

2012 Benefits Enrollment Guide



For Active Employees hired prior to July 1, 2007
Baltimore County Government

Effective January 1, 2012 - December 31, 2012

Table of Contents

Internal Contact Listing.....	1
2012 Open Enrollment Announcement.....	2-3
Premium Costs.....	4
General Open Enrollment Information.....	5
Eligibility/Benefit Changes.....	6
Continuation of Benefits after Employment.....	7
Express Scripts Prescription Plan.....	8
CareFirst Triple Choice Description.....	9
CIGNA Open Access Plus (OAP).....	10-11
CIGNA Open Access Plus In-Network (OAPIN).....	12-13
Know What's Important.....	14-15
Kaiser Permanente Description.....	16-17
Non-Medicare Plans.....	18-25
Dental Plan Descriptions.....	26-27
Employee Assistance Program (EAP).....	28
CareFirst Vision Plan Overview.....	29-30
Flexible Spending Accounts.....	31-35
Life Insurance Benefits.....	36-38
Deferred Compensation.....	39
Notice of Privacy Policy and Practices.....	40-42
Health Care Reform Impact.....	43
Online Enrollment Instructions.....	44-45
Notes Pages.....	46-47
Benefit Plan Contract Information.....	inside back cover
Open Enrollment 2012 Meetings.....	back cover

Baltimore County Government

Important Contacts For Benefits Information

CONTACT:	REGARDING:
<p>Insurance Division, Office of Budget and Finance 400 Washington Ave., Rm 111 Towson, MD 21204 Phone: (410) 887-2568 or (800) 274-4302 Fax: (410) 887-3820 MAIL STOP 2105 Email: bcbenefits@baltimorecountymd.gov Internet: www.baltimorecountymd.gov/benefits Intranet: bcnet</p>	<ul style="list-style-type: none"> ■ Who is eligible for County health plan coverage ■ General benefit questions ■ Changes in family status affecting benefits ■ Changes to life insurance beneficiaries ■ Assistance with benefits elections when retiring ■ Continuing benefits under COBRA if you or your dependent(s) lose County benefits ■ Flexible Spending Accounts (FSA) ■ Enrollment and ESS questions ■ Life status changes—i.e. marriage, divorce, birth, adoption, death of dependents, loss of dependent status
<p>Baltimore County Retirement Office 400 Washington Ave., Rm 169 Towson, MD 21204 Phone: (410) 887-8246 or (877) 222-3741</p>	<ul style="list-style-type: none"> ■ Questions about your pension benefits ■ Questions about who you designated as your retirement beneficiary ■ Requests for retirement conferences ■ Changes to your address or other retirement information on file ■ Life status changes - i.e. marriage, divorce, or death of dependent spouse or other retirement beneficiary
<p>Baltimore County Pay Systems Administration 400 Washington Ave., Rm. 169 Towson, MD 21204 Phone: (410) 887-2420</p>	<ul style="list-style-type: none"> ■ Questions about your pay deductions ■ Changes to your tax withholding amounts ■ Changes to your direct deposit designation
<p>Baltimore County Office of Human Resources 308 Allegheny Ave Towson, MD 21204 Phone: (410) 887-3120 Fax: (410) 887-6073 MAIL STOP 62</p>	<ul style="list-style-type: none"> ■ Coordination of leave status ■ Family and Medical Leave Act (FMLA) ■ Other Paid/Unpaid Leaves of Absence
<p>Baltimore County Employee Assistance Program (Administered by ComPsych) Phone: (877) 595-5283 www.guidanceresources.com (password: baltimore)</p>	<ul style="list-style-type: none"> ■ Assistance with short-term, confidential, no-cost counseling for mental health, substance abuse and/or other work or family issues ■ Prior authorization requirements for mental health and substance abuse benefits under your County health plan if enrolled in CareFirst BlueCross BlueShield Triple Choice Plan

The purpose of this Open Enrollment Guide is to give you basic information about your benefit options and how to enroll for coverage or make changes to existing coverage. This Guide is only a summary of your choices and does not fully describe each benefit option. Please refer to your Employee Benefit Guides or Certificates of Coverage provided by your health plan carriers for important additional information about the plans.

TO: Baltimore County General Government Employees hired prior to July 1, 2007

FROM: Keith Dorsey, Director, Office of Budget and Finance

SUBJECT: 2012 Open Enrollment for County Health Plans

Overview of Benefit Plan Choices offered to Baltimore County employees hired prior to July 1, 2007 for the Plan Year January 1, 2012 through December 31, 2012.

Medical Plans:	Dental Plans:	Vision Plan:	Other Plans:
CareFirst Triple Choice (current members only)	CareFirst BCBS Traditional Dental	CareFirst Davis Vision	Flexible Spending Accounts
CIGNA Open Access Plus (OAP)	CareFirst BCBS Preferred Dental PPO		Basic & Additional Life Insurance
CIGNA Open Access Plus In-Network (OAPIN)	CIGNA Dental Care DHMO		
Kaiser Permanente Select HMO			

Baltimore County's share of health plan premiums:

CareFirst Triple Choice plan (current members only) and CIGNA Open Access (OAP)

The County share of premium for 01/01/2012 will be 80%, your share will be 20%. The subsidy decreases to 80% on 1/1/12.

CIGNA Open Access Plus In-Network (OAPIN) and Kaiser Permanente HMO plan

The County share of premium cost for 1/1/2012 will be 90%, your share will be 10%.

CareFirst Regional Traditional Dental Plan

The County share of premium cost for 1/1/2012 will be 75%, your share will be 25%.

Reminder - The Triple Choice Plan will be Phased Out Effective December 31, 2012: Members of the TripleChoice plan will eventually need to select from either the CIGNA Open Access Plus In-Network Plan, the CIGNA Open Access Plus Plan, or the Kaiser Permanente Select HMO. Current members of the Triple Choice plan will be able to remain in the plan until December 31, 2012. If you are in the Triple Choice plan, you must select a different plan during open enrollment in the Fall of 2012 to be effective January 1, 2013.

Coverage for Dependents up to age 26: If you have a dependent between 20-25 years old on your plan(s), you are able to continue coverage regardless of their student status. During Open Enrollment you may enroll any dependents up to age 26 who are not currently on your plan(s). Benefits will be effective 01/01/2012. Dependent children may remain on the plan until the end of the month they reach age 26.

Review Your Current Benefits

Benefit Confirmation Statements were mailed to employees at their home addresses. Please review that statement carefully – it identifies your current benefits, current and new costs for those benefits and important personal information on file with the Insurance Division. Please use ESS to correct personal information on that form. Please contact the Insurance Division at 410-887-2568 to correct dependent information on that form.

Online Enrollment Process for Medical, Dental, and Vision

Employees who want to make changes to their medical, dental, or vision plans, including the dependents on their plans, must make those changes online between October 11th and November 14th in Employee Self Service (ESS) at www.baltimorecountymd.gov/mybenefits. If you have already used ESS/HRM, continue to use your current password. If you are a new user logging in for the first time, your password is your six-digit date of birth combined with the last four digits of your social security number (Example: MMDDYY1234). If you have trouble logging into ESS, please contact the Service Desk at 410-887-8200.

Who Must Re-enroll During Open Enrollment, 2012

You will be required to re-enroll online if any of the following applies to you:

- ◆ You want to enroll in a Medical, Dental or Vision plan for the first time.
- ◆ You want to change your health or dental plan election.
- ◆ You need to add an eligible dependent to your benefit plan(s).
- ◆ You need to remove a dependent who is no longer eligible for benefits.
- ◆ You want to continue or enroll in a Flexible Spending Account for Day Care Expenses or for Health Care Expenses.

Baltimore County Government Monthly Health, Dental and Vision Plan Premium Costs

Active Employees hired prior to 07/01/2007

Rates shown are effective 01/01/2012 through 12/31/2012.

Premium deductions effective with 2nd pay in December, 2011 for January 1, 2012 Plan Choices. These rates apply to full-time employees and part-time employees who work at least 30 hours/week in a 35 hour position or 34 hours/week in a 40 hour position.

Plan Name	Coverage Level	Total Premium	County pays	Employee pays
CareFirst TripleChoice	Individual	\$702.97	\$562.38	\$140.59
	Parent + 1 Child	\$1,031.67	\$825.34	\$206.33
	Husband/Wife	\$1,500.11	\$1,200.09	\$300.02
	Family	\$2,141.13	\$1,712.90	\$428.23
CIGNA Open Access (OAP)	Individual	\$626.25	\$501.00	\$125.25
	Parent + 1 Child	\$919.09	\$735.27	\$183.82
	Husband/Wife	\$1,336.39	\$1,069.11	\$267.28
	Family	\$1,907.46	\$1,525.97	\$381.49
CIGNA Open Access In-Network (OAPIN)	Individual	\$488.47	\$439.62	\$48.85
	Parent + 1 Child	\$709.13	\$638.22	\$70.91
	Husband/Wife	\$1,045.81	\$941.23	\$104.58
	Family	\$1,476.85	\$1,329.17	\$147.68
Kaiser Permanente HMO	Individual	\$553.72	\$498.35	\$55.37
	Parent + 1 Child	\$830.58	\$747.52	\$83.06
	Husband/Wife	\$1,107.44	\$996.70	\$110.74
	Family	\$1,661.16	\$1,495.04	\$166.12
CareFirst BCBS Traditional Dental	Individual	\$32.13	\$24.10	\$8.03
	Parent + 1 Child	\$48.17	\$36.13	\$12.04
	Husband/Wife	\$64.24	\$48.18	\$16.06
	Family	\$96.40	\$72.30	\$24.10
CareFirst Dental Preferred (PPO)	Individual	\$26.02	\$19.52	\$6.50
	Parent + 1 Child	\$36.90	\$27.68	\$9.22
	Husband/Wife	\$49.22	\$36.92	\$12.30
	Family	\$73.86	\$55.40	\$18.46
CIGNA Dental DHMO	Individual	\$16.22	\$12.17	\$4.05
	Parent + 1 Child	\$29.24	\$21.93	\$7.31
	Husband/Wife	\$32.40	\$24.30	\$8.10
	Family	\$48.83	\$36.63	\$12.20
CareFirst Davis Vision	Individual	\$2.35	\$2.12	\$0.23
	Parent + 1 Child	\$3.55	\$3.20	\$0.35
	Husband/Wife	\$4.72	\$4.25	\$0.47
	Family	\$7.06	\$6.36	\$0.70

General Open Enrollment Information

Eligibility

All full-time Baltimore County employees are eligible to participate in Open Enrollment. **Part-time employees working at least 30 hours/week in a 35 hour position or 34 hours/week in a 40 hour position are also eligible to enroll in County benefits. Part-time employees working 26-29 hours are eligible for benefits at a reduced subsidy after 3 consecutive years of service. Newly hired employees have 31 days to enroll online - benefits are effective the first of the month following completion of the enrollment process.**

Who is an Eligible Dependent?

- A **spouse** (marriage must be legally recognized in the State of Maryland)
- A **dependent child** up to the end of the month in which they reach age 26, regardless of whether the dependent is married, a student or non-student, residing at home or residing outside the home **and who is:**
 - The employee or spouse's child by birth or legal adoption recognized under Maryland law
 - A child under testamentary or court appointed guardianship recognized under Maryland law who resides with the employee or spouse
 - A child who is the subject of a Qualified Medical Child Support Order (QMCSO) that creates the right of the child to receive health insurance benefits under an employee or retiree's coverage.

Eligible dependents are required to have legal standing and/or legally sufficient documentation for residency in the United States while included on County health plans.

Age Limits

For dependent children on all CIGNA Open Access Plans, Kaiser, CareFirst BlueCross BlueShield health plans, CIGNA Dental Plan and CareFirst BlueCross BlueShield Dental and Vision Plans.

- Dependent children can remain on the plan up to the end of the month in which they reach age 26, regardless of whether the dependent is married, a student or non-student, residing at home or residing outside the home

Non-Duplication of Coverage

You are not eligible to enroll in a County medical plan if you have similar coverage through another health plan (i.e. as a dependent on a spouse's employer plan.) If you should lose other medical coverage for any reason, you will be permitted to enroll in County plans by contacting the Insurance Division and providing proof of the loss of other coverage.

Coverage Changes During Open Enrollment

Examples of changes you may need to make during open enrollment include:

- Adding or removing a dependent if you did not do so within the first 31 days of the qualifying event. Proof of dependent eligibility may be required.
- Changing the medical, dental or other plans you currently have
- Renewing or starting a Flexible Spending Account

Family Status Changes

The County plans qualify for tax-favored treatment by the IRS. As such, the IRS requires that enrollment in the plans be in effect for the entire 12 month plan year.

If you have a Family Status Change, you must notify the Insurance Division within 31 days of the event.

The Insurance Division is located in Room 111 of the Old Courthouse. The Mail Stop number for this office is 2105.

Open Enrollment Deadline

The Open Enrollment period is from October 11th through November 14th. Benefit changes and FSA enrollment for all active employees must be completed on-line at www.baltimorecountymd.gov/mybenefits by November 14, 2011. Changes will be effective January 1, 2012.

Open Enrollment Online Options

- Information about Open Enrollment 2012 can be found on the County's internet website www.baltimorecountymd.gov/go/benefits or the County's intranet **bcnet**– select “Employee Benefits” link.
- You can use the internet to email the Insurance Division with benefits questions or requests for additional information - the email address is www.bcbenefits@baltimorecountymd.gov. Responses will be forwarded within 2 business days.
- Plan website addresses are found on the inside back cover for you to access information about providers and other programs they offer.

Eligibility Rules/Changes To Benefit Plan Coverage

Basic Rules of Baltimore County's Benefits Program

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

In order to maintain this favorable tax treatment, the Internal Revenue Service (IRS) has established rules that govern our Benefit Program operation. **Most important, the IRS requires that the choices you make remain in effect for 12 months unless you have a qualifying lifestyle change.**

Qualifying family status changes include marriage, legal separation or divorce, birth or adoption, death, or changes to your (or your spouse's) other benefit coverage related to changes in employment status. Significant changes to benefit costs or coverage made by an employer providing other coverage may also qualify.

If you experience a qualifying family status change, any change you make to your benefits must be "on account of and consistent with the lifestyle change." For example, if you get married or have a child, you can add your new dependent to your plan, but you cannot change the plan you chose during open enrollment.

When You Must Contact Baltimore County's Insurance Division

It is your responsibility to notify the Insurance Office each time you have a change in your Family Status. Including your dependent(s) on County benefit plans when they do not meet County eligibility requirements is fraudulent and subject to prosecution.

