

# 2012 Benefits Enrollment Guide



*For those retired prior to July 1, 2007*  
**Baltimore County Government**

*Effective January 1, 2012 - December 31, 2012*

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# Baltimore County Government

## Important Contacts For Benefits Information

Contact:	Regarding:
<p><b>Insurance Division, Office of Budget and Finance</b>            400 Washington Ave., Rm 111            Towson, MD 21204  <b>Phone: (410) 887-2568 or (800) 274-4302</b>  <b>Fax: (410) 887-3820</b>  <b>MAIL STOP 2105</b>  <b>Email: <a href="mailto:bcbenefits@baltimorecountymd.gov">bcbenefits@baltimorecountymd.gov</a></b>  <b>Internet: <a href="http://www.baltimorecountymd.gov/benefits">www.baltimorecountymd.gov/benefits</a></b>  <b>Intranet: bcnet</b></p>	<ul style="list-style-type: none"> <li>■ Who is eligible for County health plan coverage</li> <li>■ General benefit questions</li> <li>■ Changes in family status affecting benefits</li> <li>■ Changes to life insurance beneficiaries</li> <li>■ Assistance with benefits elections when retiring</li> <li>■ Continuing benefits under COBRA if you or your dependent(s) lose County benefits</li> <li>■ Enrollment and ESS questions</li> <li>■ Life status changes – i.e. marriage, divorce, birth, adoption, death of dependents, loss of dependent status</li> <li>■ Changes to your address</li> </ul>
<p><b>Baltimore County Retirement Office</b>            400 Washington Ave., Rm 169            Towson, MD 21204  <b>Phone: (410) 887-8246 or (877) 222-3741</b></p>	<ul style="list-style-type: none"> <li>■ Questions about your pension benefits</li> <li>■ Questions about who you designated as your retirement beneficiary</li> <li>■ Requests for retirement conferences</li> <li>■ Changes to your address or other retirement information on file</li> <li>■ Life status changes – i.e. marriage, divorce, or death of dependent spouse or other retiree beneficiary</li> <li>■ Changes to your direct deposit designation</li> </ul>
<p><b>Baltimore County Employee Assistance Program (Administered by ComPsych)</b></p> <p><b>Phone: (877) 595-5283</b>  <b><a href="http://www.guidanceresources.com">www.guidanceresources.com</a> (password: baltimore)</b></p>	<ul style="list-style-type: none"> <li>■ Assistance with short-term, confidential, no-cost counseling for mental health, substance abuse and/or other work or family issues</li> <li>■ Prior authorization requirements for mental health and substance abuse benefits under your County health plan if enrolled in CareFirst BlueCross BlueShield Triple Choice Plan</li> </ul>
<p><b>Social Security Administration (SSA)</b>  <b>Phone: (800) 772-1213</b></p>	<ul style="list-style-type: none"> <li>■ Change of address</li> <li>■ General Medicare Part A or B eligibility or premiums</li> </ul>
<p><b>Medicare Help Line</b>  <b>Phone: 1-800-MEDICARE (633-4227)</b>  <b><a href="http://www.medicare.gov">www.medicare.gov</a></b></p>	<ul style="list-style-type: none"> <li>■ Request new ID card</li> <li>■ Ordering Medicare publications</li> <li>■ General Medicare information</li> </ul>
<p><b>Medicare Part A &amp; B— Maryland (Trailblazers)</b>  <b>Phone: (800) 444-4606</b></p>	<ul style="list-style-type: none"> <li>■ Questions regarding bills and services in Maryland only</li> <li>■ Questions about a Medicare Explanation of Benefits statement</li> </ul>

*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 Government Retirees that retired 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 Retirees that retired prior to July 1, 2007 for the Plan Year January 1, 2012 through December 31, 2012.**

**Medical Plans:**

CareFirst Triple Choice  
(current members only)

CIGNA Open Access Plus (OAP)

CIGNA Open Access Plus (OAPIN)

Kaiser Permanente Select HMO

**Dental Plans:**

CareFirst BCBS Traditional Dental

CareFirst BCBS Preferred Dental PPO

CIGNA Dental Care DHMO

**Vision Plan:**

CareFirst Davis Vision

**Medicare Plans:**

CIGNA Medicare Surround

Kaiser Permanente Med. Plus

**Baltimore County's share of health plan premiums:**

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

If you are enrolled in the CareFirst Triple Choice plan

- and you qualify for the same subsidy as active employees, the County share of premium will be 80%, your share will be 20%. The subsidy decreases to 80% on 1/1/12.
- if you retired prior to 2/1/1992 and are not yet eligible for Medicare, your subsidy remains at 90%
- the subsidy for retirees with less than a full service retirement remains the same as current subsidy
- the subsidy for widows and for Medicare enrollees remains the same as current subsidy

**CIGNA Open Access In-Network only plan and Kaiser Permanente HMO plan**

If you are enrolled in the an HMO plan

- and you qualify for the same subsidy as active employees, the County share of premium cost for 1/1/2012 will be 90%, your share will be 10%.
- if you retired prior to 2/1/1992 and are not yet eligible for Medicare, your subsidy remains at 90%
- the subsidy for retirees with less than a full service retirement remains the same as current subsidy
- the subsidy for widows and for Medicare enrollees remains the same as current subsidy

**CareFirst Traditional Dental**

- All Retirees (non-Medicare and Medicare eligible) may enroll in this plan at 100 percent of the premium with no County subsidy.

