.27
	Parent & Child	4.54	3.86	0.31	0.37
	Employee & Spouse	6.51	5.53	0.45	0.53
	Family	7.77	6.60	0.54	0.64
CareFirst BlueCross BlueShield Option 2—High Level	Individual	\$ 6.01	\$ 5.11	\$ 0.42	\$ 0.49
	Parent & Child	8.40	7.14	0.58	0.69
	Employee & Spouse	12.07	10.26	0.84	0.99
	Family	14.41	12.25	1.00	1.18

* Total Monthly Premium for medical consists of your medical and CVS Caremark premium

** Grandfathered plan; no new enrollments accepted.

AACPS' Healthcare Costs for 2012

Effective January 1, 2012

Units I, II, V & VI (Part-Time) – Tiers 2&3

		Tier 2 (0.46-0.749 FTE)			Tier 3 (0.1-0.459 FTE)		
Healthcare Options		Board Share	26 Pays	22 Pays	Board Share	26 Pays	22 Pays
Medical Options							
CareFirst BlueChoice HMO	Individual	\$ 390.43	\$ 19.47	\$ 23.01	\$ 205.49	\$ 104.82	\$ 123.88
	Parent & Child	610.19	30.42	35.95	321.15	163.82	193.61
	Employee & Spouse	940.29	46.88	55.41	494.89	252.45	298.35
	Family	1,127.78	56.23	66.46	593.57	302.79	357.85
CareFirst BlueCross BlueShield Triple Option	Individual	\$ 458.41	\$ 35.88	\$ 42.40	\$ 241.27	\$ 136.10	\$ 160.84
	Parent & Child	840.47	65.79	77.75	442.35	249.53	294.90
	Employee & Spouse	1094.65	85.68	101.26	576.13	325.00	384.09
	Family	1,313.06	102.77	121.46	691.09	389.84	460.72
CareFirst BlueCross BlueShield ** PPN	Individual	\$ 404.52	\$ 75.33	\$ 89.03	\$ 212.91	\$ 163.77	\$ 193.55
	Parent & Child	744.12	138.58	163.77	391.64	301.26	356.03
	Employee & Spouse	968.71	180.40	213.20	509.85	392.19	463.49
	Family	1,158.70	215.79	255.02	609.84	469.11	554.40
Dental Options							
CareFirst BlueCross BlueShield Traditional Dental	Individual	\$ 27.36	\$ 3.01	\$ 3.56	\$ 14.40	\$ 8.99	\$ 10.63
	Parent & Child	44.87	4.94	5.83	23.62	14.75	17.43
	Employee & Spouse	56.65	6.23	7.37	29.82	18.62	22.00
	Family	85.66	9.43	11.14	45.09	28.15	33.27
CareFirst BlueCross BlueShield PPO Dental	Individual	\$ 25.58	\$ 2.81	\$ 3.33	\$ 13.46	\$ 8.41	\$ 9.93
	Parent & Child	41.94	4.61	5.45	22.07	13.78	16.29
	Employee & Spouse	52.93	5.82	6.88	27.86	17.39	20.56
	Family	80.05	8.81	10.41	42.13	26.31	31.09
United Concordia Dental POS	Individual	\$ 13.07	\$ 1.44	\$ 1.70	\$ 6.88	\$ 4.29	\$ 5.07
	Parent & Child	21.78	2.40	2.83	11.46	7.16	8.46
	Employee & Spouse	26.13	2.88	3.40	13.75	8.59	10.15
	Family	34.84	3.83	4.53	18.34	11.45	13.53
Vision Options							
CareFirst BlueCross BlueShield Option 1— Low Level	Individual	\$ 2.62	\$ 0.29	\$ 0.34	\$ 1.38	\$ 0.86	\$ 1.02
	Parent & Child	3.67	0.40	0.48	1.93	1.20	1.42
	Employee & Spouse	5.26	0.58	0.68	2.77	1.73	2.04
	Family	6.27	0.69	0.82	3.30	2.06	2.44
CareFirst BlueCross BlueShield Option 2— High Level	Individual	\$ 4.85	\$ 0.53	\$ 0.63	\$ 2.55	\$ 1.59	\$ 1.88
	Parent & Child	6.78	0.75	0.88	3.57	2.23	2.63
	Employee & Spouse	9.75	1.07	1.27	5.13	3.20	3.79
	Family	11.64	1.28	1.51	6.12	3.82	4.52

AACPS' Healthcare Costs for 2012

Units III & IV (Full-Time) – Tier 1

Effective January 1, 2012

				Your Bi-Weekly Payroll Deduction	
	Healthcare Options	Total Monthly Premium*	Board's Monthly Share	26 Pays	22 Pays
Medical Options					
CareFirst BlueChoice HMO	Individual	\$ 432.61	\$ 419.63	\$ 5.99	\$ 7.08
	Parent & Child	676.10	655.82	9.36	11.06
	Employee & Spouse	1,041.87	1,010.61	14.43	17.05
	Family	1,249.62	1,212.13	17.30	20.45
CareFirst BlueCross BlueShield Triple Option	Individual	\$ 536.15	\$ 493.26	\$ 19.80	\$ 23.39
	Parent & Child	983.00	904.36	36.30	42.89
	Employee & Spouse	1,280.29	1,177.87	47.27	55.87
	Family	1,535.74	1,412.88	56.70	67.01
CareFirst BlueCross BlueShield ** PPN	Individual	\$ 567.74	\$ 425.81	\$ 65.51	\$ 77.42
	Parent & Child	1,044.37	783.28	120.50	142.41
	Employee & Spouse	1,359.58	1,019.69	156.87	185.39
	Family	1,626.24	1,219.68	187.64	221.76
Dental Options					
CareFirst BlueCross BlueShield Traditional Dental	Individual	\$ 33.89	\$ 28.80	\$ 2.35	\$ 2.77
	Parent & Child	55.57	47.23	3.85	4.55
	Employee & Spouse	70.16	59.63	4.86	5.74
	Family	106.09	90.17	7.34	8.68
CareFirst BlueCross BlueShield PPO Dental	Individual	\$ 31.68	\$ 26.93	\$ 2.19	\$ 2.59
	Parent & Child	51.94	44.15	3.60	4.25
	Employee & Spouse	65.54	55.71	4.54	5.36
	Family	99.13	84.26	6.86	8.11
United Concordia Dental POS	Individual	\$ 16.18	\$ 13.75	\$ 1.12	\$ 1.32
	Parent & Child	26.97	22.92	1.87	2.21
	Employee & Spouse	32.36	27.51	2.24	2.65
	Family	43.15	36.68	2.99	3.53
Vision Options					
CareFirst BlueCross BlueShield Option 1—Low Level	Individual	\$ 3.24	\$ 2.75	\$ 0.22	\$ 0.27
	Parent & Child	4.54	3.86	0.31	0.37
	Employee & Spouse	6.51	5.53	0.45	0.53
	Family	7.77	6.60	0.54	0.64
CareFirst BlueCross BlueShield Option 2—High Level	Individual	\$ 6.01	\$ 5.11	\$ 0.42	\$ 0.49
	Parent & Child	8.40	7.14	0.58	0.69
	Employee & Spouse	12.07	10.26	0.84	0.99
	Family	14.41	12.25	1.00	1.18

* Total Monthly Premium for medical consists of your medical and CVS Caremark premium