Contact the County Insurance Division at (410) 887-2568 if any of the information on your benefit records changes. Examples include:

- Birth or adoption of a new child – children must be added to your coverage within 31 days of birth or adoption even if you already have family coverage
- Marriage – Spouse must be added to your coverage within 31 days of marriage date.
- Divorce – the former spouse must be removed from your coverage within 31 days of the divorce decree
- Loss of dependent status 1 month prior to dependent child reaching age 26
- Obtaining other health plan coverage not identified on your health plan records
- You or your spouse lose other benefit plan coverage due to a change in employment status (i.e. changing from full-time to part-time status)

- You move to a new residence outside Maryland that is not included in your current plan's coverage area.
- If you or your dependents become eligible for Medicare contact the Insurance for coordination of benefits information.

You must provide proof of the change requested (i.e. – a copy of the divorce decree to remove a spouse from coverage, or copy of birth certificate to add newborn.) Changes to benefits will be effective the 1st of the month after the Insurance Division receives your change request and requested documentation.

Effective Dates for New Employees During the Plan Year

Your new benefits will be effective the first of the month after you complete online enrollment pending approval from the Insurance Division.

Continuation of Coverage While on an Approved Leave of Absence

If you are on an approved leave of absence from Baltimore County, your health plan contributions will continue to be deducted from your paycheck as long as you have paid leave (i.e., sick leave, vacation, holiday, etc.) available. When your accrued leave is exhausted or when you cease to be paid by Baltimore County, you must contact the County Insurance Division to make arrangements to continue your benefits.

Notice of HIPAA Special Enrollment Rights (Health Insurance Portability and Accountability Act)

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself and/or your dependents in a County benefit plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you will be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

Creditable Coverage For Medicare Eligible Active Employees

The County Medical Plans include prescription benefits that are at least as generous as the Medicare Part D standard benefits. This creditable coverage will protect you from paying a premium penalty in the future if you need to enroll in Medicare Part D Plan upon resignation or retirement from Baltimore County Government.

Continuing Benefit Coverage When You Leave Baltimore County

Continuing Coverage After Employment Ends

If your employment ends with Baltimore County, benefits terminate on the last day of the month following your last payroll deduction. (i.e. if you have a benefits deduction in June, coverage ends on the last day of July.)

Through federal legislation known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you may choose to continue coverage by paying the full monthly premium cost plus an administrative charge of 2%.

Each individual who is covered by a Baltimore County health plan immediately preceding the employee's COBRA event has independent election rights to continue his or her medical, dental, vision or Health Care Spending Account. The right to continuation of coverage ends at the earliest of when:

- you, your spouse or dependents become covered under another group health plan; or,
- you become entitled to Medicare; or,
- you fail to pay the cost of coverage; or,
- your COBRA Continuation Period expires.

You must notify Baltimore County's Insurance Division in writing within 31 days of the following COBRA events:

- divorce or legal separation
- death of an employee
- dependent child's loss of dependent status

Continuing Coverage Upon Retirement

In order to qualify for County health insurance coverage when you retire, three basic requirements must be met:

1. You must have a minimum of 10 years of County service;
2. Retirees and/or their eligible beneficiaries must have been eligible for benefits while employed with Baltimore County;
3. The retiree and/or beneficiary must be receiving a pension check sufficient to cover the retiree's or beneficiary's share of the health plan premium.

In addition, Retirees and their dependents who become eligible for Medicare for any reason **must** enroll in both Part A and Part B Medicare programs. Retirees accepting employment outside the County that includes health plan coverage cannot participate in both the County plan and another employer plan at the same time. If the retiree declines County benefit coverage due to the availability of other health plan coverage, reinstatement in County benefit plans is allowed if that coverage is lost as long as the County retirement check amount is sufficient to cover the retiree's share of health plan premium.

The amount you will pay for benefit plan participation is based on the number of years of creditable service with Baltimore County, the date of your retirement, the type of retirement (service or disability), and your date of hire with the county. A Retiree Benefit Guide is available online at www.baltimorecountymd.gov/benefits.

A Quick Look at Your COBRA Continuation Rights	Maximum COBRA Continuation		
	For You	For Your Covered Spouse	For Your Covered Children
Loss of Coverage is Due to...			
Your employment ending for any reason (except gross misconduct) or your hours are reduced so you are no longer eligible for medical, dental vision, and the health care spending account	18 months	18 months	18 months
You or your covered spouse or dependent is disabled (as determined by Social Security Administration) at the time of the qualifying event, or becomes disabled during the first 60 days of COBRA continuation	29 months	29 months	29 months
Your death	—	36 months	36 months
Your divorce or legal separation	—	36 months	36 months
You become entitled to Medicare	—	36 months	36 months
Your covered child no longer qualifies as a dependent	—	—	36 months

Express Scripts Prescription Coverage

The prescription coverage included with the CIGNA Open Access, the CIGNA Open Access In-Network, and the CareFirst BCBS Triple Choice plan is a \$5/\$20/\$35 3-tier formulary plan. That means that your copay amounts will vary depending on the type of prescription you fill.

How are Prescriptions Covered under the CIGNA Open Access, the CIGNA Open Access In-Network, and the CareFirst BCBS Triple Choice plans?

The prescription plan included in the premium cost for the CIGNA Open Access Plans and the CFBCBS Triple Choice Plan are administered by Express Scripts (ESI). When you enroll in these Plans, you will receive a separate prescription card to use when you fill your prescription medications.

The plan provides three levels of copayment requirements that are determined by the type of medication you are receiving:

- The lowest copayment amount (\$5) will be charged for Generic medications.
- The middle level of copayment (\$20) applies to brand name drugs that are only available from a single manufacturer or to brand name drugs on the ESI Preferred Formulary list.
- The highest copayment amount (\$35) is for brand name drugs that are not on the ESI Preferred Formulary list.

A copay will be charged for each month's supply of medication when filling your prescription at a retail pharmacy. Therefore, if you receive three months of medication at the pharmacy, you will be charged three copays.

Information about what brand medications are included on the Formulary list available online at www.express-scripts.com. Formulary lists will also be available at this year's Open Enrollment meetings. It's a good idea to take your formulary list with you to your physician's office so that you and your physician have the information needed to treat your condition with the most affordable medication when there are options.

Preview the costs of your prescriptions by going to: <https://member.express-scripts.com/preview/BaltimoreCounty2011>.

The ESI formulary is subject to review annually – formulary lists are updated in January of each year. The formulary status on a particular drug can change during the year due to the introduction of a generic or over-the-counter equivalent drug. Changes can also occur when the manufacturer or the FDA removes a drug from the market.

Prescriptions Filled at Retail Pharmacies

Up to 34 day supply, \$5 copay for Generic Drug, \$20 copay for Brand Formulary Drug, and \$35 copay for Brand non-Formulary Drug.

Three month supplies for maintenance drugs will be \$15 for generic, \$60 for formulary drugs, and \$105 for non-formulary drugs.

Mandatory Generic Requirement – If you receive a brand-name drug when a generic equivalent is available, you will pay your copay amount plus the difference in cost between the brand and generic drug.

Mail Order Option for Prescription Drugs

You have the option of using the ESI Mail Order program for your maintenance medications. Because mail-order facilities can most often purchase their drugs at lower cost than retail pharmacies pay for the same medications, mail order is a more cost-effective option for your maintenance medications. If you choose mail order for your maintenance medications, you will receive up to three months supply for two copayment amounts. You can order your prescription refills online at www.express-scripts.com.

Prescriptions filled through Mail Order pharmacy – up to 100 day supply, \$10 copay for Generic Drug, \$40 copay for Brand Formulary Drug, and \$70 copay for Brand non-Formulary Drug.

Specialty Medications

Express Scripts has a specialty pharmacy for patients using genetically engineered oral and injectable specialty medications (examples are medications being used to treat Multiple Sclerosis, Hepatitis C, advanced arthritis, infertility and some cancers).

Those medications can be obtained through CuraScript, a subsidiary of Express Scripts. Advantages of using CuraScript to fill your specialty medications included:

- Delivery of your medication to your home, your doctor's office, or any other location you choose
- A Patient Care Coordinator will contact you when it's time to refill your prescription
- Medications that require certain supplies (syringes, needles, sterile swabs, etc.) will have those items included at no additional cost
- A Patient Care Manager will be available to assist you and your caregivers with the proper use and administration of your medications

Frequently, due to the high cost and small number of patients needing these medications, your local pharmacy may not regularly stock your medication. In those cases, the pharmacy will have to order your medication and you will have to return to the pharmacy when it's received. CuraScript has an on-hand inventory of most specialty medications and will provide you with quick, convenient and supportive service.

To check to see if your medication can be filled through CuraScript, contact them toll free at (888) 773-7376.

Hours of CuraScript customer service are:

Monday-Friday 8 am–9 pm EST
Saturday 9 am–1 pm EST

CareFirst BlueCross BlueShield Triple Choice (Existing Members Only)

The CareFirst BlueCross BlueShield Triple Choice Plan is open to existing members only. The CFBCBS Triple Choice Plan will be phased-out January 1, 2013. Current members can remain in the Triple Choice Plan through December 31, 2012. You will be required to choose another Medical plan during the Fall Open Enrollment in 2012 that will be effective January 1, 2013.

How the Triple Choice Plan Works

The Triple Choice plan combines the features of Preferred Provider and Point of Service plans. Triple Choice is a single health plan. Your share of the cost for health care will be determined by the level of provider you choose when you need care.

Level 1 – Care received or coordinated through your Primary Care Physician (PCP)

Level 2 – Care received from Preferred Providers without a referral from a PCP

Level 3 – Care received from providers not in the CFBCBS preferred network

Benefit Description	Level 1 rendered or referred by PCP	Level 2 Preferred Providers	Level 3 all other Providers
Calendar Year Deductible	\$100 Individual/\$200 Family	\$200 Individual/\$400 Family	\$300 Individual/\$600 Family
Coinsurance	95%/5%	85%/15%	75%/25%
Calendar Year Out-of-Pocket Max	\$500/\$1,000	\$1,000 \$2,000	\$1,500/\$3,000
Lifetime Maximum	Unlimited	%1,000,000 (Levels 2&3)	\$1,000,000 (Levels 2&3)
Primary Care Office Visit	In full after \$15 copay	In full after \$15 copay	75% AA after deductible
Gynecology Office Visit	In full after \$20 copay	In full after \$20 copay	75% AA after deductible
Specialist Office Visit	In full after \$20 copay	In full after \$25 copay	75% AA after deductible
Physical/Speech/Occupational Therapy Office Visit	In full after \$20 copay/Treatment plan required after 10th visit	In full after \$20 copay/Treatment plan required after 10th visit	75% AA after deductible; Treatment plan required after 10th visit
Room and Board-Pre-Auth REQUIRED if elective/Physician/Surgical Services	95% after deductible to out-of-pocket maximum	85% after deductible to out-of-pocket maximum	75% AA after deductible to out-of-pocket maximum
Medical Emergencies (use of ER): Accidental injury/Sudden and Serious Illness	Covered in full after \$50 copay – waived if admitted/admission to the hospital from the ER is subject to Level 1 deductible of \$100 and paid at 95% to the annual out-of-pocket maximum	Covered in full after \$50 copay – waived if admitted/admission to the hospital from the ER is subject to Level 1 deductible of \$100 and paid at 95% to the annual out-of-pocket maximum	Covered in full after \$50 copay – waived if admitted/admission to the hospital from the ER is subject to Level 1 deductible of \$100 and paid at 95% to the annual out-of-pocket maximum
Mental Health/Substance Abuse (Co-ordinate through ComPsych)	Outpatient \$15 copay	Outpatient \$15 copay	Outpatient 25%/75%
Express Scripts Prescription Drug Benefit	Most drugs dispensed for up to 1 month supply		
Dispensed at Pharmacy	Covered by separate ESI prescription card; \$5 Generic/\$20 Brand Formulary/\$35 Brand Non-Formulary; One copay per monthly supply		
Mail Order – Maintenance Medications	\$10 Generic/\$40 Brand Formulary/\$70 Brand non-Formulary for 3 month supply (Mail order copays do not apply to Specialty Medications. These prescriptions are only dispensed up to 30 days at a time.)		

CIGNA Open Access Plus (OAP)

CIGNA's Open Access Plus plan gives you important choices. Each time you need care, you can choose the doctors and other health professionals and facilities that work best for you.

Enroll in the Open Access Plus plan and you'll get:

Options for accessing quality health care.

■ Primary Care Physician (PCP).

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

■ In-Network.

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

■ Visit www.CIGNA.com to access our directory.

■ No-referral specialist care.

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

■ Out-of-network.

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

■ Emergency and urgent care.

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

24/7 service.

Whenever you need us, customer service representatives are available to take your calls. You can also speak with a health care professional over the phone, any time, day or night.

Health and wellness discounts.

Enjoy discounts on a variety of health-related products and services.

Access to myCIGNA.com.

Use a personalized website to:

- **Learn** more about your plan and the coverage and programs available to you.
- **View** claim history and account transactions; print claim forms when you need them.
- **Find** information and estimate costs for medical procedures and treatments.
- **Learn** how hospitals rank by number of procedures performed, patients' average length of stay and cost.
- **Manage** and track your health care finances with the user-friendly Quicken HealthSM Expense Tracker.

Questions and Answers

Do I have to choose a Primary Care Physician (PCP)?

No. However, a PCP gives you and your covered family members a valuable resource and can be a personal health advocate.

What if my doctor isn't on your list?

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

CIGNA Open Access Plus (OAP) – *continued*

Do I need a referral to see a specialist?

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

What is the difference between in-network coverage and out-of-network coverage?

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

What if I need to be admitted to the hospital?

In an emergency, your care is covered. Requests for non-emergency hospital stays other than maternity stays must be approved in advance or “pre-certified.” This enables CIGNA HealthCare to determine if the services are covered.

Pre-certification is not required for maternity stays of 48 hours for vaginal deliveries or 96 hours for cesarean sections. Depending on your plan, you may be eligible for additional coverage. Any hospital stay beyond the initial 48 or 96 hours must be approved.

Who is responsible for obtaining pre-certification?

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

What is Case Management?

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

How do I find out if my doctor is in the CIGNA network before I enroll?

Our dedicated **Enrollment Information Line** is available 24/7 to help you learn about the benefits and advantages of CIGNA.

Call today and a knowledgeable Enrollment Specialist will provide you with assistance in identifying participating physicians and related service providers.

Call us at **1.800.896.0948**

Or go to the online provider directory found on www.cigna.com

- Click on “Provider Directory” at the top of the page
- Select provider type, city/zip location and distance
- Select the Open Access Plus, OAP Plus, Choice Fund OA Plus plan
- Choose the specific provider specialty

Print and email options are available to save your results.

After the plan effective date use www.mycigna.com, which recognizes the plan you are in, and what health care professionals are in your plan or simply call Customer Support for assistance.

What if I go to an out-of-network physician who sends me to a network hospital? Will I pay in-network or out-of-network charges for my hospitalization?