**CareFirst Preferred Dental PPO and CIGNA Dental Care DHMO**

- Retirees eligible for Medicare may enroll in these plans at 100 percent of the premium with no County subsidy.

**Medicare Supplemental Plan - CIGNA Medicare Surround:**

Our Medicare Supplemental plan for retirees over age 65 is called CIGNA Medicare Surround. The CIGNA Medicare Surround includes our Medicare Part D Prescription coverage through Express Scripts. **The Express Scripts Part D plan is sending new cards for January 1, 2012. Please begin using the new card effective January 1, 2012.**

**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

In early October 2011, Benefit Confirmation Statements were mailed to retirees 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 contact that office at 410-887-2568 if you need to make a correction to any of the information on that form.

## Online Enrollment Process for Medical, Dental, and Vision

Retirees who want to make changes to their medical, dental, or vision plans, including the dependents on their plans can make changes online between October 11th and November 14th in Employee Self Service (ESS) at [www.baltimorecountymd.gov/mybenefits](http://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. **You may also contact the Insurance Division at 410-887-2568 to request a paper application.**

## 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.
- Any Medicare or over age 65 participant that wants to add Dental or Vision.

# Baltimore County Government Monthly Insurance Contribution Rates for Retirees

Retired Prior to July 1, 2007

Effective 1/1/2012 through 12/31/2012

Current general government employees who retire with 30 or more years of service and Public Safety retirees with 25 years of service will receive same subsidy as active employees for retiree health plans.