** Grandfathered plan; no new enrollments accepted.

AACPS' Healthcare Costs for 2012

Units III & IV (Part-Time) – Tiers 2&3

Effective January 1, 2012

		Tier 2 (0.46-0.749 FTE)			Tier 3 (0.1-0.459 FTE)		
Healthcare Options		Board Share	26 Pays	22 Pays	Board Share	26 Pays	22 Pays
Medical Options							
CareFirst BlueChoice HMO	Individual	\$ 398.65	\$ 15.67	\$ 18.52	\$ 209.82	\$ 102.83	\$ 121.52
	Parent & Child	623.03	24.49	28.95	327.91	160.70	189.92
	Employee & Spouse	960.08	37.75	44.61	505.31	247.65	292.67
	Family	1,151.52	45.28	53.51	606.07	297.03	351.03
CareFirst BlueCross BlueShield Triple Option	Individual	\$ 468.60	\$ 31.18	\$ 36.85	\$ 246.63	\$ 133.62	\$ 157.92
	Parent & Child	859.14	57.17	67.56	452.18	244.99	289.54
	Employee & Spouse	1,118.98	74.45	87.99	588.94	319.09	377.10
	Family	1,342.24	89.31	105.55	706.44	382.75	452.35
CareFirst BlueCross BlueShield ** PPN	Individual	\$ 404.52	\$ 75.33	\$ 89.03	\$ 212.91	\$ 163.77	\$ 193.55
	Parent & Child	744.12	138.58	163.77	391.64	301.26	356.03
	Employee & Spouse	968.71	180.40	213.20	509.85	392.19	463.49
	Family	1,158.70	215.79	255.02	609.84	469.11	554.40
Dental Options							
CareFirst BlueCross BlueShield Traditional Dental	Individual	\$ 27.36	\$ 3.01	\$ 3.56	\$ 14.40	\$ 8.99	\$ 10.63
	Parent & Child	44.87	4.94	5.83	23.62	14.75	17.43
	Employee & Spouse	56.65	6.23	7.37	29.82	18.62	22.00
	Family	85.66	9.43	11.14	45.09	28.15	33.27
CareFirst BlueCross BlueShield PPO Dental	Individual	\$ 25.58	\$ 2.81	\$ 3.33	\$ 13.46	\$ 8.41	\$ 9.93
	Parent & Child	41.94	4.61	5.45	22.07	13.78	16.29
	Employee & Spouse	52.93	5.82	6.88	27.86	17.39	20.56
	Family	80.05	8.81	10.41	42.13	26.31	31.09
United Concordia Dental POS	Individual	\$ 13.07	\$ 1.44	\$ 1.70	\$ 6.88	\$ 4.29	\$ 5.07
	Parent & Child	21.78	2.40	2.83	11.46	7.16	8.46
	Employee & Spouse	26.13	2.88	3.40	13.75	8.59	10.15
	Family	34.84	3.83	4.53	18.34	11.45	13.53
Vision Options							
CareFirst BlueCross BlueShield Option 1— Low Level	Individual	\$ 2.62	\$ 0.29	\$ 0.34	\$ 1.38	\$ 0.86	\$ 1.02
	Parent & Child	3.67	0.40	0.48	1.93	1.20	1.42
	Employee & Spouse	5.26	0.58	0.68	2.77	1.73	2.04
	Family	6.27	0.69	0.82	3.30	2.06	2.44
CareFirst BlueCross BlueShield Option 2— High Level	Individual	\$ 4.85	\$ 0.53	\$ 0.63	\$ 2.55	\$ 1.59	\$ 1.88
	Parent & Child	6.78	0.75	0.88	3.57	2.23	2.63
	Employee & Spouse	9.75	1.07	1.27	5.13	3.20	3.79
	Family	11.64	1.28	1.51	6.12	3.82	4.52

Flexible Spending Accounts

AACPS contracts with HFS Benefits for Flexible Spending Account administrative services.

What is a Flexible Spending Account?

A Flexible Spending Account (FSA) permits you to pay for certain healthcare and/or dependent care expenses with pre-tax dollars. Because you will not pay any federal, state, or social security taxes on income placed into the plan, you can potentially save \$30-\$40 for every \$100 you elect to defer.

You should elect an FSA if you spend your own money on:

- Co-payments and/or deductibles
- Doctor visits
- Prescription drugs
- Physical therapy and/or chiropractic care
- Dental care and orthodontic expenses
- Vision care, eyeglasses, and contact lenses
- Laser eye surgery
- Child Care
- Before and/or after school care
- Day Camp/Summer camp
- Elder care

Note that over-the-counter medications (OTC) (except for insulin and certain categories of OTC medications as prescribed by a physician) are no longer eligible FSA expenses. Other forms of OTC medical items that are not drugs, such as blood sugar testing kits, bandages, and crutches, may be reimbursed by the healthcare FSA.

For a list of eligible healthcare expenses, go to the HFS Benefits website, www.hfsbenefits.com.

Keep reading! You can save up to 40% on these and other costs by enrolling in an FSA.

How FSAs Will Save You Money

Most of us have expenses for medical services and supplies that are not reimbursed by any medical, dental, vision, or other plan. Also, some of us have child care or elder care expenses that we incur so that we can work. If you anticipate expenses in either of these categories, enrolling in a Flexible Spending Account can save you money.

Flexible Spending Accounts let you use untaxed money to pay for certain health care and dependent care expenses for you and your dependents. These are expenses that are not covered by any insurance plans or other sources. By participating, you lower your federal, state, and Social Security taxes and increase your take-home pay.

There is no cost to participate in a Flexible Spending Account. You choose the pre-tax payroll contributions to make to your account; in fact, by participating in a Flexible Spending Account, you are actually using dollars you would have paid in taxes to help pay for your health care and/or dependent care costs.

FSA Cost Comparison – *See the Benefit of an FSA*

*Maryland Resident in 15% Federal Tax Bracket

Without an FSA

Gross Monthly Income	\$2500
Federal & State Tax	- 563
FICA Tax	- 191
Net Paycheck	\$1746

After-Tax Medical Expense	- 100
After-Tax Dependent Expense	- 400
Net Spendable Monthly Income	\$1246

With an FSA

Gross Monthly Income	\$2500
Before-Tax Medical Expense	- 100
Before-Tax Dependent Expense	- 400
Adjusted Gross Income	\$2000

Federal & State Tax	- 450
FICA Tax	- 153
Net Spendable Monthly Income	\$1397

Net Tax Savings =
\$151.00 per month OR \$1812.00 per year!

Flexible Spending Accounts

Reminder: If you want to elect an FSA, on-line enrollment is required *every* year during Open Enrollment.

How FSAs Work

- During Open Enrollment (or when you first become eligible) you decide how much you want to contribute from your pay to an FSA. You can establish an FSA for your health care expenses and/or for your dependent care expenses. Note that healthcare FSAs and dependent care FSAs are two separate accounts, and not interchangeable.
- Enroll on-line using the Benefits on-line enrollment system. When you enroll, enter the amount you wish to contribute to your healthcare FSA and/or your dependent care FSA for the plan year. This amount will be divided into equal payments and deducted pre-tax from each paycheck. Since your contributions are not taxed, you will enjoy an immediate tax-savings.

If you are a new employee, you may enroll within 31 days of your date of hire on the on-line Benefits enrollment system. Your enrollment will be confirmed on your Open Enrollment Confirmation Statement (available on the Benefits on-line enrollment system). Please verify you are signed up in the correct FSA plan and your deduction is accurate.

- When you enroll, you authorize AACPS to deduct a certain portion of your earnings each pay period, before taxes. Your contributions are set aside in your FSA throughout the year via payroll deduction.
- You can contribute \$5,000 a year to the **healthcare FSA**. When you have an eligible expense, you can use your FSA debit card or pay the cost up front and be reimbursed from your account. Remember, you do not pay taxes on the money reimbursed to you from your Flexible Spending Account. All the money in a healthcare FSA is available on day one.
- You can contribute up to \$5,000 a year (\$5,000 per household maximum) to the **dependent care FSA** (or \$2,500 a year if you are married but file a separate tax return from your spouse). A dependent care spending account is intended to help you pay for childcare while you and/or your spouse work. If you are married, you can only use this account if your spouse is employed. If not employed, he/she must be is a full-time student for at least five months of the year, or be disabled.

Day care contributions cannot exceed your income or your spouse's income. If your spouse is a full-time

student or disabled, your spouse is treated as having an income of \$250 per month (\$500 per month if two or more dependents receive day care). If you are in this situation, you may not contribute more than \$250 (or \$500) into the FSA each month, regardless of your income.

You can pay for day care expenses for:

- children under age 13
- disabled children
- disabled parents
- a disabled spouse, specifically someone you claim on your taxes,
- other relatives who qualify under the Internal Revenue Code

Educational expenses are not eligible.

Eligible day care expenses include:

- Licensed nursery school and day care centers for pre-school children
- Day care centers for other qualifying dependents (for example, eldercare centers)
- Housekeepers, cooks, or maids who provide dependent care in your home
- Individuals other than your dependents who provide day care for your qualifying dependents, either inside or outside your home

In addition, pre-school expenses may be eligible. Contact HFS Benefits for verification.

Please note that a dependent care FSA cannot be used for healthcare expenses of a spouse or child.

Money in a dependent care FSA is based on funds available and must accrue each pay period to be eligible for reimbursement.

How to Avoid “Use It or Lose It”

The IRS says that if you don't use all the money in your FSA by plan year end, the unused amount must be forfeited. Not to worry! Through careful planning, nearly all participants use all the funds in their FSAs each year. Here are just a few strategies you can use to be sure that you are making every penny in your FSA count.

Flexible Spending Accounts

- Plan ahead when enrolling – base your contribution on your anticipated expenses for the plan year which are not covered by other insurance or benefit plans. One way to estimate those expenses is to look back at the healthcare and dependent care expenses you paid out of your own pocket during the past plan year. This can be the basis for your annual contribution, adjusted of course for any past or future extraordinary expenses. A worksheet is available on the website to help you plan. Go to www.hfsbenefits.com. If you are a new hire, remember to estimate your out-of-pocket expenses from your hire date up to December 31 (not 12 months of estimated expenses.)
- Reschedule future health care appointments. If you reach the last quarter of the plan year and still have a significant balance in your account, consider accelerating future health care appointments before your plan year end. For example, that January eye exam you had planned? Try to reschedule for November or December.
- Pay for services that have limited coverage in your health care plans. Many health care plans offer some, but not full, coverage for certain expenses such as laser eye surgery, orthodontic visits and braces, prescription drugs, co-payments, etc. Be sure that you have requested reimbursement for any partial payments you have made for these services.
- And remember – even if you only use approximately 60-70% of the dollars you contributed to your account, you still break even thanks to the tax savings on the dollars you did spend!