CIGNA HealthCare will cover authorized medical services provided by an Open Access Plus participating hospital at your in-network benefits level – whether you were sent there by an in- or out-of-network doctor.

What is Transition of Care?

Transition of care coverage allows you to continue to receive services for specified medical and behavioral conditions for a defined period of time with health care professionals who do not participate in the CIGNA network until the safe transfer of care to a participating doctor or facility can be arranged. You must apply for Transition of Care at enrollment, or change in CIGNA medical plan, but no later than 30 days after the effective date of your coverage.

For behavioral health related services please contact CIGNA Behavioral Health by calling the Customer Services phone number on the back of your ID card.

CIGNA Open Access Plus In-Network (OAPIN)

CIGNA's Open Access Plus In-Network plan gives you important choices. Each time you need care, you can choose the doctors and other health professionals and facilities that work best for you.

Enroll in the Open Access Plus In-Network plan and you'll get:

Options for accessing quality health care.

■ Primary Care Physician (PCP).

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

■ In-Network.

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

■ Visit www.CIGNA.com to access our directory.

■ No-referral specialist care.

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

■ Out-of-network.

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

■ Emergency and urgent care.

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

24/7 service.

Whenever you need us, customer service representatives are available to take your calls. You can also speak with a health care professional over the phone, any time, day or night.

Health and wellness discounts.

Enjoy discounts on a variety of health-related products and services.

Access to myCIGNA.com.

Use a personalized website to:

- **Learn** more about your plan and the coverage and programs available to you.
- **View** claim history and account transactions; print claim forms when you need them.
- **Find** information and estimate costs for medical procedures and treatments.
- **Learn** how hospitals rank by number of procedures performed, patients' average length of stay and cost.
- **Manage** and track your health care finances with the user-friendly Quicken HealthSM Expense Tracker.

Questions and Answers

Do I have to choose a Primary Care Physician (PCP)?

No. However, a PCP gives you and your covered family members a valuable resource and can be a personal health advocate.

What if my doctor isn't on your list?

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

CIGNA Open Access Plus In-Network (OAPIN) – *continued*

Do I need a referral to see a specialist?

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

How does my plan cover my care?

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

What if I need to be admitted to the hospital?

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

Who is responsible for obtaining pre-certification?

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

How do I find out if my doctor is in the CIGNA network before I enroll?

Our dedicated **Enrollment Information Line** is available 24/7 to help you learn about the benefits and advantages of CIGNA.

Call today and a knowledgeable Enrollment Specialist will provide you with assistance in identifying participating physicians and related service providers.

Call us at 1.800.896.0948

Or go to the online provider directory found on www.cigna.com

- Click on "Provider Directory" at the top of the page
- Select provider type, city/zip location and distance
- Select the Open Access Plus, OAP Plus, Choice Fund OA Plus plan
- Choose the specific provider specialty

Print and email options are available to save your results.

After the plan effective date use www.mycigna.com, which recognizes what plan you are in, and what health care professionals are in your plan or simply call Customer Support for assistance.

What is Case Management?

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

What is Transition of Care?

Transition of care coverage allows you to continue to receive services for specified medical and behavioral conditions for a defined period of time with health care professionals who do not participate in the CIGNA network until the safe transfer of care to a participating doctor or facility can be arranged. You must apply for Transition of Care at enrollment, or change in CIGNA medical plan, but no later than 30 days after the effective date of your coverage.

For behavioral health related services please contact CIGNA Behavioral Health by calling the Customer Services phone number on the back of your ID card.

Know what's important to you

Programs and services that help you make the most of your CIGNA health plan and support your well-being.

Mycigna.com – your secure portal for benefit information and resources

Nothing is more important than understanding your benefits and your good health. That's why there's www.myCIGNA.com – your online home for assessment tools, provider search engine, explanation of benefits paid, medical updates and much more.

So get ready to click with a site that clicks with you.

How to register:

- Step 1 Enter www.myCIGNA.com in the web address line on your browser.
- Step 2 Click on the Register button
- Step 3 Enter the required identification information, as noted with the asterisk. Your Member ID number is printed on your ID card. Upon entering personal information a Confirmation Page should then appear. Click "Accept" if all information is accurate.
- Step 4 Complete your Demographic and Security Information data. Click "Continue".
- Step 5 A Confirmation Page should then appear. Click "Accept" if all information is accurate.

24 Health Information Line – 24-hour guidance on medical treatment

Dial the toll-free number on your CIGNA ID card and you'll be connected directly to a nurse who is ready to help answer your health questions. Nurses can offer detailed answers to your health questions, and help you decide where and when to seek medical attention. You can also listen to hundreds of our latest podcasts in English and Spanish to help you stay informed.

Healthy Rewards – complimentary discounts

If you have CIGNA coverage, the choice to use Healthy Rewards is entirely yours. The program is separate from your coverage, so the services don't apply to your plan's copays or coinsurance. No doctor's referral is required – and no claim forms, either. Set the appointments yourself, show your ID card when you pay for services and enjoy the savings.

Health Assessment – personalized report about your health

The health assessment can give you an idea of the current state of your health. Based on your responses, you'll also learn if you are at any risk for certain conditions like diabetes or high blood pressure. It will also help you understand what you can do to maintain and improve your health.

To start. Go to www.myCIGNA.com and select *Take my health assessment* and follow the registration instructions until you reach *my health & wellness center*. Select *Take my health assessment now* and follow the steps through the questionnaire.

When taking the health assessment, know the following: your blood pressure, total cholesterol, HDL cholesterol, height, weight, and waist circumference. If you don't know these, you can answer, "I'm not sure", but answering all questions produces the best results.

CIGNA Well Aware – special care for chronic conditions

We all have days filled with responsibilities. But if you're also coping with a chronic health condition, you may have even more of a challenge. That's why we're offering CIGNA Well Aware for Better Health®, a confidential, free resource to help you. Well Aware gives you personalized support from health advocates trained as nurses who specialize in your condition.

Participating in Well Aware can help you:

- Understand your condition and medications.
- Get answers to your questions and concerns.
- Develop a personal plan to better manage your condition.

Support is available for the following conditions:

- Asthma
- Chronic obstructive pulmonary disease (COPD)
- Diabetes
- Heart disease
- Low back pain

To participate in this free program:

Simply pick up the phone when the Well Aware health advocate calls you. If you have caller ID, it will read "Your Health Plan." Or call the Well Aware team toll-free at 1.866.797.5833, if you have a chronic health condition, but have not received a call.

Know what's important to you *(continued)*

Lifestyle Management Programs – *The easy, convenient and free way to manage your health*

Whether you're looking for help with weight, tobacco or stress management, our Lifestyle Management Programs are here for you. Each program is easy to use, available where and when you need it, and is always no cost to you.

WEIGHT MANAGEMENT

CIGNA helps you manage your weight using a non-diet approach. Get support to help build your confidence, become more active, eat healthier and change your habits. Use the program online, over the phone – or both.

On the Phone

- Personal healthy-living plan
- Individual telephone coaching
- Dedicated wellness coach
- Convenient evening and weekend coaching hours
- Program workbook and toolkit
- Healthy Rewards® discounts*
- Join 24/7/365
- Optional telephone group support

Online

- Personal health assessment and healthy-living plan
- 12-step self-paced program
- Weekly educational emails
- Interactive tools and resources
- Healthy Rewards® discounts*
- Secure, convenient support

TOBACCO

Our tobacco cessation program helps you get and stay tobacco free. Develop a personal quit plan that's right for you. Use the program online, over the phone – or both.

On the Phone

- Individual telephone coaching
- Dedicated wellness coach
- Convenient evening and weekend coaching hours
- Program workbook and toolkit
- Healthy Rewards® discounts*
- Optional telephone group support
- Free over-the-counter nicotine replacement therapy (patch or gum)
- Join 24/7/365

Online

- Personal quit plan
- 6-step self-paced program
- Weekly educational emails
- Healthy Rewards® discounts*
- Secure, convenient support
- Interactive tools and resources
- Free over-the-counter nicotine replacement therapy (patch or gum)

STRESS MANAGEMENT

Our stress management program helps you understand the sources of your stress and learn coping techniques to manage stress both on and off the job. Use the program online, over the phone – or both.

On the Phone

- Personal stress management plan
- Individual telephone coaching
- Dedicated wellness coach
- Convenient evening and weekend coaching hours
- Program workbook and toolkit
- Healthy Rewards® discounts*
- Join 24/7/365
- Optional telephone group support

Online

- 8-week self-paced program
- Weekly educational emails
- Healthy Rewards® discounts
- Secure, convenient support

* Some Healthy Rewards programs are not available in all states. If your CIGNA plan includes coverage for any of these services, this program is in addition to, not instead of, your plan benefits. A discount program is NOT insurance, and you must pay the entire discounted charge.

Kaiser Permanente Select HMO

Who Is Eligible to Enroll?

- Full-time and eligible part-time County employees
- Retired County employees who are eligible for benefits and not yet eligible for Medicare
- Eligible dependents (spouses and dependent children) of employees enrolled in Kaiser

Kaiser Permanente is a Health Maintenance Organization (HMO) that provides members with a full range of medical care benefits including preventive care services. Members of Kaiser Permanente must select a Primary Care Physician (PCP) from the over 800 physicians who practice exclusively in the Kaiser Permanente member centers or from a network of almost 12,000 community physicians who practice in the District of Columbia and Maryland, including Howard and Baltimore counties. It is important that you choose a PCP when you enroll, as this doctor will act as your good-health advocate and coordinate your care.

Kaiser Permanente Physicians

For help in choosing a primary care physician, review the physicians listed in the Kaiser Permanente Provider Directory included with your enrollment information. Physicians are listed according to their specialty and the county in which they practice. You will find two lists of physicians – those who practice in the Kaiser Permanente medical centers and are part of the Mid-Atlantic Permanente Medical Group, and those who practice in the community and are part of our network.

The list of Kaiser Permanente physicians also includes where the physician went to school, where they did their residency, their board certification and if they speak any foreign languages. This information should help you select a physician that best matches the needs of you and your family.

You may select a PCP for yourself and each member of your family. You can opt to have a single physician for your entire family or choose a different physician for each family member. Your PCP will work with you to coordinate your care, referring you for specialty care as needed and acting as your good health advocate, guiding you through the preventive care services aimed at keeping you healthy through all your stages of life.

If you do not choose a PCP on your own when you enroll, Kaiser Permanente will choose one for you by selecting a physician from a medical center located close to your home. If you decide

that you do not like the PCP selected for you or the one you have chosen for yourself, you may change your physician for any reason at any time. To change your physician, simply contact the Kaiser Permanente member services department. You can find this contact number in the provider directory or online, at www.kp.org.

What You Must Pay For Medical Services

Hospital care coordinated through your Kaiser Permanente PCP or your community-based PCP is covered in full. Office visits for illness require a \$10 per visit copay. PCP visit copays are waived for children up to age 5. Emergency room visits require a \$50 copay, which will be waived if you are admitted to the hospital from the emergency room.

Covered Preventive Care Services

Members will have no copay requirement for preventive care services. Those services include, but are not limited to, the following age and gender appropriate physical exams, screening tests and the corresponding explanation of the results:

- Routine physical examinations
- Well-woman exams- including pap smear and screening mammograms
- Well-child examinations
- Routine age-based immunizations
- Bone mass measurement to determine risk for osteoporosis
- Prostate cancer screening exams and routine screening Prostate Specific Antigen (PSA) tests
- Colorectal cancer screenings
- Cholesterol screening tests

Note: Non-preventive issues and services managed during a scheduled preventive visit or service can result in additional charges for those non-preventive services.

What is not covered as preventive?

The exam, screening tests, or interpretations for the following is not considered preventive:

- Monitoring chronic disease or as follow-up tests once you have been diagnosed with a disease
- Testing for specific diseases for which you have been determined to be at high risk for contracting
- Travel consultations, immunizations, and vaccines

Prescription Benefits

Prescriptions are \$5 per prescription for generic or \$15 for brand name drugs, if filled at a Kaiser Permanente medical center; \$11 for generic or \$27 for brand drugs for up to a 60-day supply, if filled at a participating community pharmacy. A mail order program is also available, which allows you to receive up to a 90 day supply of maintenance drugs for a single copay.

When you fill your prescriptions at a Kaiser Permanente Medical Center pharmacy, you will pay the smallest copay amount. Prescriptions can also be filled at participating community pharmacies, such as Giant, Safeway, Rite Aid, Target, Wal-Mart and K-Mart. Prescription copays are higher when filled at participating community pharmacies than when you obtain your drugs at a Kaiser Permanente medical center.

Members are also able to order prescription refills online through the members-only section of the Kaiser Permanente Web site, www.kp.org.

Wellness Services

Kaiser Permanente offers a variety of services aimed at preventing illness. Your PCP can encourage you to attend the “Be Well” classes offered in the Kaiser Permanente medical centers. The list of classes offered is printed in your provider directory and includes classes on such topics as asthma management for children, heart failure, pediatric weight management, prenatal care/breastfeeding, smoking cessation, managing high blood pressure and more.

Members can also access a number of online services that Kaiser Permanente offers to aid in weight management, smoking cessation and relaxation. At www.kp.org/healthylifestyles, members can learn how to balance weight management and physical fitness through individualized programs. They can create an individualized nutrition plan, a personalized stress management program based on their own sources and symptoms of stress, or a personal plan to help decrease dependency on cigarettes.

Other Plan Features

- When your dependent children age off your Kaiser Permanente plan, they can choose to continue to receive their care through Kaiser Permanente by enrolling on their own through the Kaiser Permanent for Individuals and Family plan. You can find more information on receiving this individual coverage online at www.kp.org.
- For children up to age 5, the copay for PCP visits are waived (PCP visits are covered in full).

- Kaiser Permanente offers discounted programs for alternative medical services – acupuncture, chiropractic and massage therapy are some examples of those services.
- Managed Mental Health Services are coordinated through the plan (contact (866) 530-8778 for assistance).
- Kaiser Permanente offers discounts to members on new health club membership when they join through GlobalFit. Just go to www.globalfit.com/kaiser.
- Discounts of Weight Watchers memberships are also available through Kaiser Permanente. Members can get discounts on community meetings, online subscriptions and the new Weight Watchers At Home Kit. For more information, go to www.kp.org/weightwatchers.