Plan Name	Coverage Level	Total Premium	Date of Retirement On/After 2/2/92 with 30 years service*	Date of Retirement On/After 2/2/92 with 20-29 years service*	Date of Retirement On/After 2/2/92 with 10-19 years service*	Date of Retirement Before 2/1/92 County pays 90% for medical also disability retirees, retired prior to 3/11/96	Non-Medicare spouse of Medicare Retiree; Non-Medicare Widow/Widower; Age 65 Retiree/Spouse not eligible for Medicare subsidy is 75% of total premium
			County pays same as active employees	75% of active employees	50% of active employees		
			1	2	3	4	5
Carefirst BCBS Triple Choice	Individual	\$ 702.97	\$ 140.59	\$ 281.19	\$ 421.78	\$ 70.30	\$ 175.74
	Parent/Child	\$ 1,031.67	\$ 206.33	\$ 412.67	\$ 619.00	\$ 103.17	\$ 257.92
	Husband/Wife	\$ 1,500.11	\$ 300.02	\$ 600.04	\$ 900.07	\$ 150.01	\$ 375.03
	Family	\$ 2,141.13	\$ 428.23	\$ 856.45	\$ 1,284.68	\$ 214.11	\$ 535.28
CIGNA Open Access Plus (OAP)	Individual	\$ 626.25	\$ 125.25	\$ 250.50	\$ 375.75	\$ 62.62	\$ 156.56
	Parent/Child	\$ 919.09	\$ 183.82	\$ 367.64	\$ 551.45	\$ 91.91	\$ 229.77
	Husband/Wife	\$ 1,336.39	\$ 267.28	\$ 534.56	\$ 801.83	\$ 133.64	\$ 334.10
	Family	\$ 1,907.46	\$ 381.49	\$ 762.98	\$ 1,144.48	\$ 190.75	\$ 476.86
CIGNA Open Access Plus In-Network (OAPIN)	Individual	\$ 488.47	\$ 48.85	\$ 158.75	\$ 268.66	\$ 48.85	\$ 122.12
	Parent/Child	\$ 709.13	\$ 70.91	\$ 230.47	\$ 390.02	\$ 70.91	\$ 177.28
	Husband/Wife	\$ 1,045.81	\$ 104.58	\$ 339.89	\$ 575.20	\$ 104.58	\$ 261.45
	Family	\$ 1,476.85	\$ 147.68	\$ 479.98	\$ 812.27	\$ 147.68	\$ 369.21
Kaiser HMO	Individual	\$ 553.72	\$ 55.37	\$ 179.96	\$ 304.55	\$ 55.37	\$ 138.43
	Parent/Child	\$ 830.58	\$ 83.06	\$ 269.94	\$ 456.82	\$ 83.06	\$ 207.64
	Husband/Wife	\$ 1,107.44	\$ 110.74	\$ 359.92	\$ 609.09	\$ 110.74	\$ 276.86
	Family	\$ 1,661.16	\$ 166.12	\$ 539.88	\$ 913.64	\$ 166.12	\$ 415.29
Carefirst Traditional Dental	Individual	\$ 32.13	\$ 32.13	\$ 32.13	\$ 32.13	\$ 32.13	\$ 32.13
	Parent/Child	\$ 48.17	\$ 48.17	\$ 48.17	\$ 48.17	\$ 48.17	\$ 48.17
	Husband/Wife	\$ 64.24	\$ 64.24	\$ 64.24	\$ 64.24	\$ 64.24	\$ 64.24
	Family	\$ 96.40	\$ 96.40	\$ 96.40	\$ 96.40	\$ 96.40	\$ 96.40
Carefirst Preferred Dental PPO	Individual	\$ 26.02	\$ 6.50	\$ 6.50	\$ 6.50	\$ 6.50	\$ 6.50
	Parent/Child	\$ 36.90	\$ 9.22	\$ 9.22	\$ 9.22	\$ 9.22	\$ 9.22
	Husband/Wife	\$ 49.22	\$ 12.30	\$ 12.30	\$ 12.30	\$ 12.30	\$ 12.30
	Family	\$ 73.86	\$ 18.46	\$ 18.46	\$ 18.46	\$ 18.46	\$ 18.46
CIGNA Dental DHMO	Individual	\$ 16.22	\$ 4.05	\$ 4.05	\$ 4.05	\$ 4.05	\$ 4.05
	Parent/Child	\$ 29.24	\$ 7.31	\$ 7.31	\$ 7.31	\$ 7.31	\$ 7.31
	Husband/Wife	\$ 32.40	\$ 8.10	\$ 8.10	\$ 8.10	\$ 8.10	\$ 8.10
	Family	\$ 48.83	\$ 12.20	\$ 12.20	\$ 12.20	\$ 12.20	\$ 12.20
Vision	Individual	\$ 2.35	\$ 0.23	\$ 0.23	\$ 0.23	\$ 0.23	\$ 0.23
	Parent/Child	\$ 3.55	\$ 0.35	\$ 0.35	\$ 0.35	\$ 0.35	\$ 0.35
	Husband/Wife	\$ 4.72	\$ 0.47	\$ 0.47	\$ 0.47	\$ 0.47	\$ 0.47
	Family	\$ 7.06	\$ 0.70	\$ 0.70	\$ 0.70	\$ 0.70	\$ 0.70

**Subsidy rules:**

\* Retired after 2/2/92 w/30 years service - pays same as active employees - Column # 1

\* Disability retirees retired on/after 3/11/96, pay same as active - Column # 1

\* Police/Corrections Officers/Deputy Sheriffs w/20 yrs. service retired after 2/2/92-Column # 1

\* Fire w/25 years service, retired after 2/2/92 or age 50 w/20 yrs. service retired after 2/2/92- Column # 1

\* Incentive retirees, 1996 - Column # 1

\* Retired after 2/2/92 w/20-29 years service - receives 75% of active subsidy - Column # 2

\* Retired after 2/2/92 w/10-19 years service- receives 50% of active subsidy - Column # 3

\* Disability retirees retired prior to 3/11/96, County pays 90% - Column # 4

\* Widows/Widowers; Non-Medicare spouses of Medicare retirees - Column #5

\* Retirees on/after 7/1/06 w/less than 10 years service receive no subsidy for health benefits

# Baltimore County Government Monthly Insurance Contribution Rates for Retirees

*Retired Prior to July 1, 2007*

**Effective 1/1/2012 through 12/31/2012**

*Retirees MUST enroll in Medicare Parts A and B when eligible.*

*Retirees DO NOT need to enroll in a Medicare Part D Plan. The County offers an approved Medicare Part D Prescription plan.*

Medicare Supplemental Plans	Total Monthly Premium	Retiree/Dependent Monthly Cost
CIGNA Medicare Surround	\$404.42	<b>\$101.10</b>
Kaiser Medicare Plus	\$305.18	<b>\$76.29</b>

Dental and Vision Rates for Medicare/Over 65 Retirees/Spouses and non-Medicare Spouses of Medicare Retirees (no County Subsidy)	Total Monthly Premium	Retiree/Dependent Monthly Cost
Carefirst Traditional Dental	Individual	\$ 32.13
	Parent/Child	\$ 48.17
	Husband/Wife	\$ 64.24
	Family	\$ 96.40
Carefirst Preferred Dental PPO	Individual	\$ 26.02
	Parent/Child	\$ 36.90
	Husband/Wife	\$ 49.22
	Family	\$ 73.86
CIGNA Dental DHMO	Individual	\$ 16.22
	Parent/Child	\$ 29.24
	Husband/Wife	\$ 32.40
	Family	\$ 48.83
Vision	Individual	\$ 2.35
	Parent/Child	\$ 3.55
	Husband/Wife	\$ 4.72
	Family	\$ 7.06