IMPORTANT! Requests for reimbursement of eligible expenses incurred during 2011 may be submitted through March 31, 2012.

The FSA Debit Card

When you enroll in a healthcare FSA, HFS Benefits will send you and your dependents a “Benefits Card” (like a debit card). You may receive additional cards for a small fee by contacting HFS Benefits directly.

The FSA Debit Card offers the convenience of paying for your eligible healthcare expenses directly at the point of sale. It may not be used for dependent care expenses. It works a lot like your bank ATM debit card. Since the card lets you pay for eligible healthcare expenses directly from your health care FSA, it means no more paying cash for services up front. It also eliminates the waiting period for reimbursement checks and the hassle of filling out claims forms. The FSA debit card can be used at most healthcare providers where MasterCard is accepted.

Since the FSA plan is a pre-tax benefit, the Internal Revenue Service (IRS) requires that all purchases be substantiated. Therefore, when requested, you are required to submit copies of your receipts to the plan administrator to comply with the guidelines provided by the IRS.

For the healthcare FSA, the limit on your card is your annual elected contribution amount. If a provider does not accept the card, you can always submit a claim for reimbursement. HFS Benefits will either mail a reimbursement check to your home address or issue a direct deposit into the bank account that you have provided. More information about the FSA Debit Card is available at www.hfsbenefits.com.

Remember, you cannot use your FSA debit card for over-the-counter (OTC) purchases unless specifically prescribed by your physician for eligible products.

Required Recordkeeping

Save all your receipts in a convenient location since purchases made with your FSA Debit Card may need documentation substantiation. The plan administrator is required to substantiate all transactions that do not match an exact co-payment associated with your employer's health plan. This system will also be helpful when preparing your taxes!

Flexible Spending Accounts

Your FSA Administrator

HFS Benefits is the FSA administrator for AACPS. Please contact your dedicated FSA Representative with any questions regarding your FSA plan. The FSA Service Team is available Monday–Friday 8:00 a.m. to 5:00 p.m. E.S.T.

HFS Benefits

4 North Park Drive, Suite 500

Hunt Valley, MD 21050

Phone: 1-410-771-1331 or 1-888-460-8005

Fax: 410-771-5533 or 1-888-510-4218

Email: customerservice@hfsbenefits.com

Debit card substantiation: debitcard@hfsbenefits.com

Website and Online Access: www.hfsbenefits.com
(check account balances here)

All forms are available from the Flexible Spending Accounts link on the AACPS website, or by contacting HR/Benefits (410-222-5221/5219) or from the FSA website at www.hfsbenefits.com.

Submitting Claims

To receive reimbursement from your Dependent Care FSA, or for certain healthcare expenses when you cannot use your “Benefits Card,” you will need to complete a claim form. Claim forms are available from the Flexible Spending Account link on the AACPS website, or by contacting HR/Benefits. Submit your claims forms to:

HFS Benefits

4 North Park Drive, Suite 500

Hunt Valley, MD 21050

Fax: 410-771-5533 or 1-888-510-4218

Email with scanned receipts: claims@hfsbenefits.com

Reimbursements are issued once a week by check or direct deposit. Claims received by close of business Wednesday will be paid on Friday. You may set up a direct deposit with HFS Benefits so that reimbursements go directly into your account. To set up direct deposit, you will need to complete an HFS Benefits Direct Deposit Authorization form. Claim forms and the HFS Benefits Direct Deposit form are available from the Flexible Spending Account link on the AACPS website, or by contacting HR/Benefits.

If you terminate employment during the plan (i.e. calendar) year, you must submit your healthcare or dependent case claims within 90 days after your termination of employment. If you so choose, you may elect to continue making contributions to your FSA through COBRA (contact Discovery Benefits at 1-866-451-3399).

FSA Direct Deposit

When you elect an FSA account, you can also sign up to have your reimbursements directly deposited into the account of your choice. What could be more convenient?

Life and Accidental Death & Dismemberment Insurance

Group Term Life Insurance

Life and Accidental Death and Dismemberment (AD&D) insurance provides financial security to your survivors if you die. AACPS provides eligible employees with Group Term Life and AD&D insurance at no cost. All permanent employees are eligible for this benefit. These benefits are offered through CIGNA Life Insurance Company, and are provided without evidence of insurability. In the event of your death, your beneficiary(ies) will receive your designated benefit amount. You may update your beneficiary at any time by completing the Self-Administered Beneficiary Designation form. This form is maintained in your benefits file and should be kept up to date, especially if you experience a lifestyle change (e.g., marriage or divorce).

Only the first \$50,000 of group term life insurance is tax-free. Federal tax law requires that you be taxed on the cost of your group term life insurance in excess of \$50,000 depending on your age and the amount of your coverage. This cost is called *imputed income* and is included in your W-2 earnings.

AD&D insurance provides benefits in addition to your life insurance coverage. Benefits will be paid to your designated beneficiary if you die, suffer the loss of a limb in an accident, or are injured in any accident occurring during business or pleasure. The maximum amount of insurance is equal to the amount of your AACPS-sponsored group life term insurance.

If bodily injuries result in death or dismemberment within one year of the date of the covered accident, the plan will pay benefits according to plan guidelines. Refer to the CIGNA Life booklet available at www.aacps.org > **Human Resources/Employment > Benefits** for more details.

Group Term Life Conversion and AD&D Conversion

When you terminate employment or retire, Human Resources will send you information about converting your coverage to an individual policy. When your coverage ends, you may elect to convert coverage to an individual life insurance policy subject to the following terms:

- Term insurance is not available.
- You may not apply for an amount greater than your coverage under this policy.
- The policy will not contain disability or other extra benefits.
- No evidence of insurability required.
- If the group policy is terminated, you may not convert unless you have been covered for at least three years. In this case, you may not apply for more than \$10,000 of insurance.

To convert your coverage to an individual policy, you must:

- apply within 31 days after your coverage under this policy ends, and
- pay the required premium, based on our table of rates for such policies, your age, and class of risk.

The policy will take effect at the end of this 31-day conversion period. If you die during this period, CIGNA will process the benefit amount as if you had converted to an individual policy. It does not matter whether you applied for a converted policy. If such a policy is issued, it will be in exchange for any further benefits from your policy.

Your negotiated agreements determine your Group Life coverage amounts.

Life and Accidental Death & Dismemberment Insurance

Supplemental Life

Supplemental Life Insurance coverage is available to all permanent employees at a reasonable cost through CIGNA Life Insurance Company. If you purchase Supplemental Life when you are first hired, you need not complete a medical questionnaire (Evidence of Insurability, or EOI) unless you are electing over \$100,000 in coverage. Complete the Voluntary Life Insurance Application in your packet and return to HR/Benefits within 31 days of your employment.

Thereafter, you may purchase Supplemental Life Insurance during any annual Open Enrollment period with EOI. You may also make changes to the amount of your coverage, with EOI, if you experience a lifestyle change. This protection can provide additional coverage to your AACPS group term program and any other life insurance coverage you may have. You may elect to buy in \$5,000 increments at a minimum of \$5,000 coverage up to \$50,000, then increments of \$25,000 up to a maximum of \$200,000 during Open Enrollment upon approval by CIGNA (see below). Please note that Unit III members may only purchase up to \$100,000 in Supplemental Life coverage.

During Open Enrollment, if you elect new or additional coverage, please complete the Voluntary Life Insurance Application and the medical questionnaire, which you may download from the on-line enrollment system or obtain at your work location, and submit forms to HR/Benefits by November 11, 2011.

Premiums for Supplemental Life Insurance are based on your age and the dollar amount of coverage. All premiums are deducted on a post-tax basis. If you are currently enrolled in voluntary life, you are not required to take any action during Open Enrollment, unless you wish to increase or decrease your coverage.

Your Supplemental Life Insurance is portable if you terminate your employment. You may elect to convert your coverage within 31 days after your coverage terminates. You may convert your group and supplemental life coverage on the same form provided at termination.

Long Term Disability

Long Term disability insurance is designed to replace a portion of your income if you are unable to work due to a certifiable illness or injury that lasts more than 90 days. *This benefit is provided, at no cost, for permanent employees in Unit V and Unit VI who are at least a 0.46 FTE.*

The Plan, offered through CIGNA, pays 66.67% of your monthly base pay up to a maximum monthly benefit of \$6,000. The benefit that you receive will be offset by any other payments from other sources, such as Social Security Disability Income, other disability policies, or disability retirement pay. Benefits will continue to be paid as long as your disability is medically documented by your attending physician and approved by CIGNA. Disability benefits will stop when you are no longer deemed disabled, released to return to duty by your attending physician, die, or reach age 65.

*** Please note that disability income benefits through payroll deduction are available to other units through AACPS-sponsored voluntary benefit vendors. Refer to the Voluntary Benefits section of this guide for more information.**

Voluntary Benefits

The Voluntary Benefits Guide

The *Voluntary Benefits Guide* details other voluntary benefits that are available from AACPS through payroll deductions. The guide is available on-line at www.aacps.org>**Human Resources/Benefits**, at your work location or by requesting one from HR/Benefits at 410-222-5219/5221.