Kaiser Permanente Medical Centers and After Hours Services

- Kaiser Permanente medical centers have multiple specialties under the same roof. Most have primary care services, such as pediatrics, obstetrics/gynecology and internal medicine, and specialty care services in the same location.
- Most Kaiser Permanente medical centers also provide services including laboratory, radiology and pharmacy in a single convenient location.
- For specialty referrals from a Kaiser Permanente physician, the specialist is often available within the same medical center or another area Kaiser Permanente medical center.
- Kaiser Permanente maintains a 24-hour, 7-day/week Medical Advice help line that is staffed by registered nurses who are available to answer urgent, as well as routine, medical questions over the telephone.
- Eight of the Kaiser Permanente medical centers also serve as Urgent Care After-Hours centers. The Towson and Woodlawn Medical Centers, as well as others in Maryland and Virginia, have Urgent Care After-Hours services. On weekends and holidays, members who need to be seen due to an urgent medical condition can call the Appointments Line and arrange an urgent care appointment at one of the designated Urgent Care centers. The hours available for these urgent care centers can be found in the provider directory or on the Kaiser Permanente Web site, www.kp.org.

Plan Options for Active Employees

This chart summarizes the benefits for the CIGNA Open Access Plus, CIGNA Open Access Plus In-Network and Kaiser Medical plans.

Plan Facts	CIGNA Open Access Plus In-Network (OAPIN)
Member services	(800) 896-0948
Group Number	3333726
COST SHARING LIFETIME LIMITS	
Calendar Year Deductible	\$0 Individual / \$0 Family
Calendar Year Out-of-Pocket Maximum	\$1,100 Individual / \$3,600 Family
Lifetime Maximum	Unlimited
PROFESSIONAL SERVICES	
Primary Care Office Visit	You pay \$15 per visit
Gynecology Annual Office Visit	PCP – You pay \$15 per visit Specialist – \$20 per visit
Specialist Office Visit	You pay \$20 per visit
Physical/Speech/Occupational Therapy Office Visit	You pay \$20 per visit 40 days for each therapy per calendar year
Acupuncture	PCP – You pay \$15 per visit Specialist – \$20 per visit Unlimited days per calendar year
Chiropractic Office Visit	You pay \$20 per visit Limited to 40 days per calendar year
Allergy Shots/Other Covered Injections	You pay 0% / Plan pays 100%
Allergy Serum/Testing	You pay 0% / Plan pays 100%
Diagnostic tests	PCP – \$15 per visit Specialist – \$20 per visit
Diagnostic tests performed by lab or other testing facility and billed separately from office visit	Independent X-ray or Lab Facility Outpatient Facility You pay 0% / Plan pays 100%
Annual Adult Physical	PCP – \$15 per visit Specialist – \$20 per visit
Well Child Visit/Immunization	PCP – \$15 per visit Specialist – \$20 per visit Immunizations – You pay 0%
Mammography Screening / PAP / PSA Testing (Routine)	You pay 0% / Plan pays 100%
Mammography Screening / PAP / PSA Testing (Diagnostic / Non-Routine)	PCP – \$15 per visit Specialist – \$20 per visit

CIGNA Open Access Plus (OAP)		Kaiser Permanente HMO
In-Network	Out-of-Network	
(800) 896-0948	(800) 896-0948	(800) 777-7902
3333726	3333726	1651-8
\$200 Individual / \$400 Family	\$300 Individual / \$600 Family	N/A
\$1,000 Individual / \$2,000 Family	\$1,500 Individual / \$3,000 Family	N/A
Unlimited	Unlimited	Unlimited
You pay \$15 per visit	You pay 25% / Plan pays 75% after the deductible is met	\$10 copay applies (waived to age 5)
You pay 0% / Plan pays 100% no deductible	You pay 25% / Plan pays 75% after the deductible is met	\$10 copay applies
You pay \$25 per visit	You pay 25% / Plan pays 75% after the deductible is met	\$10 copay applies
You pay \$25 per visit Unlimited days per calendar year for all therapies combined	You pay 25% / Plan pays 75% after the deductible is met Unlimited days per calendar year for all therapies combined	\$10 copay – days/visits limits apply
PCP – \$15 copay Specialist – \$25 copay	You pay 25% / Plan pays 75% after the deductible is met Unlimited days per calendar year	\$15 copay per visit limited to 20 visits per calendar year
You pay \$25 per visit Unlimited days per calendar year	You pay 25% / Plan pays 75% after the deductible is met Unlimited days per calendar year	\$15 copay applies limited to 20 visits/year
You pay 0% / Plan pays 100% no deductible	You pay 25% / Plan pays 75% after the deductible is met	\$10 copay applies
You pay 0% / Plan pays 100% No deductible	You pay 25% / Plan pays 75% after the deductible is met	\$10 copay applies
Physician's Office Primary Care Physician – You pay \$15 per visit Specialist – You pay \$25 per visit	You pay 25% / Plan pays 75% after the deductible is met	Tests covered in full on same day as office visit; \$10 copay applies unless on list of \$0 copayment preventive screenings
Independent X-ray or Lab Facility Outpatient Facility You pay 5% / Plan pays 95% after the deductible is met	You pay 25% / Plan pays 75% after the deductible is met	Approved tests covered in full
You pay 0% / Plan pays 100% No deductible	You pay 25% / Plan pays 75% after the deductible is met	100% Covered
Well Child Visit/Immunization You pay 0% / Plan pays 100% No deductible	Well Child Visit/Immunization You pay 25% / Plan pays 75% after the deductible is met	100% Covered
You pay 0% / Plan pays 100% No deductible	You pay 0% / Plan pays 100% No deductible	100% Covered
You pay 0% / Plan pays 100% No deductible	You pay 25% / Plan pays 75% after the deductible is met	100% Covered

Plan Facts	CIGNA Open Access Plus In-Network (OAPIN)
INPATIENT CARE HOSPITAL	
Room and Board Pre-auth REQUIRED if elective	\$100 copay per admission, then You pay 0% / Plan pays 100%
Physician/Surgical Services	You pay 0% / Plan pays 100%
Anesthesia Services	You pay 0% / Plan pays 100%
Medical Consultations	You pay 0% / Plan pays 100%
ICU/CCU	\$100 copay per admission, then You pay 0% / Plan pays 100%
Maternity/Nursery/Birthing Center	<p>Initial Visit to confirm pregnancy Primary Care Physician – You pay \$15 per visit Specialist – You pay \$20 per visit</p> <p>Global Maternity Professional Fees You pay 0% / Plan pays 100%</p> <p>Inpatient Facility \$100 copay per admission, then You pay 0% / Plan pays 100%</p>
Skilled Nursing/Rehab Facility Care	You pay 0% / Plan pays 100% 100 days per calendar year
Dialysis/Radiation/Chemotherapy	\$100 copay per admission, then You pay 0% / Plan pays 100%
Hospice	You pay 0% / Plan pays 100%
Physical/Speech/Occupational Therapy	\$100 copay per admission, then You pay 0% / Plan pays 100%
OUTPATIENT HOSPITAL SERVICES	
Surgical/Anesthesia Services	You pay 0% / Plan pays 100%
Dialysis/Radiation/Chemotherapy – Physician’s Office	PCP \$15 / Specialist \$20 copay
Dialysis/Radiation/Chemotherapy – Outpatient Facility	You pay 0% / Plan pays 100%
Physical/Speech/Occupational Therapy Preauthorization required after 10th visit	You pay \$20 per visit 40 days for each therapy per calendar year
Outpatient Diagnostic Services	You pay 0% / Plan pays 100%
MATERNITY/INFERTILITY SERVICES	
1st prenatal visit	<p>Initial Visit to confirm pregnancy Primary Care Physician – You pay \$15 per visit Specialist – You pay \$20 per visit</p>
Pre- and Postnatal care and delivery	<p>Global Maternity Professional Fees You pay 0% / Plan pays 100%</p> <p>Inpatient Facility \$100 copay per admission, then You pay 0% / Plan pays 100%</p>

CIGNA Open Access Plus (OAP)		Kaiser Permanente HMO
In-Network	Out-of-Network	
You pay 15% / Plan pays 85% after the deductible is met	You pay 25% / Plan pays 75% after the deductible is met	Covered in full when authorized
You pay 15% / Plan pays 85% after the deductible is met	You pay 25% / Plan pays 75% per visit after the deductible is met	Covered in full when authorized
You pay 15% / Plan pays 85% after the deductible is met	You pay 25% / Plan pays 75% after the deductible is met	Covered in full when authorized
You pay 15% / Plan pays 85% after the deductible is met	You pay 25% / Plan pays 75% after the deductible is met	Covered in full when authorized
You pay 15% / Plan pays 85% after the deductible is met	You pay 25% / Plan pays 75% after the deductible is met	Covered in full when authorized
Initial Visit to confirm pregnancy Primary Care Physician – You pay \$15 per visit Specialist – You pay \$25 per visit	You pay 25% / Plan pays 75% after the deductible is met	Covered in full when authorized
Global Maternity Professional Fees You pay 5% / Plan pays 95% after the deductible is met		
Inpatient Facility / Outpatient Facility You pay 15% / Plan pays 85% after the deductible is met		
You pay 15% / Plan pays 85% after the deductible is met Combined 120 days per calendar year (in-network and out-of-network)	You pay 25% / Plan pays 75% after the deductible is met Combined 120 days per calendar year (in-network and out-of-network)	Covered in full when authorized, 100 days/year
You pay 15% / Plan pays 85% after the deductible is met	You pay 25% / Plan pays 75% after the deductible is met	Covered in full when authorized
You pay 5% / Plan pays 95% after the deductible is met	You pay 5% / Plan pays 95% after the deductible is met	Covered in full when authorized
You pay 15% / Plan pays 85% after the deductible is met	You pay 25% / Plan pays 75% after the deductible is met	Covered in full when authorized
You pay 15% / Plan pays 85% after the deductible is met	You pay 25% / Plan pays 75% per visit after the deductible is met	\$10 copay applies
\$15 PCP / \$25 Specialist copay	You pay 25% / Plan pays 75% after the deductible is met	\$10 copay applies
You pay 5% / Plan pays 95% after the deductible is met	You pay 25% / Plan pays 75% after the deductible is met	\$10 copay applies
You pay \$25 per visit	You pay 25% / Plan pays 75% after the deductible is met	\$10 copay applies
You pay 5% / Plan pays 95% after the deductible is met	You pay 25% / Plan pays 75% after the deductible is met	\$10 copay applies for office visit
Initial Visit to confirm pregnancy Primary Care Physician – You pay \$15 per visit Specialist – You pay \$25 per visit	You pay 25% / Plan pays 75% after the deductible is met	\$10 copay
Global Maternity Professional Fees You pay 5% / Plan pays 95% after the deductible is met	You pay 25% / Plan pays 75% after the deductible is met	Covered in full when authorized
Inpatient Facility / Outpatient Facility You pay 15% / Plan pays 85%		

Plan Facts	CIGNA Open Access Plus In-Network (OAPIN)
MATERNITY/INFERTILITY SERVICES cont'd.	
Routine nursery care	<p>Inpatient Facility \$100 copay per admission, then You pay 0% / Plan pays 100%</p>
Sterilization/Reverse Sterilization requires preauthorization	<p>Physician's Office Primary Care Physician – You pay \$15 per visit Specialist – You pay \$20 per visit</p> <p>Inpatient Facility \$100 copay per admission, then You pay 0% / Plan pays 100%</p> <p>Outpatient Facility You pay 0% / Plan pays 100% Excludes reversal of sterilization</p>
Elective Abortions in inpatient or outpatient facility	<p>Inpatient Facility \$100 copay per admission, then You pay 0% / Plan pays 100%</p> <p>Outpatient Facility You pay 0% / Plan pays 100%</p>
Artificial Insemination (AI)	<p>Primary Care Physician You pay \$15 per visit Specialist – You pay \$20 per visit</p> <p>Inpatient Facility \$100 copay per admission, then You pay 0% / Plan pays 100%</p> <p>Outpatient Facility; Professional Services You pay 0% / Plan pays 100% \$100,000 lifetime maximum on all infertility</p>
InVitro Fertilization (IVF) available only after 12 months benefit-eligible employment with BCG – maximum of 3 IVF attempts/lifetime REQUIRES PRE-AUTH	<p>Primary Care Physician You pay \$15 per visit Specialist – You pay \$20 per visit</p> <p>Inpatient Facility \$100 copay per admission, then You pay 0% / Plan pays 100%</p> <p>Outpatient Facility; Professional Services You pay 0% / Plan pays 100% \$100,000 lifetime maximum on all infertility</p>
MEDICAL EMERGENCIES (Use of Emergency Room)	
Accidental Injury	You pay \$50 per visit Copay waived if admitted
Sudden and Serious Illness	You pay \$50 per visit Copay waived if admitted
Follow-up visits	You pay \$50 per visit

CIGNA Open Access Plus (OAP)		Kaiser Permanente HMO
In-Network	Out-of-Network	
Inpatient Facility You pay 15% / Plan pays 85% after the deductible is met	Inpatient Facility You pay 25% / Plan pays 75% after the deductible is met	Covered in full when authorized
Primary Care Physician – You pay \$15 per visit Specialist – You pay \$25 per visit Inpatient Facility / Outpatient Facility Physician's Services You pay 15% / Plan pays 85% after the deductible is met Includes reversal of sterilization	You pay 25% / Plan pays 75% after the deductible is met Includes reversal of sterilization	\$10 copay applies, reversal not covered
Inpatient Facility / Outpatient Facility You pay 15% / Plan pays 85% after the deductible is met	Inpatient Facility / Outpatient Facility You pay 25% / Plan pays 75% after the deductible is met	\$10 copay applies in outpatient setting
Primary Care Physician You pay \$15 per visit Specialist – You pay \$25 per visit Inpatient Facility / Outpatient Facility Physician's Services You pay 15% / Plan pays 85% after the deductible is met \$100,000 lifetime maximum on all infertility	You pay 25% / Plan pays 75% after the deductible is met \$100,000 lifetime maximum on all infertility	Covered at 50% of non-member rate when authorized
Primary Care Physician You pay \$15 per visit Specialist – You pay \$25 per visit Inpatient Facility / Outpatient Facility Physician's Services You pay 15% / Plan pays 85% after the deductible is met \$100,000 lifetime maximum on all infertility	You pay 25% / Plan pays 75% after the deductible is met \$100,000 lifetime maximum on all infertility	50% copay applies, limited to 3 attempts per live birth up to \$100,000 per lifetime
You pay \$50 per visit Copay waived if admitted	You pay \$50 per visit Copay waived if admitted	Covered in full after \$50 copay – waived if admitted
You pay \$50 per visit Copay waived if admitted	You pay \$50 per visit Copay waived if admitted	Covered in full after \$50 copay – waived if admitted
You pay \$50 per visit	You pay \$50 per visit	Coordinate w/ PCP – Office visit copays apply

Plan Facts	CIGNA Open Access Plus In-Network (OAPIN)
MEDICAL EQUIPMENT/SUPPLIES	
Durable Medical Equipment	You pay 0% / Plan pays 100% Unlimited Maximum per Calendar Year
Diabetic Supplies	Covered under DME or RX – copays may apply
MENTAL HEALTH SUBSTANCE ABUSE Pre-Authorization Required - Must contact CIGNA Behavioral Health at 800-896-0948 for authorization.	
Inpatient	\$100 per admission You pay 0% / Plan pays 100%
Outpatient	Physician office visit \$20 per visit
OTHER SERVICES	
Ambulance (Ground only)	You pay 0% Plan pays 100% <i>(Includes Air Ambulance when medically necessary)</i>
Kidney, Cornea Bone Marrow Transplants	Primary Care Physician You pay \$15 per visit Specialist – You pay \$20 per visit Inpatient Facility \$100 copay per admission, then You pay 0% / Plan pays 100% Outpatient Facility – Physician Services You pay 0% / Plan pays 100%
Heart, Heart-Lung, Lung, Pancreas, Liver Transplants – Precertification Required	Primary Care Physician You pay \$15 per visit Specialist – You pay \$20 per visit Inpatient Facility \$100 copay per admission, then You pay 0% / Plan pays 100% Outpatient Facility – Professional Fees You pay 0% / Plan pays 100%
Outpatient Cardiac Rehabilitation	Limited to 40 days per calendar year \$15 PCP / \$20 Specialist copay
Hearing Aids	You pay 0%, Plan pays 100% of allowed benefit Limited to \$2,800 per 3 years
OUTPATIENT PRESCRIPTION DRUG BENEFIT Most drugs dispensed for up to 1 month supply	
Dispensed at Pharmacy*	Covered by separate ESI prescription card (copays apply for each one month supply) – \$5 Generic / \$20 Brand Formulary / \$35 Brand Non-Formulary
Mail Order – Maintenance Medications Mail order copays do not apply to Specialty Medications. These prescriptions are only dispensed up to 30 days at a time.	\$10 Generic / \$40 Brand Formulary / \$70 Brand non-Formulary (you pay only 2 copays for each 3 month supply)

* If you receive a brand name medication when a generic is available, you will pay the cost difference between the generic and name brand plus your copay.

CIGNA Open Access Plus (OAP)		Kaiser Permanente HMO
In-Network	Out-of-Network	
You pay 5% / Plan pays 95% Unlimited Maximum per Calendar Year	You pay 5% / Plan pays 95% Unlimited Maximum per Calendar Year	Covered in full when authorized
Covered under DME or RX – copays may apply	Covered under DME or RX – copays may apply	Covered at 80% – 20% copay
Provider Payment is based on MHSA Allowed Amounts.		
You pay 15% /Plan pays 85% after deductible is met.	You pay 25% /Plan pays 75% after the deductible is met	Covered in full
Physician office visit \$25 per visit		\$10 per visit for individual therapy \$10 per visit for group therapy
You pay 5% Plan pays 95% after the deductible is met <i>(Includes Air Ambulance when medically necessary)</i>	You pay 5% Plan pays 95% after the deductible is met <i>(Includes Air Ambulance when medically necessary)</i>	Covered in full when authorized
Primary Care Physician You pay \$15 per visit Specialist – You pay \$25 per visit Inpatient Facility / Outpatient Facility Physician's Services You pay 15% / Plan pays 85% after the deductible is met <i>(COVERED AT 100% AT LIFESOURCE CENTER)</i>	You pay 25% /Plan pays 75% after the deductible is met	Covered in full when authorized
Primary Care Physician You pay \$15 per visit Specialist – You pay \$25 per visit Inpatient Facility / Outpatient Facility Physician's Services You pay 15% / Plan pays 85% after the deductible is met <i>(COVERED AT 100% AT LIFESOURCE CENTER)</i>	You pay 25% /Plan pays 75% after the deductible is met	Covered in full when authorized
Calendar Year Maximum: Unlimited \$15 PCP / \$25 Specialist copay	You pay 25% /Plan pays 75% after the deductible is met	\$10 copay upon Medical Review Necessity (outpatient)
You pay 0%, Plan pays 100% of allowed benefit Limited to \$2,800 per 3 years	You pay 0%, Plan pays 100% of allowed benefit Limited to \$2,800 per 3 years	One hearing aid for each hearing impaired ear every 36 months up to a \$1,000 maximum for adults and children
Most drugs dispensed for up to 1 month supply		
Covered by separate ESI prescription card (copays apply for each one month supply) – \$5 Generic / \$20 Brand Formulary / \$35 Brand Non-Formulary		One copay for up to a 60 day supply. \$5 Generic / \$15 Brand for Kaiser Facility \$11 Generic / \$27 Brand at other network pharmacies
\$10 Generic / \$40 Brand Formulary / \$70 Brand non-Formulary (you pay only 2 copays for each 3 month supply)		\$5 Generic / \$15 Brand for mail order refills. Up to 90 day supply for maintenance medications

Dental Options – Highlights

CIGNA Dental Care is a Dental Health Maintenance Organization (DHMO). You must select and seek services from your DHMO facility. No benefits are available if non-participating dentists are used. For the most current information regarding participating dentists in your area, you may obtain a personalized provider directory by calling CIGNA's automated dental office locator at (800) 367-1037. You may also visit CIGNA's Website at www.cigna.com/dental. Both resources are available 24 hours a day. You may change your primary dentist selection by calling Member Services. In most cases, the change will take effect on the first day of the following month.

Plan Highlights

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

An informational package is available from the Insurance Division which contains the CIGNA provider directory and the patient schedule of copayments for all covered dental services.

CareFirst BlueCross BlueShield Traditional Dental Plan

The CareFirst BlueCross Blue Shield offers a national network of dental providers – 100,000 participating dentist locations nationwide. If you seek care from a CareFirst participating provider, the dentist cannot bill you the difference between their charge and the allowed amount. You are only responsible for deductibles and coinsurance. A non-participating provider will bill for any amount over the CareFirst allowed benefit. Some of the features include:

- No claim forms to file when you receive in-network care
- Each enrolled family member receives up to \$1500 in paid benefits per calendar year
- Flexibility to choose any dentist
- CareFirst's Participating Providers file claims for you and cannot balance bill

CareFirst BlueCross BlueShield Preferred Dental PPO

The CareFirst BlueCross BlueShield Preferred Dental PPO Program offers two levels of benefits in one plan. When you need dental care, you may see the dentist of your choice. Benefit

levels and out-of-pocket expenses are determined based upon whether you receive dental care from a preferred dentist. Some of the features include:

- Each enrolled family member receives up to \$1,000 in paid benefits per calendar year
- Flexibility to choose any dentist
- CareFirst Preferred and Participating Providers file claims for you and cannot balance bill you
- Preventive care is available with no out-of-pocket expense if a CareFirst Preferred Provider is used
- The CareFirst Dental PPO Program offers two levels of benefits in one plan. When you need dental care, you may see the dentist of your choice. Benefit levels and out-of-pocket expenses are determined by whether or not you receive dental care from a preferred dentist.

In-Network Benefits

When you use a Preferred Provider, you receive the highest level of coverage with the least amount of out-of-pocket expense. In order to choose a preferred dentist, please refer to the Preferred Dental Provider directory at www.carefirst.com or contact member services at 1-866-891-2802.

Out-of-Network Benefits

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

- Participating dentists are not "preferred" dentists, but they have agreed to bill only up to the CareFirst BlueCross BlueShield allowed benefit amount, thus limiting your out-of-pocket expense.
- Non-participating dentists do not have an agreement with CareFirst BlueCross BlueShield. They may bill you their regular rates, which may increase your out-of-pocket expense. Members who receive care from non-participating dentists must pay for their services at the time the services are rendered and must file a claim for reimbursement directly to CareFirst BlueCross BlueShield

Baltimore County Dental Benefits Summary

	CF Traditional Dental	CF Preferred Dental PPO		CIGNA DENTAL DHMO
Covered Service	Participating or Non-Participating*	In-Network (Preferred)	Out-of-Network	In- Network Only
Deductible per Calendar Year	\$100 Per person \$200 Per family	\$100 Per person \$200 Per family	\$100 Per person \$200 Per family	\$0
Maximum Benefit per Calendar Year	\$1500 Per person	\$1000. Per person		Unlimited
	Plan Pays	Plan Pays		Member Pays
Preventative Care, Exams, Cleanings, X-Rays, Fluoride	100% when using a participating provider (Non-participating providers can bill the balance)	100%	80%	\$5
Restorative Care, Fillings, Crowns, Root Canals	80% after deductible*	80% after deductible	60% after deductible	\$5 to \$225
Periodontal Services	50% for limited services after deductible; treatment plan required	80% for limited services after deductible; treatment plan required	60% for limited services after deductible; treatment plan required	\$5 to \$250
Prosthetic Services, Dentures, Bridgework	50% after deductible; treatment plan required	50% after deductible; treatment plan required	30% after deductible; treatment plan required	\$20 to \$325
Emergency Care	No additional emergency provisions provided	No additional emergency provisions provided		\$5 (\$45.After regularly scheduled hours)
Orthodontia Services	50% (\$2000 lifetime maximum) For dependent children only up to age 19	50% after deductible (\$1500 lifetime maximum) For dependent children only	50% after deductible (\$1000 lifetime maximum) For dependent children only	\$50 to \$400 (\$1500 lifetime maximum for children up to age 19) \$2000 lifetime maximum for adults)

*CareFirst payments based on allowed benefits. Non-participating providers can bill any amount over the CF allowed benefit.

Employee Assistance Program (EAP)

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Baltimore County's EAP Services are administered by ComPsych. The phone number for ComPsych is (877) 595-5283.

Commitment to Superior Mental Health Services

Baltimore County recognizes that the success of all County programs depends on the well-being and commitment of Baltimore County employees. In order to support a healthy and productive workplace, the County has worked with ComPsych to develop a coordinated Managed Mental Health/Employee Assistance Program. These services have been designed to meet employees needs and to conform to the highest standards of quality.

Using Your Baltimore County Employee Assistance Program

Baltimore County employees, under age 65 retirees and their family members have access to an Employee Assistance Program (EAP) provided by the professional counseling staff through ComPsych. The EAP can help if you or a family member need assistance with problems that may respond to short-term problem solving. EAP services are not tied to your selection of a County health plan if you are an active employee working 26+ hours per week. Baltimore County retirees under age 65 who are enrolled in any County health plan can also receive EAP services. The EAP can provide up to 8-10 visits for each problem. There is no charge for EAP services. For more information and confidential assistance, you can contact **ComPsych at (877) 595-5283**. When you call, ask for an EAP referral. In most cases, an EAP counseling session is the best place for an initial assessment of your need for mental health or substance abuse treatment.

If the EAP is not the right setting for your care, you will be assisted with obtaining the Managed Mental Health Benefits available to you through your County-sponsored health plan.

LEGALCONNECT

Employees concerned with personal legal problems may be distracted at work and spend time during the workday to manage those issues. The ComPsych LegalConnect program provides immediate access to the expertise and support these employees' needs so they can remain focused and performing on the job.

ComPsych's on-staff attorneys can help you with the following and other legal matters:

- Family law matters, including divorce, custody, child support and adoption
- Bankruptcy and credit issues
- Landlord/tenant issues, including eviction & lease questions
- Wills and living wills
- Trusts
- Name changes
- Contracts

Get the help you need. Here's how:

Call your GuidanceResources toll-free number. You'll be connected to a Guidance Consultant who will talk with you about your specific situation and schedule a phone appointment for you with one of the staff attorneys. If you need more immediate help, you can be put in a queue to talk to an attorney as soon as one becomes available.

FINANCIALCONNECT

Financial issues touch the life of every individual. Without the appropriate information or knowledge, these issues can become time-consuming and stressful, affecting job productivity.

ComPsych's on-staff financial experts can help you with the following and other financial matters:

- Managing personal and financial challenges
- Credit cards / debt management
- Budgeting
- Tax questions
- Financing for college
- Investment Options
- Mortgages, loans and refinancing
- Retirement planning
- Estate planning

Get the help you need. Here's how:

Call your GuidanceResources toll-free number. You'll be connected to a Guidance Consultant who will talk with you about your specific situation and schedule a phone appointment for you with one of their financial experts. Their in-house includes Certified Public Accountants, Certified Financial Planners and other professionals whom are exclusively dedicated to providing financial information by phone.

ComPsych GuidanceResources
Call: 877-595-5283
TDD: 800-697-0353
Go online: guidanceresources.com
Your company Web ID: BALTIMORE

Your CareFirst BlueCross BlueShield Vision Coverage

Your CareFirst Vision Plan is called BlueVision

Davis Vision administers your BlueVision coverage. Davis Vision, a leading administrator of vision benefits programs throughout the U.S. and abroad, has a provider network consisting of 18,000 private practitioners, independent optometrists and ophthalmologists, opticians and point-of-service retail centers (Wal-Mart, Pearle, Target, Vision Works, etc.).

Larger Provider Network

Davis Vision has a comprehensive network of optometrists and ophthalmologists in Maryland and throughout the United

States. However, while there are more providers from which to choose, there may be cases where your current eye care provider does not participate in this network. To find a provider near you, please visit www.DavisVision.com and select “Find a Provider” or call Davis Vision at (888) 336-7125. Some offices participate for exams only and some provide significant discounts on lenses and frames. You will pay the least amount out-of-pocket by selecting a full-service office and choosing from the Davis tower of frames or Davis contact lens provider.

Benefits in Brief	Davis Provider You Pay	Out-of-Network You Pay	
Routine Eye Exam (once every 12 months)	No copay	Plan reimburses up to \$45*, you pay balance	*You are responsible for all charges for services received out-of-network and must file a claim for reimbursement to Davis Vision.
Tower Collection Frames (Fashion)	\$10	N/A	
Tower Collection Frames (Upgrade)	\$30	N/A	** If your frames cost more than the allowance, you will pay 2 times the difference between the wholesale cost and the \$20 allowance. For instance, if the wholesale cost of your frames is \$50, your out-of-pocket costs will be determined as follows: \$50 - \$20 allowance = \$30 x 2 \$60 (your out-of-pocket cost for the frames)
Non-Tower Frames	Out-of-pocket costs varies**	Plan reimburses up to \$35*, you pay balance	
Single Vision Lenses Only	Included with frames	Plan reimburses up to \$40*, you pay balance	\$50 - \$20 = \$30 x 2 = \$60
Bifocal/Trifocal Lenses Only	Included with frames	Plan reimburses up to \$60/\$90*, you pay balance	
Contact Lenses (in lieu of eyeglasses)	\$10 copay on formulary or \$75 Single/\$95 Bifocal contact lens allowance towards provider supplied contacts	Plan reimburses up to \$75/\$95*, you pay balance (Single/Bifocal)	

If you need glasses and contacts, your plan will only reimburse for one or the other every 24 months. It may benefit you to use your vision plan for the glasses and use the Lens 123 program for replacement contacts. To compare your out-of-pocket cost, you may access Lens 123 costs by accessing the CareFirst website at www.carefirst.com, or by calling Lens 123 at (800) 536-7123.