Credit Union

AACPS employees are eligible to join the Anne Arundel County Federal Employees' Credit Union. Various savings and checking options are available through payroll deductions and/or direct deposit. See the *Voluntary Benefits Guide* for office locations, phone numbers, and more information on other perks available for members.

Savings Accounts

The *Voluntary Benefits Guide* also details information about the Savings Account direct deposit option, where you may direct funds from your paycheck to the financial institution of your choice.

Savings Bonds

The U.S. Savings Bonds program is available through payroll deduction. Employees enroll in savings bonds through Treasury Direct. Once an account is established, employees sign up for a savings account direct deposit deduction by completing a Savings Bond Authorization Form, including account information, and sending it to HR/Benefits to initiate the deduction.

Other Voluntary Benefits

Finally, you have the option to enroll for other voluntary payroll deducted benefits, such as additional life insurance for you and your dependents, disability protection, long-term care, supplemental retirement income plans, and cancer expense/hospital protection plans. Refer to the *Voluntary Benefits Guide* for more information, including the program representatives and phone numbers. This guide may be obtained at www.aacps.org>**Human Resources/Employment>Benefits**, at your work location or through HR/Benefits at 410-222-5221/5219.

Long-term Care Insurance Program

Long-term Care insurance is available on a group-sponsored voluntary basis (at group discounted rates) for all permanent employees (16 or more hours per week) through Unum. New employees are eligible to enroll in the plan within 31 days of their date of hire with a guaranteed issue coverage (no medical underwriting required) up to certain benefit levels. Current employees may only enroll during Open Enrollment, with a medical questionnaire.

Family members including spouses, parents/parents-in-law, grandparents and grandparents in-law, siblings, and adult children (ages 18-80) are eligible to enroll, but are required to complete the Evidence of Insurability (EOI). Employees (including spouse's plan) may have payroll deduction through AACPS. Other family members who are approved would be directly billed by Unum.

All benefit levels include coverage for professional home healthcare, assisted living facilities, and nursing homes. Benefits are differentiated by inflation protection options and non-forfeiture benefits. Facility benefit duration length includes three years, six years, or unlimited duration options.

Enrollment Kits may be obtained the following ways:

- at Open Enrollment meetings
- by contacting Unum at 1-800-227-4165
- by downloading enrollment forms by going to the on-line benefits enrollment site and following the long-term care link
- by e-mailing your request to benefits@aacps.org
- by calling HR/Benefits at 410-222-5221 or 410-222-5219

Note: Your benefit deductions in 2012, including voluntary benefits, will be in deducted in conjunction with your payroll frequency, either 22 or 26 pays (except retirement which will continue at 20 or 26 payroll deductions).

Voluntary Benefits

College Savings Plans of Maryland (529 Plan)

AACPS participates in the College Savings Plans of Maryland, which is designed to help families prepare for future college costs (for dependents or yourselves). The plan consists of two programs—the Maryland College Investment Plan and the Maryland Prepaid College Trust.

Funds invested in this plan can be used for tuition, room and board, and other college-related expenses at any accredited college in the U.S. and some abroad as well. **The Maryland College Investment Plan** offers investors a choice of ten different investment portfolios managed by T. Rowe Price. This gives you the flexibility to select the portfolio that is best for you and your family. This plan is available through AACPS payroll deduction (minimum \$25 per pay), and you may enroll at any time. Up to \$2,500 in contributions per account per year is tax deductible for Maryland State withholding purposes.

The Maryland Prepaid College Trust is also available to AACPS employees through payroll deduction; however, there is a limited enrollment period during the first quarter of every calendar year. Please check plan information for more specific details. This plan:

- allows you to lock in tomorrow's college costs based on today's prices
- provides the security of a Maryland legislative guarantee
- pays the full in-state tuition and fees at any Maryland public college; for out-of-state or private schools, the Prepaid College Trust will pay the weighted average tuition

You may call the College Savings Plans of Maryland at 1-888-4MD-GRAD with questions about these programs, or go on-line for more information and to enroll at www.collegesavingsmd.org. Enrollment forms should be sent directly to: Maryland College Investment Plan, P.O. Box 17479, Baltimore, MD 21297-1479.

In order to have a College Savings Plan deduction from your paycheck, you will need to forward the College Savings Plan Payroll Deduction form received from the College Savings Plan to HR/Benefits.

If you want to make changes in the amount deducted from your paycheck, email Benefits at benefits@aacps.org or write to HR/Benefits directly.

Other Useful Information

Tuition Reimbursement

Certain levels of reimbursement for tuition expenses are available, depending on your Unit. Refer to your Negotiated Agreement or Board Policy for details. Contact Human Resources at 410-222-5078 for more information.

Unit	Association	Includes	Website: www.aacps.org/humanresources/
I	TAAAC	Teachers, Social Workers, PPWs, etc.	TAAAC.pdf
II	AEL	Administrators	AELA.pdf
III	AFSCME	Custodial, Food Service, Bus Drivers, Maintenance	AFSCME.pdf
IV	SAAAAC	Secretaries, Clerks, T.A.s	SAAAC.pdf
V	None	Professional Support	bene_forms/prof.pdf
VI	None	Executive Staff	bene_forms/exec.pdf

Retirement and Pension Plans

Maryland State Retirement and Pension Systems

All new permanent employees scheduled to work over 500 hours annually are automatically enrolled in the State Retirement and Pension System, and a contribution of 7% of annual salary is required. Full retirement benefits are available after 30 years of service or age 62 with five years of service. If hired on or after July 1, 2011, full retirement benefits are available at age 65 with 10 years of service or if age plus service equals 90.

As an active member, you should be aware that your accumulated benefits are protected if you leave the State Retirement and Pension System and you are vested (have accrued at least five years of eligibility service or if hired on or after July 1, 2011, 10 years of service). Once you are vested, if you should leave your job for any reason, you are guaranteed to receive a future benefit for the years and months of service earned before termination, unless you withdraw your accumulated contributions from the Contributory Pension System.

Details about benefit accruals, early retirement eligibility, and payment options can be found in the Pension System Handbook. You may also update your beneficiary information to the state at any time or, if you are eligible and within one year of retirement, request an estimate of your pension.

Information about retiree healthcare, including eligibility, benefits, and costs is available from the Office of Retirement. If you were hired on or after September 15, 2002, a separate retiree healthcare funding schedule applies. For more information, review Board Policy 800.13 or contact the Office of Retirement.

For more information about retirement benefits, to obtain a beneficiary/estimate form, or a copy of the handbook, please call our retirement counselors in the Office of Retirement at 410-222-5224.

You may access the Maryland State Retirement System by linking to www.aacps.org > **Human Resources/ Employment > Benefits > Retirement (for Active Employees.)** Forms and MSRA handbooks can be downloaded from this site. This website also houses the “Mentor” newsletter and information about pre-retirement counseling sessions.

AACPS Pre-Retirement Planning Program

When you want to plan for your retirement, these are some questions to consider:

- How much retirement income will you receive from the State Retirement and Pension Systems?
- How much retirement income will your supplemental plan(s) generate and what will your payment options be?
- What will you have to pay in taxes?
- How do you apply for Social Security benefits?
- What are the available healthcare options?
- How can you properly plan for your survivors if something happens to you?

Unfortunately, many retire without the benefit of a good pre-retirement planning program. AACPS presents a program each spring and fall to help answer questions like these, and more! Topics cover the Maryland State Retirement System benefits, Social Security benefits, estate planning, and retiree healthcare benefits, to name a few. It's never too late...or too early to plan for your retirement.

Information about these sessions appears each spring and fall in flyers distributed to each school and work location. If you have any questions about this program or would like to offer ideas on course content, please email the Office of Retirement at retirement@aacps.org.

Supplemental Retirement Program

Supplemental Retirement Plan 403(b) and 457(b) Plans

The Supplemental Retirement Plan is an important component of your overall benefits and compensation as an AACPS employee.

Four investment providers: ING, Lincoln, MetLife, and Valic are available for permanent and temporary employees to select. Each provides both 403(b) and 457(b) investment options. This program provides AACPS participants with lower fees and great investment choices.

There are many advantages of the Supplemental Retirement Plan that will help you save for retirement, including:

- The ability to save regularly for retirement on a tax-deferred basis (in accordance with the annual IRS limits), which can reduce your taxable income – only \$1 per pay period is required for you to start saving.
- Lower investment fund fees.
- Easy transfer of balances between investment funds.
- A wide array of investment options.
- Flexibility.
- Online planning tools.

AACPS permanent and temporary employees are eligible to participate in a 403(b), and/or 457(b) plan(s) immediately from date of hire or thereafter at any time during employment.

You may participate in a number of plans, such as contributing to a 403(b) and 457(b) plan at the same time through one or different vendors, as long as your total annual contribution amount does not exceed the IRS maximum. You may change (increase/decrease) your contributions any time by having your provider submit a Payroll Reduction Authorization form to HR/Benefits.