Davis Providers

<p>Independent providers with Tower Collection of frames Independent providers will offer the exclusive Tower Collection. You will pay:</p> <ul style="list-style-type: none"> • \$10 Fashion frame with a gold tag • \$30 Designer or Premier frame with a red or blue tag • One \$20 wholesale allowance for non-Tower frames 	<p>Retailers with selection of frames National retailers will offer their own selection of frames.</p> <ul style="list-style-type: none"> • You will be given a retail allowance of at least \$40 (equates to a \$20 wholesale allowance) which will be credited towards the retail cost of the frame
<p>All in-network or participating Davis providers will offer the following services at no additional cost.</p> <ul style="list-style-type: none"> • One year breakage warranty on plan eyeglasses • Plastic or glass lenses • Oversized lenses 	

Your CareFirst BlueVision Coverage

Out-of-Network Providers

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

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

BlueVision Discounted Rates on Special Services

In addition to your standard eye glass coverage, BlueVision also offers discounts or pre-negotiated fees for additional options.

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

Tinting	\$11
Standard Progressive Lenses	\$50
Premium Progressive Lenses	\$90 (Varilux™, Kodak™, Rodenstock™)
Scratch Resistant Coating	\$20
Ultra-violet Coating	\$12
Plastic Photosensitive Lenses	\$65 (Transitions™)
Polycarbonate Lenses	\$30 (Polycarbonate lenses covered in full for dependent children, monocular patients and patients with prescription \pm +/- 6.00 diopter.

Example Costs

You can save a significant amount of money if you use a Davis Vision provider as shown below.

	You Pay:
Example 1	
Single vision with Davis Fashion Frame	\$10
Example 2	
Single vision with Davis Designer or Premier Frame	\$30 (\$10 material copay + \$20 upgrade)
Example 3	
Single vision with a Non-Davis Frame Retail Cost: \$200 Wholesale Cost: \$50	\$60 (2 times the difference between the wholesale cost minus the \$20 wholesale allowance) \$50 - \$20 = \$30 x 2 = \$60

Does Davis Vision offer same-day service?

There are Davis Vision network providers who have the ability to deliver your glasses within 24 hours, but the lens strength, material design and/or frame style may influence availability of same day services. Please ask your Davis Vision provider when your glasses will be available. Generally, eyeglasses will be available for dispensing within 5 business days of your order.

For more information call Davis Vision at (888) 336-7125, Monday through Friday from 8 a.m. to 8 p.m., or Saturday from 9 a.m. to 4 p.m. You can access the Davis Vision website by visiting www.carefirst.com without being a current member of the plan. No ID name or Password is needed. Click on “**Find a Doctor or Provider in your Plan**”, “**Find a Doctor**”, “**Vision Tab**”, highlight Davis (BlueVision and BlueVision Plus) circle. Follow the links on the Davis Vision Website for Provider information.

You will have the least amount to pay out-of-pocket when you use a full-service Davis office that carries the Davis tower of frames.

Flexible Spending Accounts

Plan Administrator

Baltimore County uses the services of Hirsch Financial Services, Inc. to administer our Flexible Spending Accounts. The online address is www.hfsbenefits.com.

Who Should Consider Using Flexible Spending Accounts?

- Employees with dependent daycare expenses they are now paying with after-tax dollars
- Employees with predictable health care out-of-pocket expenses (co-pays, orthodontia, laser vision correction, etc.)

Why You Should Consider Using Flexible Spending Accounts

The money you have set aside from your paycheck in a Flexible Spending Account is not subject to Federal, State, Local, FICA or Medicare taxes. You can save 28% or more using money that has not been taxed to pay for predictable expenses that qualify for FSA reimbursement.

Rules for Dependent Daycare Flexible Spending Accounts

Dependent Daycare FSAs are used to reimburse you for expenses you have for dependent care only. Do not use the Dependent Daycare FSA for anticipated medical expenses for your dependents – those expenses are reimbursed through the Health Care FSA.

The IRS requires the following conditions to be met:

- The dependent daycare expenses must be necessary because you (and spouse if married) work or attend school on a full-time basis.
- The expenses must be for children up to the age of 13 or for other dependents you report for federal income tax purposes who are incapable of self-care
- Your dependent daycare provider must be an organization or an individual that is not an immediate family member who provides the care either in your home or outside your home
- Educational programs for pre-school age children and summer day camp programs may also qualify for reimbursement
- You must obtain a receipt for your dependent daycare expenses that includes the provider's taxpayer identification number or social security number

How Dependent Care FSAs Work

- Estimate what you think you will spend for dependent daycare expenses in the upcoming Plan Year (January 1, 2012 through December 31, 2012 and the applicable grace period January 1, 2013 through March 15, 2013).
- Enroll online at www.baltimorecountymd.gov/mybenefits by entering the amount you expect to spend this year on the Flexible Spending Accounts page. The annual minimum contribution is \$130 (\$5/pay) and the annual maximum contribution is \$5,000 (\$192.31/pay).
- Beginning with the first paycheck in January 2012, you will see a deduction for your Dependent Daycare Account. That amount will be credited to your Dependent Daycare Account each pay period. You can reimburse yourself with the money in your account bi-weekly, monthly, or even annually if you prefer.
- You submit your receipts for dependent daycare to HFS with a simple claim form.
- You have the option of receiving your reimbursement either by check or by direct deposit to your bank account.
- If the claims you submit are more than the balance in your account, any excess amount will carry over to the next pay date and be paid at that time.

Some services such as nursing home expenses and overnight expenses do not qualify for Dependent Care FSA reimbursement – consult IRS Publication #503 for more information.

Dependent Care FSA Savings Example

	Without FSA	With FSA
Gross Annual Salary	\$35,000	\$35,000
Pre-Tax Dependent Care Cost	-0-	\$3,900
Taxable Income	\$35,000	\$31,100
Federal Tax (15%)	\$5,250	\$4,665
Local Tax (7.5%)	\$2,625	\$2,333
FICA (7.65%)	\$2,678	\$2,379
After-Tax Dependent Care Cost	\$3,900	-0-
Net Annual Salary	\$20,547	\$21,723
ANNUAL SAVINGS	-0-	\$1,176

Health Care Flexible Spending Accounts

The Health Care FSA is used to reimburse your predictable out-of-pocket medical expenses. If you expect to spend \$130 or more this year on medical expenses for yourself or your spouse and/or dependent children you should consider participating in a Health Care FSA.

Example of expenses allowed by the IRS include:

- Copayments or coinsurance amounts that you must pay for doctors office visits, diagnostic tests or prescriptions
- Your share of the cost for orthodontia treatment for yourself, spouse or your children
- Medical or dental services not covered by your benefit plans (laser vision correction or dental implants for example)
- The cost of some over-the-counter medical products as allowed by the IRS (bandaids, bandages, contact lens solution, medical equipment, etc.)
- Prescribed over-the-counter medications
- A full list of eligible expenses is available at www.hfsbenefits.com

Check Your FSA Balance Online

Visit www.hfsbenefits.com	
<ul style="list-style-type: none"> • Click “HFS Participant Login” • Click on “register (create an account)” • Enter the following information: <ul style="list-style-type: none"> - Employee ID (SSN or Alternate ID) - Last Name - Zip Code - Email • Click on “Save” 	<p>Once the information is provided, you will be prompted to select a user name and password and then enter your date of birth or debit card number.</p>

Consult IRS Publications #502 for more information on allowable health care expenses

continued on next page

Flexible Spending Accounts – *continued*

Options for Receiving Health Care FSA Reimbursements

- For Health Care FSAs, only, participants will receive a debit card that has been credited with the annual amount you elected for this plan year. The card can be used at numerous medical, dental and vision care practices for copays or coinsurance amounts as well as for qualified purchases or medical purchases at retail outlets. When using your card at retail outlets, that do not have the IIAS system in place, you will be required to submit a receipt for those expenses to verify they are qualified under IRS rules. A complete list of IIAS approved merchants can be found on our website www.hfsbenefits.com. Most office visits and Prescription copays will not require receipts.

However, please retain all receipts when using your debit card.

- You can elect to have your reimbursements posted to your bank account through a direct deposit option
- You can elect to be reimbursed by check mailed to your home address

Health Care FSA Savings Example

The following example illustrates how a Health Care FSA could help lessen the costs of what you may have to pay for medical expenses. Assume Jane is a County employee enrolled in the Triple Choice Plan—below are some of the expenses she expects to have for her health care needs this year.

Jane will elect an annual Health Care FSA in the amount of \$615. Her annual amount will be taken from her pay, on a pre-tax basis, in 26 equal amounts — \$23.65 per pay. These are the savings she will have because her \$615 is not subject to Federal, State or OASDI taxes:

Prescriptions	2/month – 1 Generic (\$5/Mo x 12= \$60) 1 Brand (\$20/Mo X 12 = \$240)	\$300
Primary Care Copays	5/year (\$15/visit)	\$75
Specialist Copays	2/year (\$20/visit)	\$40
Deductible & Copays for outpatient procedure estimated at \$2,100	\$100 deductible \$100 (5% of \$2,000 balance)	\$200
TOTAL EXPENSES		\$615

In this example, after-tax income increases by \$186 when using the Health Care FSA.

Federal and State tax savings are estimates based on taxable income in 15% Federal tax bracket – taxpayers in high Federal tax brackets will realize even greater savings.

Health Care FSA Savings Example

	Without FSA	With FSA
Gross Annual Salary	\$35,000	\$35,000
Pre-Tax Health Care Cost	-0-	\$615
Taxable Income	\$35,000	\$34,385
Federal Tax (15%)	\$5,250	\$5,158
Local Tax (7.5%)	\$2,625	\$2,579
OASDI (6.2%)		\$2,630
After-Tax Dependent Care Cost	\$615	-0-
Net Annual Salary		
ANNUAL SAVINGS	-0-	\$186

Use It or Lose It Rule

Any amount that remains in your January 1, 2012 Plan Year account after March 15, 2013 must be forfeited. Keep in mind that you save at least 28% on every dollar you set aside and use to pay for qualified expenses – if you have a small balance at the end of the year, you will still have saved more in taxes than you lose if you didn't have enough expenses to claim all your money.

Flexible Spending Accounts are governed by the Internal Revenue Service (IRS) regulations. Under current law, amounts set aside in FSAs must be spent for qualified expenses you have during the plan year plus an additional 2½ month period after the plan year ends.

- For the plan year that begins January 1, 2012, you must incur the expenses between January 1, 2012 and March 15, 2013.
- **Claims for expenses incurred during the allowed period must be submitted for reimbursement no later than April 30, 2013.**

Coverage Upon Termination of Employment

Upon termination of employment, you may continue your Health Care FSA coverage under COBRA through the end of the plan year in which you terminate employment. This is important if you have money left in your Health Care FSA that you expect to use before the end of the plan year. Payments for your Health Care FSA made after termination are after-tax. If you do not elect COBRA you will only be eligible to be reimbursed for expenses with dates of services prior to your termination date.

Annual Enrollment Required

You are required to re-enroll during open enrollment each year if you want to participate in one or both FSA plans for the new benefit year. This applies even if you want to elect the same amount you have in the current plan year. If you do not enroll online during the Open Enrollment period, you will not be able to have an FSA in the new benefit year.

Things to Know When Using Your Flexible Spending Account Debit Card

Your FSA debit card allows you to directly pay for your eligible FSA expenses at the point of services. This allows you to avoid the traditional hassles, such as paying out of pocket for services and then filling out and submitting a claim form and waiting for a reimbursement check. Your card can be used at any

Medical provider who accepts MasterCard®. The payment that you make to the provider of services will be deducted directly from your FSA account.

- Your FSA debit card can only be used to pay for eligible expenses.

Examples include:

- Eligible Medical, Dental and/or Vision expenses not covered by your insurance plan (i.e. copays and deductibles)
- Prescription copays
- Eligible over-the-counter (OTC) supplies (i.e. bandaids, bandages, contact lens solution, etc.)
- Contact lenses, eyeglasses and other vision care expenses
- Alternative healing (acupuncture and chiropractic visits)
- The debit card system is coded to only accept charges from qualified merchants (i.e. doctor's office, dentist's office, pharmacy, etc). Be Careful! Please do not use your FSA debit card to pay for your prescription(s) at the same time you purchase non-eligible items like toothpaste, shampoo, vitamins, etc.
- Your FSA debit card transaction will be denied if the amount of your transaction is greater than the remaining balance in your FSA account.
- Your FSA debit card offers 24/7 online access to real-time account balances plus other vital information. Go to www.hfsbenefits.com to view your account status.
- Please retain all receipts for goods and services that are purchased with your FSA debit card. HFS Benefits will request to review receipts for charges, which cannot be determined to be an exact copayment match or previously substantiated recurring expense. If you cannot provide a receipt to prove that your purchase is an eligible charge, you will be asked to reimburse your FSA for the amount of the purchase.
- When using your FSA debit card, please be sure to notify the merchant to process the transaction as a "credit". If "debit" is selected in error, the transaction will be declined as there is no PIN number associated with the card.
- Be sure that you are using your FSA Debit card to pay for current plan year expenses. You will be asked to reimburse the plan if you pay for any expenses that were incurred in the previous plan year. The date that the service was rendered is considered to be the date the expense was incurred.

Flexible Spending Accounts – *continued*

Very Important

Failure to return requested receipts or payment reimbursement will result in the suspension of your FSA debit card.

More information about the Plan and online account inquiry is available at www.hfsbenefits.com or contact:

Hirsch Financial Services, Inc.
P.O. Box 1550
Hunt Valley, MD 21030-1550
Ph: (410) 771-1331 Fax: (410) 771-5533

NEW January 2011

Over the Counter Medications (OTC) such as antacids, allergy medicines, pain relievers and cold medicines will require a prescription from a health care provider to qualify for reimbursement starting with all purchases beginning January 1, 2011. No diagnosis or explanation from the provider is required for OTC medications. You have a choice. You can either have your physician complete a prescription on his/her prescription pad or you can use our updated letter of medical recommendation form available at www.hfsbenefits.com. Once completed, simply submit it to HFS Benefits along with a signed reimbursement request and the sales receipt(s) for reimbursement. HFS Benefits will maintain the prescription on file for twelve months.

Life Insurance

Life Insurance offers protection for your loved ones in the event of your death. The County has partnered with The Standard as our Life Insurance vendor. This overview is provided for brief information purposes only.

Eligibility

Life Insurance is available to active employees working either: 30 hours or more each week in a 35-hour position or 34 hours or more each week in a 40-hour position.