The IRS annual limits for 2011 and 2012 are detailed on page 35. If you are age 50 or older, you may contribute \$22,000 to each program or a combined total of \$44,000 (2012 limit information not available at time of print).

How Do I Enroll?

- First, you should refer to the link for Supplemental Retirement Plans at www.aacps.org > **HR/Employment > Benefits > Supplemental Retirement** for information about saving for retirement, the different investment providers, and a comparison of the funds offered.
- Second, contact the investment provider(s) of your choice. They will meet with you to discuss retirement planning and the representative will submit a Salary Reduction Authorization form on your behalf to HR/Benefits, to commence payroll deductions.

Supplemental Retirement Program

You may contribute to one or multiple plans (403b and/or 457b) provided you do not exceed IRS limits (see plan limit information below) for either plan.

Did you know that an advantage of contributing to a 457(b) program is that you may receive a distribution from your account at age 55 without tax penalties, unlike a 403(b) plan where there are penalties incurred prior to age 59 ½.

	403(b)	457(b)
2011 Contribution limit under age 50	\$16,500	\$16,500
2011 Contribution limit over age 50	\$22,000	\$22,000
2012 Contribution limit under age 50	\$16,500*	\$16,500*
2012 Contribution limit over age 50	\$22,000*	\$22,000*
Federal/State Tax	Deferred	Deferred
Normal distribution age – 10% penalty applies prior to this age	59.5	55
Payroll reduction	Yes	Yes
Loan Provision	Yes	No
Investment Options	Mutual Funds	Mutual Funds

** updated IRS limits for 2012 not available at time of print.*

Tips for selecting your AACPS Supplemental Retirement Program



Educate yourself on the investment providers and new options available to you. Visit the AACPS intranet/Internet for comprehensive information.



Evaluate each investment provider to determine how the options they offer fit into your overall investment strategy. Schedule a one-on-one appointment with a provider representative. Contact information is on the AACPS intranet or internet sites.

Continuing Your Healthcare Coverage

If you leave AACPS, or your covered dependents lose eligibility for healthcare coverage, you and/or your dependents may elect to continue coverage through COBRA (Consolidated Omnibus Reconciliation Act). COBRA allows you to continue coverage when that coverage would otherwise end because of a life event known as a “qualifying event.”

COBRA must be offered to each person who is a “qualified beneficiary.” Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Qualified beneficiaries who elect COBRA continuation coverage must pay 102% of the full premium.

If you are an employee, you are a qualified beneficiary if you lose your coverage because:

- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you are a qualified beneficiary if you lose your coverage because the employee:

- Dies
- Employment ends for any reason other than his or her gross misconduct
- Becomes enrolled in Medicare (Part A, Part B, or Part D) or
- Becomes divorced

Your dependent children become qualified beneficiaries if they lose coverage under the plan because:

- The parent-employee dies
- The parent-employee’s hours of employment are reduced
- The parent-employee’s employment ends for any reason other than his or her gross misconduct
- The parent-employee becomes enrolled in Medicare (Part A, Part B, or Part D)
- The parents become divorced or
- The child stops being eligible for coverage under the plan as a “dependent child”

How COBRA Continuation Coverage Works

AACPS’ COBRA administrator is Discovery Benefits. Discovery Benefits will send out COBRA notifications to eligible participants based on the criteria listed earlier. Notice must be provided within certain timeframes, and documentation may be required. COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

Keep in mind that COBRA is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, Part D), your divorce, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage generally lasts for up to **36 months**.

When the qualifying event is the end of employment or reduction of the employee’s hours of employment, COBRA continuation coverage lasts for up to **18 months**. There are two ways in which this 18-month period of COBRA continuation coverage can be extended: in the case of disability and a second qualifying event.

Please Note:

This section is a summary of COBRA continuation coverage.

For additional information about specifics of COBRA coverage, COBRA rights, and COBRA costs, please contact Discovery Benefits at 1-866-451-3399. For additional information, you may visit Discovery’s website at www.discoverybenefits.com.

Some Final Words

AACPS is proud to provide a very comprehensive and affordable benefits package to its dedicated employees. This guide contains highlights of the benefit plans available to Anne Arundel County Public Schools employees. It does not include every detail about the plans. Each benefit is governed by an official plan document or insurance contract. If there is a conflict between this guide and the wording of the corresponding plan documents, the plan documents will prevail.

CareFirst BlueCross BlueShield provides detailed summaries to participants.

Summaries are available on-line at

www.aacps.org>Human Resources/Employment>Benefits>Healthcare.



Glossary

Allowed Benefit (AB)

A term used by insurance carriers (like reasonable and customary) which represents the amount of benefit allowed to be paid by the carrier for a procedure or service.

COBRA

COBRA is the abbreviated term for the Consolidated Omnibus Reconciliation Act. COBRA requires employers to provide continuation of coverage, up to a maximum of 36 months, to terminating employees or eligible dependents losing coverage. Other terms of coverage also apply. Employers may charge up to 102% of the premium.

Co-insurance

Your share of medical expenses normally after you have paid your deductible.

Coordination of Benefits (COB)

COB applies if you or a family member is covered under another medical plan in addition to the coverage you have through AACPS. The benefits payable under your AACPS-sponsored coverage are coordinated with the other plan so that your total benefits from both plans will not exceed 100% of the benefit.

Co-payment

Your out-of-pocket payment when you visit your physician or other healthcare provider (e.g., a \$5 co-payment applies for primary care visits under the Aetna HMO).

Covered Expenses

Routine medical care and specific medical expenses incurred as a result of a non-occupational illness, injury, or disease which are benefits provided by your healthcare plan.

Deductible

The amount of medical expenses that must be paid in full each calendar year before benefits are usually paid from the plan.

Eligible Expenses

Allowable expenses for necessary medical care, which are determined by the healthcare plan in which you participate. Reasonable and customary guidelines may apply (see definition of reasonable and customary).

Flexible Spending Accounts (FSAs)

FSAs provide employees with the opportunity to save money on a pre-tax basis and reduce their taxable income up to permitted IRS limits to save for related expenses. AACPS provides a Dependent Day Care FSA and Healthcare FSA option to employees. Careful planning is required for funding the FSA because there is a “use-or-lose” condition if funds are not requested by the annual deadline.

Guaranteed Issue

A term associated with applying for coverage when no evidence of insurability is required, up to certain limits (e.g., long-term care or supplemental life insurance benefits).

Health Care Provider

A doctor, hospital, laboratory, nurse, or anyone who delivers medical or health related care. This is not to be confused with primary care physician.

Health Insurance Portability & Accountability Act (HIPAA)

Healthcare legislation passed to ensure confidentiality of plan members and to ensure safeguards for transmitting healthcare information in a confidential and secure fashion.

Health Maintenance Organization (HMO)

HMOs provide health care services for a fixed fee and a low co-payment for services. You are covered only for treatment approved by the HMO and you must use HMO physicians and facilities (refer to page 11).

In-Network

You receive the highest level of benefits when you use in-network providers (i.e., CareFirst PPN or United Concordia Dental Plan). In-network providers have negotiated agreements with health insurance companies to accept the health insurance companies’ payment for services rendered in addition to your co-payment.

Lifestyle Change

Normally involves the addition or loss of a dependent family member or a change in your or your spouse’s employment or healthcare coverage. You have 31 days to notify HR/Benefits to change your benefits (refer to page 6 for more information).

Maintenance Medications

Maintenance medications are considered medications as defined by the prescription drug plan which are usually taken over a long period. In this program's case, if a medication is taken typically over 60 days, it is considered a maintenance medication. Examples include blood pressure medication, diabetic products, and birth control pills. Maintenance medications must be ordered through the mail-order service with CVS Caremark or at a CVS pharmacy.

Managed Care

Managed care is a concept that permits healthcare plans and employers to administer healthcare plans in a more efficient and cost-effective manner. Examples of managed care include networks of providers, pre-certification, preventive care, and health education programs.

Out-of-Network

Some plans, such as the CareFirst PPN and United Concordia, give you the additional flexibility to seek care outside of your network and still receive coverage, but at reduced benefits. Coverage includes satisfying a deductible and then co-insurance where you pay usually 20% or 30% of the cost of service. Claims forms must be submitted to the carriers for out-of-network visits.

Par/Non Par Providers

Terms used by insurance companies that reflect participating status of providers in the network.

Patient Protection and Affordable Care Act (PPACA)

Healthcare reform legislation, which includes numerous health-related provisions, to take effect between 2011 and 2014. This act expands Medicaid eligibility, subsidizes insurance premiums, provides incentives for businesses to provide healthcare benefits, prohibits denial of coverage based on pre-existing conditions, establishes health insurance exchanges, and supports medical research amongst many other provisions.

Point of Service (POS)

POS is a category of healthcare plans in which carriers negotiate agreements with a network of participating physicians to provide healthcare at a reasonable co-payment to participants.