Requesting Life Insurance as a New Hire

Employees electing life insurance coverage within 31 days of employment may obtain coverage without providing Evidence of Insurability. The effective date of coverage is the 1st of the following month after online enrollment. Simply select the basic life and the additional life option that you wish to purchase online at www.standard.com/enroll.

Requesting Life Insurance

Employees may enroll, cancel, increase, or decrease the amount of life insurance by completing an enrollment online at www.standard.com/enroll. All late applications and requests for increases are subject to medical underwriting approval after providing Evidence of insurability.

Requesting Life Insurance Due to Family Status Change (ex. marriage, newborn, adoption, divorce)

Employees may request a change in the amount of life insurance by completing a paper enrollment application within 31 days of the event. You will be required to submit documentation of your status change with your enrollment form.

Basic Life Insurance

Benefit Amount

- Employees hired and eligible prior to July 1, 1997 receive two times their annual salary calculated by rounding the annual salary up to the nearest \$1,000 then multiplying by two, up to a maximum of \$200,000. (This coverage may be carried into retirement).
- Employees hired on or after July 1, 1997 receive one times their annual salary rounded up to the nearest \$1,000 up to a maximum of \$200,000.

Employee Rate / County Subsidy

The cost is shared by you and the County. The County subsidizes the Basic Life Insurance as outlined below. Effective 09/01/2010, the total premium is \$.40 per \$1,000 of coverage.

County Subsidy	Employee Group
90%	Supervisory, Management, and Confidential group employees, Elected Officials, Directors of Offices and Departments, Administrative Officer, BCFPE employees hired and eligible prior to July 1, 1997.
80%	IAF Firefighters, Professional Staff Nurses Association members, AFSCME employees, FOP, and any other employee hired and eligible prior to July 1, 1997.
80%	Eligible employees hired and eligible on or after July 1, 1997.

Example of employee with 80% Subsidy

80% Subsidy – Employee Rate = \$.08 per \$1,000		
	\$50,000 salary / \$1,000 =	50
	\$.40 rate x 20% EE share =	x \$.08
	Monthly Payroll Deduction	\$4.00

Additional Life Insurance Plans

The County recognizes that individuals have different needs and has provided you the opportunity to apply for the right amount of protection for you at very competitive group rates. Enrollment in Basic Life is a requirement for enrollment in Additional Life Insurance. Additional life coverage can be purchased as follows:

Legacy Additional Life Insurance for Employees Hired and Eligible Prior to July 1, 1997

Employees hired and eligible prior to July 1, 1997 may elect \$10,000 or \$20,000 at the rate of \$1.00 per every \$1,000 of coverage. This coverage may be carried into retirement.

Additional Life Insurance with Age-Banded Rates

All eligible employees, including those hired prior to July 1, 1997, may elect Additional Life Insurance in any multiple of \$10,000, starting at \$10,000 up to \$100,000 with rates based on your age. **This coverage cannot be carried into retirement; however, you may apply for portability. Refer to the portability section of this document for additional information.**

Additional Life Insurance Rates

Monthly Additional Life Rates					
Age as of January 1	Rate Per \$1000 of Total Coverage	Additional Life Insurance Calculation Worksheet (refer to the rates to the left to calculate your monthly deduction)		Your Calculation	Example Calculation (Age 40)
<30	\$0.035	Step 1 - Amount Elected: Between \$10,000 and \$100,000	Line 1	_____	\$100,000
30-34	\$0.035	Step 2 - Line 1 divided by \$1,000 = Line 2	Line 2	_____	100
35-39	\$0.046	Step 3 - Select your rate from the rate table and enter on Line 3	Line 3	_____	.065
40-44	\$0.065	Step 4 - Line 2 multiplied by Line 3 = Your monthly cost	Line 4	_____	\$6.50/month
45-49	\$0.098				
50-54	\$0.130				
55-59	\$0.225				
60-64	\$0.385				
65-69	\$0.700				
70-74	\$1.132				
75+	\$4.292				

Features of All County Life Insurance Plans

- Accelerated Death Benefit:** If you become terminally ill as a result of an illness or physical condition which is reasonably expected to result in death within 12 months, you may have the right to receive a portion of your insurance as an accelerated benefit within your lifetime. You must apply and may receive up to 75% of your insurance. The minimum accelerated benefit is \$5,000 or

10% of your insurance, whichever is greater. There are no restrictions on how this money can be spent, and no fees will be charged.

- Portability:** If your coverage ends because your employment terminates, you may buy a term life policy. You must be under age 65, able to be gainfully employed and meet minimum coverage requirements. You must

complete an application (available online) within 31 days of the date that your coverage ends.

- **Conversion:** If your coverage ends or reduces for any reason except failure to pay premium or payment of an accelerated benefit, you may buy an individual policy of life insurance without evidence of insurability. You must complete a conversion application within 31 days of the date that your coverage ends or call 1-800-378-4668, ext. 6785.
- **Reductions in Additional Life Insurance:** Your additional life insurance policy will reduce at age 65 in accordance with the Schedule of Insurance. Please refer to the Certificate of Group Life Insurance for details.

How Do I Change My Beneficiary Election?

You may designate or update your life insurance beneficiary information quickly and easily at www.standard.com/enroll. If you have not already established an online account, simply click “Need A Login?” and follow the instructions to create your account with The Standard. To begin the designation process, Click “My Benefits”, “Change My Benefits”, “Change of Beneficiary”. If you have any questions about The Standard’s web site or need additional assistance, contact The Standard’s Customer Service at 866-623-0622, Monday-Friday, 8:30 am -6:30 pm EST.

Your basic life insurance benefit plus your additional benefit (if elected) will be paid to the beneficiary(ies) named. You may select a person(s), your estate, or an organization, such as a charity, as your beneficiary(ies). You must designate a primary beneficiary and have the option of designating contingent beneficiaries. A primary beneficiary is the person(s) who will receive a benefit upon your death. A contingent beneficiary is the person(s) who will receive a benefit in the event that all of the designated primary beneficiaries are deceased at the time of your death. If you name two or more beneficiaries in a class (primary or contingent), two or more surviving beneficiaries will share equally, unless you provide for unequal shares.

It is very important that you update your beneficiary designations as your life situation changes (e.g., marriage, divorce, death, birth of a child, etc.) to ensure that your life insurance proceeds are paid to the appropriate person(s).

A change in your life insurance beneficiary election does not change your pension beneficiary designation; they are separate elections and must be updated separately.

Additional Plan Feature - Travel Assistance Available at No Cost with All Life Insurance Plans

MEDEX® Travel Assist helps you cope with emergencies when you travel more than 100 miles from home or internationally for trips of up to 180 days. MEDEX Travel Assist can also help you with non-emergencies, such as planning your trip.

You do not have to enroll. As a participant in your Baltimore County’s Group Life insurance coverage from The Standard, you and your family members are automatically covered. All services are provided by MEDEX Assistance Corporation and are available 24 hours a day, every day.

MEDEX Travel Assist offers the following services:

- **Pre-trip Assistance** including passport, visa, weather and currency exchange information, health hazards advice and inoculation requirements
- Medical Assistance Services including locating medical care providers and interpreter services
- Travel Assistance Services including emergency ticket, credit card and passport replacement assistance, funds transfer assistance and missing baggage assistance
- Legal Assistance Services including locating a local attorney, consular officer or bail bond services
- Emergency Transportation Services including arranging and paying for emergency evacuation to the nearest adequate medical facility and medically-necessary repatriation to the employee’s home, including repatriation of remains
- Personal Security Services including evacuation and logistical arrangements in the event of political unrest, social instability, weather conditions, health or environmental hazards

Deferred Compensation for Baltimore County Employees

Baltimore County has selected Nationwide Retirement Solutions (NRS) to administer the Deferred Compensation program

What is Deferred Compensation and how can it benefit me?

Deferred compensation lets you defer a portion of your current earnings into an account for your retirement. When you do this, you reduce the amount of your income that's taxable now. So you're not only investing for tomorrow, you're postponing federal income taxes today.

How a little can mean a lot

The hypothetical compounding example below assumes a \$50 contribution every other week. Assuming a 28% tax bracket, each paycheck is only reduced by \$36. Total returns reflect accumulated account balances at the end of the indicated periods based on contributions during that time period and the assumed annual rates of return. Costs of investing and taxes due upon withdrawal were not included; if they had been, returns would have been lower.

	Years	at 4%	at 6%	at
8%	5	\$7,187	\$7,554	\$7,939
	10	\$15,930	\$17,664	\$19,605
	15	\$26,568	\$31,193	\$36,746
	20	\$39,510	\$49,297	\$61,931
	25	\$55,257	\$73,252	\$98,937

Because this is purely an illustration, your results may vary. It is not intended to serve as a projection or prediction of the results of any specific investment. It does not account for taxes that would be due upon withdrawal. However, it does offer a realistic example of how your retirement investments may grow through deferred compensation.

The amount you choose to contribute to your program will depend on your specific situation. There is no "one-size-fits-all" solution. Your strategy likely will involve contributing as much as you can on a regular basis. The strategy you choose will depend on many variables, including the amounts you might receive from your pension and Social Security, what your investments earn between now and the time you retire, and what kind of standard of living you want at retirement. Regardless of how much you can afford to contribute, there are huge benefits to joining the deferred compensation program sooner rather than later.

Participating is easy

Begin by enrolling in the Baltimore County Deferred Compensation Program. Kevin McQuarrie, your NRS Retirement Specialist, can get you started. Just call (410) 519-3416. You can also take advantage of several other services that will allow you to manage your retirement investments whenever and wherever you want:

- Visit www.BaltimoreCountyDC.com to enroll, change your deferral allocation or current investment, and receive financial information and education.
- Contact a Direct Access Retirement Specialist between 8 a.m. and 9 p.m. EST at (877) NRS-FORU (677-3678), then *0.
- Use the NRS automated telephone service anytime day or night to process an exchange or allocation change, and check your account balance: 877-NRSFORU (877-677-3678), Option 1, then 1.

For more information

Contact Kevin McQuarrie, your local Retirement Specialist, at (410) 519-3416.

Appendix I

BALTIMORE COUNTY GOVERNMENT NOTICE OF PRIVACY POLICY AND PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED IF YOU ARE COVERED BY BALTIMORE COUNTY HEALTH BENEFIT PLANS. PLEASE REVIEW IT CAREFULLY.

This Notice applies to the following Benefit Plans sponsored by Baltimore County, Maryland:

Medical Benefit Plans

- Medical Plans
- Prescription Drug Benefits Included With Medical Plans
- Dental And Vision Plans
- EAP And Managed Mental Health Plans
- Health Care Flexible Spending Accounts (FSAs)

These plans are treated as a single plan for purposes of this Notice and the privacy rules that require it. For purposes of this Notice, we will refer to these plans as a single “Plan.” Please note that Baltimore County provides personal and demographic information required to establish your eligibility in these plans and provides the funding for the plans. In instances where the use or disclosure of your medical information is required for purposes of treatment, payment or operation of our health plans, Baltimore County has assigned those responsibilities to Plan Administrators.

The Plans covered by this notice may share information with each other when required and as permitted under law. The amount of health information used or disclosed will be limited to the Minimum Necessary to provide or pay for medical care. The Plans may also contact you to provide appointment reminders or other health-related services.

The Plan’s Duty to Safeguard Your Protected Health Information.

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered “Protected Health Information” (“PHI”). The Plan is required to extend certain protections to your PHI, and to give you this Notice about its privacy practices that explains how, when and why the Plan may use or disclose your PHI.

The Plan is required to follow the privacy practices described in this Notice, though it reserves the right to change those practices and the terms of this Notice at any time. If it does so, and the change is material, you will receive a revised version of this Notice either by hand delivery, mail delivery to your last known address, or some other fashion. This Notice, and any material revisions of it, will also be provided to you in writing upon your request, and will be posted on the website maintained by Baltimore County Government that describes benefits available to employees and dependents.

You may also receive one or more other privacy notices, from insurance companies that provide benefits under the Plan. Those notices will describe how the insurance companies use and disclose PHI, and your rights with respect to the PHI they maintain.

How the Plan May Use and Disclose Your Protected Health Information.

The Plan uses and discloses PHI for a variety of reasons. For its routine uses and disclosures it does not require your authorization, but for other uses and disclosures, your authorization (or the authorization of your personal representative (e.g., a person who is your custodian, guardian, or has your power-of-attorney) may be required. The following offers more description and examples of the Plan’s uses and disclosures of your PHI.

Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations.

- **Treatment:** Generally, and as you would expect, the Plan Administrators are permitted to disclose your PHI for purposes of your medical treatment. Thus, they may disclose your PHI to doctors, nurses, hospitals, emergency medical technicians, pharmacists and other health care professionals where the disclosure is for your medical treatment. For example, if you are injured in an accident, and it is important for your treatment team to know your blood type, the Plan Administrators could disclose that PHI in order to allow you to receive effective treatment.
- **Payment:** Of course, the Plan’s most important function, as far as you are concerned, is that it pays for all or some of the medical care you receive (provided the care is covered by the Plan). In the course of its payment operations, the Plan Administrators receive a substantial amount of PHI about you. For example, doctors, hospitals and pharmacies that provide you care send the Plan Administrators detailed information about the care they provided, so that they can be paid for their services. The Plan Administrators may

also share your PHI with other plans, in certain cases. For example, if you are covered by more than one health care plan (e.g., covered by this Plan, and your spouse's plan, or covered by the plans covering your father and mother), they may share your PHI with the other plans to coordinate payment of your claims.

- **Health care operations:** The Plan Administrators may use and disclose your PHI in the course of its "health care operations." For example, it may use your PHI in evaluating the quality of services you received, or disclose your PHI to an accountant or attorney for audit purposes. In some cases, the Plan may disclose your PHI to insurance companies for purposes of obtaining insurance coverage.

Other Uses and Disclosures of Your PHI Not Requiring Authorization.

The law provides that the Plan may use and disclose your PHI without authorization in the following circumstances:

- **To the Plan Sponsor:** The Plan Administrators may disclose PHI to Baltimore County who is the Plan sponsor and maintains the benefit plans offered to its employees, retirees and dependents. However, the PHI may only be used for limited purposes, and may not be used for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the employers. PHI may be disclosed to: the County's Insurance Division for purposes of enrollment and disenrollment, census, claim resolutions, and other matters related to Plan administration; payroll department for purposes of ensuring appropriate payroll deductions and other payments by covered persons for their coverage; information technology department, as needed for preparation of data compilations and reports related to Plan administration; finance department for purposes of reconciling appropriate payments of premium to and benefits from the Plan, and other matters related to Plan administration; internal legal counsel to assist with resolution of claim, coverage and other disputes related to the Plan's provision of benefits.
- **Required by law:** The Plan may disclose PHI when a law requires that it report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to a court order. It must also disclose PHI to authorities who monitor compliance with these privacy requirements.
- **Workers' Compensation:** We may release medical information about you for workers' compensation or for similar programs that provide benefits for work-related injuries or illness.

- **For public health activities:** The Plan may disclose PHI when required to collect information about disease or injury, or to report vital statistics to the public health authority.
- **For health oversight activities:** The Plan may disclose PHI to agencies or departments responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.
- **Relating to decedents:** The Plan may disclose PHI relating to an individual's death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
- **For research purposes:** In certain circumstances, and under strict supervision of a privacy board, the Plan may disclose PHI to assist medical and psychiatric research.
- **To avert threat to health or safety:** In order to avoid a serious threat to health or safety, the Plan may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
- **For specific government functions:** The Plan may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons.
- **Uses and Disclosures Requiring Authorization:** For uses and disclosures beyond treatment, payment and operations purposes, and for reasons not included in one of the exceptions described above, the Plan is required to have your written authorization. Your authorizations can be revoked at any time to stop future uses and disclosures, except to the extent that the Plan has already undertaken an action in reliance upon your authorization.
- **Uses and Disclosures Requiring You to have an Opportunity to Object:** The Plan may share PHI with your family, friend or other person involved in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death. However, the Plan may disclose your PHI only if it informs you about the disclosure in advance and you do not object (but if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests; you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so).

Your Rights Regarding Your Protected Health Information.

You have the following rights relating to your protected health information:

- **To request restrictions on uses and disclosures:** You have the right to ask that the Plan (or Plan Administrator) limit how it uses or discloses your PHI. The Plan will consider your request, but is not legally bound to agree to the restriction. To the extent that it agrees to any restrictions on its use or disclosure of your PHI, it will put the agreement in writing and abide by it except in emergency situations. The Plan cannot agree to limit uses or disclosures that are required by law.
- **To choose how the Plan contacts you:** You have the right to ask that the Plan (or Plan Administrator) send you information at an alternative address or by an alternative means. The Plan (or Plan Administrator) must agree to your request as long as it is reasonably easy for it to accommodate the request.
- **To inspect and copy your PHI:** Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI in the possession of the Plan or its Administrators if you put your request in writing. The Plan, or someone on behalf of the Plan, will respond to your request, normally within 30 days. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to receive, upon request, prior information on the cost of copying.
- **To request amendment of your PHI:** If you believe that there is a mistake or missing information in a record of your PHI held by one of the Plan Administrators, you may request, in writing, that the record be corrected or supplemented. The Plan or Plan Administrator will respond, normally within 60 days of receiving your request. The Plan may deny the request if it is determined that the PHI is: (i) correct and complete; (ii) not created by the Plan or its Administrator and/or not part of the Plan's or Administrator's records; or (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the request for amendment is approved, the Plan or Plan Administrator, as the case may be, will change the PHI and so inform you, and tell others that need to know about the change in the PHI.

- To find out what disclosures have been made: For actions that occur on and after April 14, 2003 (the date of this notice) you have a right to request a list of when, to whom, for what purpose, and what portion of your PHI has been released by the Plan and/or its Plan Administrators, other than instances of disclosure for which you gave authorization, or instances where the disclosure was made to you or your family. In addition, the disclosure list will not include disclosures for treatment, payment, or health care operations. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or before the date the federal privacy rules applied to the Plan. You will receive a response to your written request for such a list within 60 days after you make the request in writing. You may make one (1) request in any 12-month period at no cost to you. There may be a charge for more frequent requests.

How to Complain about the Plan's Privacy Practices.

- If you think the Plan or one of its Plan Administrators may have violated your privacy rights, or if you disagree with a decision made by the Plan or a Plan Administrator about access to your PHI, you may file a complaint with the person listed in the section immediately below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. The law does not permit anyone to take retaliatory action against you if you make such complaints.

Contact Person for Information, or to Submit a Complaint.

- If you want more information about Baltimore County's privacy practices with respect to your health plans and who is covered on your plans, contact the County Insurance Division at (410) 887-2568.
- If you want more information about the privacy practices of the County's Plan Administrators, contact them directly at the Member Services number on your Plan ID card. Additional contact information for the County's Plan Administrators can be found on the County's website.

Privacy Official.

Baltimore County's Office of Budget and Finance HIPAA Privacy Compliance Officer:

Health Insurance Administrator

Rebecca Ellis

400 Washington Ave, Rm 111

Towson, MD. 21204

410-887-2568

Effective Date.

The effective date of this Notice is: April 14, 2006.

HEALTH CARE REFORM IMPACT ON BALTIMORE COUNTY BENEFIT PLANS

To maintain status as a grandfathered health plan, an employer benefit plan or health insurance coverage must have had individuals enrolled in the plan on the date the Patient Protection and Affordable Care Act (PPACA) was enacted (March 23, 2010). Accordingly, Baltimore County, Maryland believes that the Triple Choice, CIGNA Open Access Plus In-Network (OAPIN), and Kaiser Staff Model HMO plans meet the criteria to operate as grandfathered health plans. The new CIGNA Open Access Plus (OAP) plan does not meet the criteria and thus will be required to comply with all the consumer protections of the PPACA.

As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means the plans that qualify for grandfather status may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, coverage of adult dependent children to age 26, elimination of lifetime benefit maximums and other provisions.

Detailed benefit charts for each of the plans sponsored by Baltimore County, Maryland are included in this benefit guide – please review them carefully for plan coverage differences.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Baltimore County's Health Insurance Division at 410-887-2568. Information on grandfathered plans can also be found online at www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Online Enrollment - Getting Started

New Hires – New employees must enroll online within 31 days of their hire date. Benefits will be effective the 1st of the month following completion of your enrollment process.

Open Enrollment – The 2012 Open Enrollment period for Baltimore County employees and retirees is October 11th through November 14, 2011. Active employees must make all enrollment changes online. You will be able to review your benefits and make changes from anywhere you have access to a PC and internet service.

Retirees may enroll online or request a Retiree Benefits Application form from the Insurance Division to make benefit changes or to update your dependent information. New Medicare enrollees must complete a paper application. Please contact the Insurance Division. Numbers for the County Insurance Division are on the inside front cover of this guide.

Any changes made during Open Enrollment will have an effective date of January 1, 2012.

Before You Enroll

You must have the following information available for yourself and for each dependent you are enrolling in your plans; use this checklist to record that information before enrolling online.

Names, Birth, Social Security numbers, and Primary Care Physician and Dentist ID Numbers and Names for yourself and each dependent you are including on your plans. (ID Numbers can be located on the plan websites or in the provider directories)

Member Name	Date of Birth MM/DD/YY	Social Security #	Primary Care Physician ID Number and Name (ex. 1234 Smith) PCP Required for Kaiser Only	Primary Care Dentist ID Number and Name (ex 1234 Smith) PCP Required for CIGNA DHMO Only

Active Employees Only

FSA Dependent Daycare Contribution Amount for plan year 1/1/2012 through 12/31/2012	\$
FSA Health Care Contribution Amount for plan year 1/1/2012 through 12/31/2012	\$

To help you navigate the Employee Self Service (ESS) system, the County has posted video instructions on the enrollment site. These videos will allow you to “watch” the steps required or, by choosing “try” option, you will be given an opportunity to interact with the online instructions.

To access these “Watch-Try” exercises go to www.baltimorecountymd.gov/mybenefits.

After you’ve reviewed the video instructions and gathered all the required information, you’re ready to enroll online. Select the Log into Employee Self Service link to begin.

Employee Self Service (ESS) On-line Enrollment Instructions

Please follow the enrollment instructions as outlined below. **Please note: Clicking the Save and Exit button throughout the ESS Enrollment process DOES NOT enroll you in benefits.** The Save and Exit button allows you to sign-in to the ESS System multiple times. **Enrollment will not be finalized until the Electronic Signature Box and the Finish Button are clicked on page 5 — ENROLLMENT SUMMARY PAGE.**

Login Instructions:

1. Go to www.baltimorecountymd.gov/mybenefits.
 2. **Enter your user ID** – typically first initial and last name (ex. – jdoe). Call the OIT service desk at 410-887-8200 if your user ID or password are not recognized.
 3. **Enter your password** – If you have already used ESS/HRM, continue to use your current password. If you are a new user logging in for the first time, your password is your six-digit date of birth combined with the last four digits of your social security number (mmddy1234). For security reasons the system will prompt you to change your password.
 4. Review the HIPAA and COBRA notices found on the **County Forms / Websites** tab.
 5. Click on the **Home** tab.
 6. To begin Enrollment, click on the “**Launch Enrollment Wizard**” blue arrow.
 7. If more than one Job Title is displayed, select the Job Title that entitles you to benefits, then click the **Continue** button.
 8. Click on **Start New** or **Modify Existing Enrollment**, and then click the **Continue** button.
 9. Click Open Enrollment or New Hire Enrollment, and then click the Continue button.
 10. You will be prompted to complete your on-line enrollment through a 5 step process. Follow the instructions on each page.
- 1 – **Appointment Page**
Use this page to verify your current Job Title.
 - 2 – **Dependent Page**
Use this page for modifying existing dependents or adding new dependents. **Adding dependents on Page 2 does not enroll the dependents on plans. After completing Page 2, enroll your dependents on Page 3 to plans that you choose.**
 - 3 – **Benefits Enrollment Page**
Use this page for adding/changing Benefit Plans. **This is also the page that you would use to terminate OR ADD coverage for one of your dependents or for yourself.** New Hires must Enroll or Waive each Benefit Plan. **Reenrollment is required each plan year for Health Care and Daycare Flexible Spending Accounts.** If not enrolling, they must be waived.
 - 4 – **Miscellaneous Deductions Page**
This page is currently not in use.
 - 5 – **Enrollment Summary Page**
Use this page to verify and complete your enrollment. and print a **Confirmation Statement** for your records.

Enrollment is not complete until the electronic signature box is checked AND the FINISH button is clicked. After a “Completed Successfully “ message appears on the top left of page, print a Confirmation Statement for your records.

Problems or Questions?

If you do not have access to the Internet or need help enrolling on-line, please contact your supervisor for assistance.

How to Contact Your Benefit Plans Directly

	Plan Name	Customer Service Number	Website
MEDICAL	CIGNA Open Access Plus OAP CIGNA Open Access Plus In-Network (OAPIN) CIGNA Medicare Surround	1-800-896-0948	www.cigna.com
	CareFirst BCBS Triple Choice	1-877-691-5856	www.carefirst.com (Point of Service, MPOS)
	Kaiser Permanente Select HMO/Prescription	1-800-777-7902	www.kaiserpermanente.org
RX	Express Scripts, Inc Prescription Coverage for CIGNA OAP, CIGNA OAPIN, CF Triple Choice Non-Medicare Plans	1-866-852-4061	www.express-scripts.com
RETIREE MEDICARE SUPPLEMENTAL/RX	Express Scripts, Inc CIGNA Medicare Surround Medicare Part D Prescription Drug Plan	1-866-344-2922	www.express-scripts.com
	Kaiser Permanente Medicare Plus/Prescription	1-800-777-7902	www.kp.org
DENTAL	CareFirst BCBS Traditional Dental CareFirst BCBS Dental PPO	1-866-891-2802	www.carefirst.com
	CIGNA Dental Plan (DHMO)	1-800-896-0948	www.cigna.com
MENTAL HEALTH	ComPsych (CFBCBS Provider)	1-877-595-5283	www.guidanceresources.com (password: baltimore)
	CIGNA Open Access Plus OAP and OAPIN	1-800-896-0948	www.cigna.com
	Kaiser Permanente HMO	1-866-530-8778	www.kp.org
EAP	ComPsych Employee Assistance Plan Triple Choice Managed Mental Health	1-877-595-5283	www.guidanceresources.com (password: baltimore)
VISION	CareFirst BCBS Davis Vision	1-800-783-5602	www.carefirst.com
FSA	Hirsch Financial Services, Inc Health and Dependent Care Flexible Spending accounts	1-410-771-1331 1-877-595-5283	www.hfsbenefits.com
LIFE INSURANCE	The Standard	1-866-623-0622	www.standard.com/enroll

Employee Benefits Open Enrollment Meetings

For Baltimore County Employees & Retirees

This year's meetings will give employees and retirees the opportunity to meet individually with the following plan representatives. The meetings will also include plan materials and promotional items as well as healthy lifestyle information.

- CIGNA HealthCare
- CareFirst BlueCross BlueShield
- Kaiser Permanente
- Express Scripts Prescription Administrators
- HFS Benefits
- PEPSICO Nationwide Retirement Solutions
- ComPsych EAP/Managed Mental Health
- Standard Life Insurance

Open Enrollment Meetings will take place at the following locations and times:

LOCATIONS

Wednesday, October 12-Towson Armory
Friday, October 14 – Public Safety Bldg.
Monday, October 17 – Oregon Ridge
Wednesday, October 26 – Towson Armory
Thursday, October 27 – CCBC Dundalk Campus
Wednesday, November 2 – Public Safety Bldg.
Wednesday, November 9 – Oregon Ridge
Thursday, November 10 – CCBC Catonsville Campus

TIMES

10:00 a.m. to 2:00 p.m.
12:30 p.m. to 4:30 p.m.
10:00 a.m. to 2:00 p.m.

Public Safety Building: I-695 to Providence Rd. exit (Toward Towson). After light at, Goucher Blvd, look for Public Safety Parking lot on left – left into lot, visitor parking on right.

Oregon Ridge: I-695 to I-83 North. Take 2nd Shawan Rd exit. Follow Shawan Rd to 1st light and turn left on Beaver Dam Rd. Follow approximately 1 mile to gate for Oregon Ridge Lodge. Park in front lot.

Towson Armory: I-695 to York Rd (Towson) exit. Left on West Rd. Right on York Rd. Go through 3 lights, then go halfway around “circle” stay on York Rd. Turn right at 3rd light after circle onto Towsontowne Blvd. Make 1st right onto Washington Ave. Garage will be on left. Towson Armory is on the corner of Washington and Chesapeake.

CCBC Dundalk Campus: Take Exit 39 (Merritt Blvd), proceed about 2 1/2 miles. At the 8th traffic light (intersection of Merritt Blvd - Peninsula Expressway and Merritt Ave) turn right. If you cross RR tracks you've gone too far. At the first traffic light, Merritt Ave becomes Sollers Point Road. Go Straight. The college is at the top of the crest on the right. (Athletic and Wellness Center- Building H)

CCBC Catonsville Campus: CCBC Catonsville is located at 800 South Rolling Road in Catonsville. Take Baltimore Beltway (695) Exit 12, Wilkens Avenue West. Follow Wilkens Avenue West to Valley Road. Make a right on Valley Road to the college entrance.



Baltimore County Office of Budget and Finance

Insurance Division

400 Washington Avenue, Towson, MD 21204