Preferred Provider Network (PPN)

A PPN healthcare plan is provided by an insurance carrier whereby the insurance carrier has negotiated agreements with a network of participating providers to accept the negotiated payment for services rendered and provide a reasonable co-payment to participants. A PPN does not require participants to select a primary care physician and they may seek care from specialists without the need for a referral. Most PPNs provide benefits for both in- and out-of-network services (refer to page 14).

Premium

A charge applied either to an employer and/or participant that represents the costs of healthcare.

Primary Care Physician (PCP)

An old-fashioned family doctor called by a new name. A general physician, pediatrician, and gynecologist can qualify, depending on your healthcare plan. You must specify a PCP if you select an HMO or POS plan.

Referral

If your primary care physician determines that you have a condition that requires the attention of a specialist, a written referral will be provided for you to see a specialist.

Reasonable and Customary

A charge that is determined by the insurance carrier to be considered a reasonable or fair charge for services rendered and the maximum amount the carrier will pay for the services.

Triple Option Plan

The CareFirst BlueChoice Triple Option Plan is actually three plans in one, for one monthly premium. Your level of coverage is based on the doctor that you choose to visit on any given day.

Important Notice From Anne Arundel County Public Schools About Your Prescription Drug Coverage And Medicare Notice of Credible Coverage

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Anne Arundel County Public Schools (AACPS) and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. AACPS has determined that the prescription drug coverage offered by the AACPS Prescription Plan CVS Caremark is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered Creditable Coverage.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. This may mean that you may have to wait to join a Medicare drug plan and that you may pay a higher premium (a penalty) if you join later. You may pay that higher premium (a penalty) as long as you have Medicare prescription drug coverage. However, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible for a two (2) month Special Enrollment Period (SEP) because you lost creditable coverage to join a Part D plan.

In addition, if you lose or decide to leave employer/union sponsored coverage, you will be eligible to join a Part D plan at that time using an Employer Group Special Enrollment Period.

You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area.

Your Share Of Prescription Cost – For The 2012 Plan Year						
Medicare	AACPS Plans	Medical Option	Deductible	Retail	Mail Order	Maximum You Could Pay Per Benefit Year
		<ul style="list-style-type: none">CareFirst BlueChoice Triple Option PlanCareFirst BlueChoice HMOCareFirst BCBS Traditional Medicare Supplemental	None	You pay: \$5 generic \$15 brand-name \$25 Non-pref brand	You pay \$10 (generic) or \$20 (brand name) or \$40 (non-preferred brand) <i>applies for mail-order or CVS 90-day supplies</i>	Unlimited
		Standard Medicare Part D Prescription Drug Benefits	\$320	You pay: 5%, 25%, or 100% ¹ of the prescription cost (depending on where you are in accumulating drug costs during the year)		Unlimited You pay \$4,700 of the first \$6,657.50 in expenses, then 5% thereafter.

Remember, the insurance companies who offer Medicare Part D plans may have benefit structures that are different from the Standard Medicare Part D structure shown above.

¹ For 2012, Medicare Part D participants will receive a 50% discount from pharmaceutical manufacturers on the total cost of Medicare Part D-covered brand-name drugs purchased while in the coverage gap. The full retail cost of the brand-name drugs will still apply to satisfying your \$6,657.50 in total drug costs, even though the 50% was paid by pharmaceutical manufacturers. In addition, Medicare Part D participants will pay 93% of the cost of Medicare Part D-covered generic drugs purchased while in the coverage gap.

If you decide to join a Medicare drug plan, your AACPS coverage will be affected. Read on for more information about what happens to your current coverage if you join a Medicare drug plan.

If you do decide to join a Medicare drug plan and drop your AACPS prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

You should also know that if you drop or lose your coverage with AACPS and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (incur a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium may go up by at least 1% of the base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may consistently be at least 19% higher than the base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For more information about this notice or your current prescription drug coverage...

Contact the Human Resources Retirement Office at 410-222-5224 for more information. **NOTE:** You will receive this notice each year. You will also receive it before the next period you can join a Medicare drug plan, and if this coverage through AACPS changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).

Date: September 2011

Name of Entity/Sender: Anne Arundel County Public Schools

Contact: HR/Benefits Office

Address: 2644 Riva Road, Annapolis, MD 21401

Phone Number: 410-222-5221/5219/5206

Anne Arundel County Public Schools
Division of Human Resources

Notice of Privacy Practices

Responsible Office for Administration

Office of HR Operations – Benefits
410-222-5221

Contact Information

Anne Arundel County Public Schools
Office of Human Resources Operations
Attn: Susan Baugher, Benefits Manager
2644 Riva Road
Annapolis, Md. 21401

This notice describes how medical information about you may be used and disclosed, and how you may gain access to this information. Please review this notice carefully.

This notice applies to the privacy practices of all Anne Arundel County Public Schools (AACPS) health plans. Please be advised since these plans are affiliated (related) entities, we might share your protected health information and the protected health information of others on your insurance policy as needed for payment or Healthcare operations in regards to the plans listed below:

CareFirst Medical, Dental, and Vision Plans, CVS Caremark Prescription Plan, UCCI Dental Plan, and the AACPS Flexible Spending Account Program.

Our Legal Duty

AACPS is required by law to maintain the privacy of your protected health information (PHI). We are obligated to provide you with a copy of this Notice of our legal duties and of our privacy practices with respect to PHI, and we must abide by the terms of this Notice. We reserve the right to change the provisions of our Notice and make the new provisions effective for all PHI that we maintain. If we make a material change to our Notice, we will mail a revised Notice to the address that we have on record for the policyholder.

Effective Date

This Notice of Privacy Practice became effective on April 14, 2003.

Uses and Disclosure of Medical Information

Payment: We may use or disclose your PHI to pay claims for services provided to you, and to fulfill our responsibilities for plan coverage and providing plan benefits. For example, we may disclose your PHI to pay claims for services provided to you by doctors, hospitals, pharmacies and others for services delivered to you that are covered by your health plan. We might also use this information to determine your eligibility for benefits, coordination of benefits, to obtain premiums, to determine medical necessity, and to issue explanations of benefits.

Healthcare Operations: We might use and disclose your PHI for all activities as defined by the HIPAA Federal Regulations. For example, we might use and disclose your protected health information to determine premiums for the health plans, to conduct quality assessment, to engage in care and case management, and to manage our business.

Business Associates: We contract with individuals and entities (Business Associates) to perform certain types of services. To perform these functions or services, our Business Associates will receive, create, maintain, use or disclose PHI, but only after we require the Business Associates to agree in writing to contract terms designed to appropriately safeguard your information. For example, we may disclose your PHI to a Business Associate to administer claims or to provide service support, utilization management, coordination of benefits, or pharmacy benefit management.

Other Covered Entities: We may use or disclose your PHI to assist other covered entities in connection with payment activities and certain healthcare operations. For example, we may disclose or share your PHI with other insurance carriers in order to coordinate benefits.

Other Possible Uses/Disclosures of Protected Health Information

In addition to uses and disclosures for payment and healthcare operations, we may use/or disclose your PHI for the following purposes (this list is not completely inclusive):

Personal Representatives: We may disclose PHI to the patient or patient's personal representative. That could be a legal guardian, or a person designated by you to act on your behalf in making decisions related to your healthcare.

Required by Law: We may use or disclose your PHI when we are required to do so by law. For example, such information may be disclosed to the U.S. Department of Health & Human Services upon request for determining whether we are in compliance with federal privacy laws as well as for requests pursuant to workers' compensation or similar programs. This could also include releasing information to a medical examiner as authorized by law and law enforcement officials in compliance with a legal order.

To You or with your Authorization: We must disclose your PHI as described in the Individual Rights section of this notice. You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose not listed in this notice. If you provide such authorization, you may revoke it in writing at any time.

Public Health & Safety/Military and National Security: We might use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to the U.S. Department of Health & Human Services upon their request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your PHI to authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or other crimes.

We might disclose to military authorities the protected information of Armed Forces personnel under certain circumstances. We might disclose to federal officials protected health information required for lawful intelligence, counterintelligence, and other national security activities.

Your Rights

Right to Inspect and Copy: You have the right to inspect and copy your PHI that is contained in a "designated record set." This information contains your medical and billing records, as well as other records that are used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set. You may request access to your health records in an electronic format if they are available electronically. You may request that your electronic health records be transmitted directly to you or someone you designate. You may be charged a fee for access to electronic health records, but this amount must be limited to the cost of labor involved in responding to your request. To inspect and copy your PHI, in paper or electronic form, you must make your request in writing to the Privacy Officer, through the HR Department.

Restriction Requests: You have the right to request a restriction on the PHI we use or disclose about you for treatment, claim payment, or healthcare operations. In addition, you have the right to restrict disclosure of PHI to the health plan for payment or health care operations (but not for carrying out treatment) in situations where you have paid the health care provider out-of-pocket in full. To request a restriction, you must make your request, in writing, to the Privacy Officer through the HR Department. We are not required to agree to any restriction that you may request, unless it involves a situation described above where you paid a provider out-of-pocket in full. If we do agree to the restriction, we will comply with the restriction unless the information is needed to provide emergency treatment to you.

Right to Request Confidential Communications: If you believe a disclosure of your PHI may endanger you, you may request that we communicate with you regarding your information in an alternative manner or at an alternative location. For example, you may ask that we only contact you at your work address or via your work e-mail.

Right of an Accounting: You have a right to an accounting of certain disclosures of your PHI that are made for reasons other than treatment, claim payment, or healthcare operations. This includes an accounting of disclosures of electronic health records, even those used for treatment, payment, and health care operations. No accounting is required for disclosures you authorized. You should know that most disclosures of your PHI will be for purposes of treatment, claim payment or healthcare operations, and therefore, will not be subject to accounting. You may request an accounting of disclosures for the previous six years (previous three years, if it was a disclosure of electronic health records). For these requests, you must submit your request, in writing, to the Privacy Officer through the HR Department.

Right to Amend: You may request us to amend your information if you believe that PHI is incorrect or incomplete. This office may deny your request if the information you want to amend is not maintained by us, but by another entity.

Breach of Unsecured PHI

You must be notified in the event of a breach of unsecured PHI. A “breach” is the acquisition, access, use, or disclosure of PHI in a manner that compromises the security or privacy of the PHI. PHI is considered compromised when the breach poses a significant risk of financial harm, damage to the individual’s reputation, or other harm to you. This does not include good faith or inadvertent disclosures or when there is no reasonable way to retain the information. You must receive a notice of the breach as soon as possible and no later than 60 days after the discovery of the breach.

Questions and Complaints

If you have questions in regards to your PHI, you may contact:

Contact Office: AACPS HR Office of Operations
Telephone: 410-222-5221, 410-222-5219 or 1-800-909-4882
Fax: 410-222-5610
Address: 2644 Riva Road, Annapolis, MD 21401

You may notify our office if you believe your PHI privacy rights have been violated. You may file a written complaint with the above address or contact us at the designated phone numbers.

You may also file a written complaint with the Secretary of the U.S. Department of Health & Human Services. This complaint may be submitted to:

Department of Health & Human Services
Suite 346, Public Ledger Building
150 S. Independence Mall West
Philadelphia, PA 19106-3499

Please be advised we will not penalize you in any way if you choose to file a complaint with us or the U.S. Department of Health & Human Services.

2012 Medical Plans Comparison Chart

Active Employees



CareFirst BlueCross BlueShield is the business name of CareFirst of Maryland, Inc. CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. are independent licensees of the Blue Cross and Blue Shield Association. ® Registered trademark of the Blue Cross and Blue Shield Association.
® Registered trademark of CareFirst of Maryland, Inc.



**New 3 Tier Prescription
Plan for 2012**

Our goal...to educate all employees so they can make an informed healthcare decision.

2012 Medical Plans

- Dependents must be added within 31 days of becoming eligible or wait until the next open enrollment period.
- Dependents are covered until end of the month in which they turn 26.
- *This chart is for comparison purposes only. Please consult each plan benefit summary (available on-line) for full details.*

Benefit	BlueChoice (HMO)
Acupuncture Services	Discount program available through CareFirst Options Program.
Chiropractic Services	\$10 co-pay, 20 visits per calendar year
Dental Services as a result of an accidental injury	\$10 co-pay – Covered for accidental bodily injury or to correct congenital anomalies
Diagnostic, Lab Services, X-ray	Covered in full for x-rays and lab services. Diagnostic – \$10 co-pay
Durable Medical Equipment	Covered in full
Emergency Room Visits	Medical Emergency – \$50 co-pay, waived if admitted Urgent Care Centers – \$10 co-pay
Family Planning/Fertility	Infertility Counseling & Testing – \$10 co-pay Artificial Insemination – covered at 50% of the plan allowance; IVF – covered at 50% of the plan allowance <i>(limited to 3 attempts per live birth, lifetime maximum benefit \$100,000)</i>
Hearing Exams/Hearing Aids	Hearing exam – no co-pay. No co-pay per aid per ear, benefit once every 36 months.
Hospitalization (Inpatient)/ Surgery	Covered in full
Inpatient Nervous and Mental; Alcohol/Substance Abuse	Contact Magellan Behavioral Health for pre-authorization at 1-800-245-7013.
Outpatient Nervous and Mental; Alcohol/Substance Abuse	No pre-authorization required. Contact Magellan Behavioral Health for provider network information at 1-800-245-7013. \$5 co-pay per visit.
Maternity Care	\$5 co-pay PCP/\$10 co-pay specialist per visit, not to exceed \$100 per pregnancy
Outpatient Surgery	\$5 co-pay PCP; \$10 co-pay specialist
Physical Therapy	\$10 co-pay; 30 visits/per condition/per calendar year. PCP referral required.
Prescription Drug Card (CVS CAREMARK)	RETAIL: \$5 generic/\$15 preferred brand/\$25 non-preferred brand
Routine Physicals	No co-pay
Vision Care	\$10 co-pay through Davis Vision Providers – Optometrists or Ophthalmologists. Limited to one examination per calendar year. Discounts on glasses and contact lenses from participating Davis Vision Providers. You may also use your Vision Option 1 or 2 Plans.
Well Child Care	No co-pay
Additional Program Benefits	Discount program for alternative therapies. Magellan Behavioral Health
Primary Care Office Visit Co-pays/ Specialist Office Visit Co-pays	\$5 co-pay \$10 co-pay
Calendar Year Deductible	N/A
Co-insurance	100%
Out-of-Pocket Maximum	N/A
Calendar Year Maximum	Unlimited
Lifetime Maximum	Unlimited, except for fertility services

Comparison Chart

BlueChoice Triple Option Plan		
Level 1	Level 2	Level 3
Not covered	\$15 co-pay	80% Allowed Benefit after deductible
\$10 co-pay (limited to 20 visits per year)	\$15 co-pay (unlimited visits)	80% Allowed Benefit after deductible (unlimited visits)
\$10 co-pay covered for accidental bodily injury or to correct congenital anomalies	90% Allowed Benefit after deductible covered for accidental bodily injury or to correct congenital anomalies	80% Allowed Benefit after deductible
Diagnostic \$10 co-pay, Lab no co-pay (Lab Corp only)	\$15 co-pay	80% Allowed Benefit after deductible
No co-pay	90% Allowed Benefit after deductible	80% Allowed Benefit after deductible
\$50 co-pay (waived if admitted) Urgent Care Centers – \$10 co-pay	Considered under Level 1. If Benefits are not available under Level 1, benefits may be payable under the appropriate level.	
	Urgent Care Centers – \$15 co-pay	80% Allowed Benefit after deductible
50% Allowed Benefit (subject to state mandate)	90% Allowed Benefit after deductible (subject to state mandate)	80% Allowed Benefit after deductible (subject to state mandate)
Hearing exam – no co-pay. No co-pay per aid per ear, benefit once every 36 months.	Hearing exam – \$15 co-pay. 100% of Allowed Benefit every 36 months per aid per ear.	Hearing exam – 80% of Allowed Benefit, after deductible. 100% of Allowed Benefit every 36 months per aid per ear.
No co-pay	90% Allowed Benefit after deductible	80% Allowed Benefit after deductible
Contact Magellan Behavioral Health for pre-authorization at 1-800-245-7013.	Contact Magellan Behavioral Health for pre-authorization at 1-800-245-7013.	Contact Magellan Behavioral Health for pre-authorization at 1-800-245-7013.
No pre-authorization required. Contact Magellan Behavioral Health for provider network information at 1-800-245-7013. \$10 co-pay per visit.	No pre-authorization required. Contact Magellan Behavioral Health for provider network information at 1-800-245-7013. \$10 co-pay per visit.	No pre-authorization required. Contact Magellan Behavioral Health for provider network information at 1-800-245-7013. Deductible and co-insurance applies.
\$10 co-pay not to exceed \$100 per pregnancy	90% Allowed Benefit after deductible	80% Allowed Benefit after deductible
\$10 co-pay	\$15 co-pay	80% Allowed Benefit after deductible
\$10 co-pay (limited to 30 visits/per condition/per year)	\$15 co-pay (limited to 100 visits per year)	80% Allowed Benefit after deductible (limited to 100 visits per year)
MAIL ORDER or CVS RETAIL MAINTENANCE CHOICE: \$10 generic/\$20 preferred brand/\$40 non-preferred brand		
No co-pay	No co-pay	80% Allowed Benefit, no deductible
\$10 co-pay at Plan-designated Vision Care Centers (Davis Vision Providers). Discounts on glasses and contact lenses from Davis Vision Providers. You may also use your Vision Option 1 or 2 Plans.	Not Covered - refer to Level 1 benefits or Vision Option 1 and 2 plans.	
No co-pay	No co-pay	80% Allowed Benefit, no deductible
Disease Management/Case Management Magellan Behavioral Health	Disease Management/Case Management Magellan Behavioral Health	Disease Management/Case Management Magellan Behavioral Health
\$10 co-pay \$10 co-pay	\$15 co-pay \$15 co-pay	80% Allowed Benefit, after deductible
Individual/family – \$0	Individual = \$200; family = \$400	Individual = \$300; family = \$600
100%	90%	80%
Individual/family-none	\$500/\$1,000	\$1,000/\$2,000
Unlimited	Unlimited	Unlimited
Unlimited, except for fertility services	Unlimited, except for fertility services	Unlimited, except for fertility services

Benefit	CareFirst/BCBS Preferred Provider Network (PPN)	
	In-Network	Out-of-Network
Acupuncture Services	Only covered with certain diagnosis. Contact BCBS to verify. \$15 co-pay for participating provider.	Only covered with certain diagnosis. Contact BCBS to verify. 80% of Allowed Benefit, after deductible.
Chiropractic Services	\$15 co-pay in-network. See BCBS Summary.	Benefit paid at 80% of Allowed Benefit after deductible. See BCBS Summary.
Dental Services as a result of an accidental injury	Restorative services for accidental injury to natural teeth—100% of Allowed Benefit	Restorative services for accidental injury to natural teeth—100% of Allowed Benefit
Diagnostic, Lab Services, X-ray	100% of Allowed Benefit	80% of Allowed Benefit after deductible
Durable Medical Equipment	100% of Allowed Benefit	80% of Allowed Benefit after deductible
Emergency Room Visits	\$25 co-pay or if admitted 100% of Allowed Benefit. Urgent Care Centers – \$15 co-pay	\$25 co-pay or if admitted 100% of Allowed Benefit. Urgent Care Centers – \$15 co-pay
Family Planning/Fertility	Plan of treatment required – Subject to State Mandate; Artificial Insemination – 100% of allowed mandate, some services may require co-pay; IVF – 100% of Allowed Benefit, some services may require co-pay <i>(limited to 3 attempts per live birth, lifetime maximum benefit \$100,000)</i>	Plan of treatment required – Subject to State Mandate; Artificial Insemination – 80% of allowed benefit after deductible; IVF – 80% of Allowed Benefit after deductible <i>(limited to 3 attempts per live birth, lifetime maximum benefit \$100,000)</i>
Hearing Exams/Hearing Aids	Hearing exam – \$15 co-pay. 100% of Allowed Benefit every 36 months per aid per ear.	Hearing exam – 80% of Allowed Benefit, after deductible. 100% of Allowed Benefit every 36 months per aid per ear.
Hospitalization (Inpatient)/ Surgery	100% up to 365 days	80% after deductible/365 days
Inpatient Nervous and Mental; Alcohol/Substance Abuse	Contact Magellan Behavioral Health for pre-authorization at 1-800-245-7013.	
Outpatient Nervous and Mental; Alcohol/Substance Abuse	No pre-authorization required. Contact Magellan Behavioral Health for provider network information at 1-800-245-7013. \$15 co-pay per visit	No pre-authorization required. Contact Magellan Behavioral Health for provider network information at 1-800-245-7013. Deductible and co-insurance applies.
Maternity Care	100% of Allowed Benefit	80% of Allowed Benefit after deductible
Outpatient Surgery	100% of Allowed Benefit	80% after deductible
Physical Therapy	100 visits per year with \$15 co-pay per office visit. See BCBS Summary.	Deductible, then 80% of Allowed Benefit for 100 visits per calendar year. See BCBS Summary.
Prescription Drug Card (CVS CAREMARK)	RETAIL: \$5 generic/\$15 preferred brand/\$25 non-preferred brand MAIL ORDER or CVS RETAIL MAINTENANCE CHOICE: \$10 generic/\$20 preferred brand/\$40 non-preferred brand	
Routine Physicals	No co-pay	80% of Allowed Benefit, after deductible
Vision Care	Not included in medical benefit See CareFirst BCBS Summary Dental and Vision Plans.	Not included in medical benefit See CareFirst BCBS Summary Dental and Vision Plans.
Well Child Care	No co-pay	80% of Allowed Benefit, after deductible
Additional Program Benefits	Case Management/Disease Management – Magellan Behavioral Health	
Primary Care Office Visit Co-pays/ Specialist Office Visits Co-pays	100% of Allowed Benefit after \$15 100% of Allowed Benefit after \$15	80/20 after deductible
Calendar Year Deductible	N/A	\$200 individual/\$400 family
Co-insurance	100%	80/20
Out-of-Pocket Maximum	\$1,200 individual/\$2,400 family	\$1,200 individual/\$2,400 family
Calendar Year Benefit Max.	Unlimited	Unlimited
Lifetime Maximum	Unlimited, except for fertility services	Unlimited, except for fertility services



ANNE ARUNDEL
COUNTY PUBLIC SCHOOLS

Anne Arundel County Public Schools

Dental and Vision Options

Active Employees and Retirees

Benefits as of January 2012

Dental and Vision Options

Active Employees and Retirees

Dental Options	CareFirst Traditional	CareFirst PPO		Concordia Plus DHMO MD1160*
		In-Network	Out-of-Network	In-Network
Oral Examination	100% of AB	100% of AB	80% of AB	\$5 copay
Routine Cleaning	100% of AB	100% of AB	80% of AB	100%
Sealants (limited to permanent molars – until end of year in which a member turns 19)	100% of AB	100% of AB	80% of AB	100%
Bitewing X-ray	100% of AB	100% of AB	80% of AB	100%
Palliative Treatment	100% of AB	100% of AB	80% of AB	95%
Other X-rays as required	100% of AB	100% of AB	80% of AB	100%
Space Maintainers	100% of AB	100% of AB	80% of AB	95%
Fillings	100% of AB	80% of AB	60% of AB**	100%
Simple Extractions	100% of AB	80% of AB	60% of AB**	75%-85%
Pulpotomy	100% of AB	80% of AB	60% of AB**	75%-80%
Direct Pulp Caps	100% of AB	80% of AB	60% of AB**	75%-80%
Root Canals	100% of AB	80% of AB	60% of AB**	75%-80%
Apicoectomy	80% of AB**	80% of AB	60% of AB**	75%-80%
Oral Surgical Services	80% of AB**	80% of AB	60% of AB**	75%-85%
Surgical Extractions	80% of AB**	80% of AB	60% of AB**	75%-85%
Oral Surgery	80% of AB**	80% of AB	60% of AB**	75%-85%
General Anesthesia	80% of AB**	80% of AB	60% of AB**	See note 1
Periodontics	50% of AB**	80% of AB	60% of AB**	50%-65%
Crown	80% of AB**	80% of AB	60% of AB**	60%-80%
Prosthetic Appliances (including implants)	50% of AB	80% of AB	60% of AB**	60%-80% Implants not covered
Orthodontics Children and Adults	50% of AB	50% of AB	35% of AB	See note 3
Annual Deductible	\$25 Ind./\$50 Family	None	\$50 Ind./\$150 Family	None
Annual Benefit Maximum	\$1,500	\$1,500		None/See note 2
Ortho Lifetime Maximum	\$1,500	\$1,500		See note 3

(AB Allowed Benefit)

Under the Concordia Plus DHMO (MD1160*) Plan, out-of-network services are reimbursed up to a maximum amount, based on the fee schedule provided by United Concordia.

*The above DHMO Plan percentages are approximate and used for comparison purposes only. Please refer to the United Concordia (UCCI) Schedule of Benefits for actual co-payment amounts.

**After Deductible

Note 1 - General Anesthesia is considered integral to other procedures under this plan and is not covered separately.

Note 2 - No annual maximum for in-network services. United Concordia will reimburse up to a maximum of \$1,000 per family member per contract year for out-of-network services.

Note 3 - After \$2,900 member co-payment satisfied, benefits applicable to in-network services; provider should submit pre-treatment estimate. United Concordia will not reimburse covered members for any orthodontic services performed out-of-network.

Vision Options

Vision Options	Vision Option 1 Once every 24 months	Vision Option 2 Once every 12 months
Eye Exam	100% of Allowed Benefit* Once every 24 months	100% of Allowed Benefit* Once every 12 months
Single Vision Lenses	\$52.00	\$52.00
Bifocal Lenses	\$82.00	\$82.00
Double Bifocal Lenses	\$100.50	\$100.50
Trifocal Lenses	\$101.00	\$101.00
Cataract (º) Lenses	\$181.00	\$181.00
Contact Lenses Medically Indicated	\$352.00	\$352.00
Contact Lenses instead of glasses Cosmetic - Single	\$97.00	\$97.00
Frames	\$45.00	\$45.00

**Patient may be balance billed for eye exams, lenses, frames and contact lenses*

This is to be used as a guide. Actual benefits will be governed by the terms and conditions of the contract between CareFirst BlueCross BlueShield and Anne Arundel County Public Schools.



These benefits are issued under policies:

13.800 (6/98) • 13.801 (R. 10/99) • 13.802 (R. 10/99) • 13.803 (R. 10/99)
13.804 (R. 10/99) • 13.805 (R. 10/99) • 13.806 (R. 10/99) • 13.810 (R. 10/99)
13.812 (R. 10/99) • BCBSMD-APPEAL (1/99) • Preferred Dental Amendment (10/00)



www.carefirst.com

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