# General Open Enrollment Information

## Eligibility Guidelines

- In order to qualify for health insurance benefits as a retiree, the member must have been eligible for health insurance benefits as an active employee and have 10 or more creditable years of County service prior to retirement. (Retirees that retired prior to 7/1/2006 must have been eligible for health insurance as an active employee and have 5 or more creditable years of County service prior to retirement, in order to qualify for health insurance benefits as a retiree.)
- In order to qualify for health insurance coverage, retirees and/or their eligible beneficiaries must be receiving a pension check sufficient to cover the retiree's share of the health plan premium deductions.

## 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 retiree 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 plan, 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. Eligibility guidelines must be met.

## 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 first 31 days of the qualifying event
- Changing the medical, dental or other plans you currently have

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

## Open Enrollment Deadline

***Benefits changes for all retirees must be completed either by Retiree application or on-line at [www.baltimorecountymd.gov/mybenefits](http://www.baltimorecountymd.gov/mybenefits) from October 11 to November 14, 2011. Applications must be received in the Insurance Division by November 14, 2011. Changes will be effective January 1, 2012.***

The Insurance Division is located at 400 Washington Ave., Rm. 111, Towson, MD 21204. The Mail Stop number for this office is 2105.

## Open Enrollment Online Options

- Information about Open Enrollment 2012 can be found on the County's internet website [www.baltimorecountymd.gov/benefits](http://www.baltimorecountymd.gov/benefits).
- You can use the internet to email the Insurance Division with benefits questions or requests for additional information – the email address is [bcbenefits@baltimorecountymd.gov](mailto: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 programs.

# Eligibility Rules/Changes To Benefits

## 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 or (800) 274-4302 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
- 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 (**including eligibility for Medicare**) not identified on your health plan application
- 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 health plan's coverage area.

**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.**

## Continuing Coverage Upon Retirement

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

1. Retirees must have 10 or more years of County service upon retirement.
2. Retirees and/or their eligible beneficiaries must have been eligible for benefits while employed with Baltimore County; and,
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 deductions.

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. Enrollment in Medicare Part D is not necessary.

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 pension 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.

## 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. Eligibility guidelines must be met.

# Basic Guidelines: Non-Medicare Retirees

In order to remain in either the life insurance or group health and prescription plans, a retiree must be receiving a monthly pension check sufficient to cover the retiree's share of the premium deduction(s).

## Coverage For Non-Medicare Retirees and Dependents

### Medical Plans

An employee who retires under the age of 65, who is not on Medicare, may elect any of the health insurance plans available to active employees at the time they retire.

### Dental and Vision Plans

Retirees may continue (or enroll) in the CareFirst BlueCross BlueShield Traditional Dental Plan by paying 100% of the premium with no County subsidy. Retirees may enroll in the CareFirst BCBS Preferred Dental PPO or the CIGNA Dental Care HMO. Retirees not yet eligible for Medicare may enroll in either of the Dental plans and/or the Vision plan if they choose. Medicare eligible retirees will pay 100% of the premium with no County subsidy for any one of these dental plans.

### Life Insurance

Retirees who are immediately receiving a pension check, and who enrolled in life insurance prior to 7/1/1997 can continue that coverage into retirement. The amount of coverage will be determined by the amount of your final salary. Once determined, it will not decrease or increase during your retirement.

## Who Is Eligible to be Included on Your Plans

You can include your legal spouse, as well as legal dependent children on your health, dental and vision plans. Children are eligible through the end of the month in which they reach age 26.

## What You Will Pay for Coverage

The amount the County pays toward your benefits will be determined by the creditable years of service, the type of retirement, your hire date/retirement date, and by bargaining agreements with active employees.

## It is Important to Read the Open Enrollment Announcement Each Year

Retirees are notified each year, by mail, of the annual open enrollment dates and plan offerings for the next year. Rates for the upcoming year are also included in that packet. It is the only way Baltimore County routinely notifies you of plan and/or rate changes.

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# Basic Guidelines: Medicare Retirees

**Baltimore County requires that as soon as a retiree or spouse of a retiree is eligible for Medicare that they accept Medicare as their primary health carrier. Contact Social Security for eligibility and enrollment questions.**

- You must obtain Part A (hospital) and Part B (medical) of Medicare
- Part B will require a monthly premium deduction from your social security check
- You do not need to enroll in an Independent Medicare Part D Medicare Prescription plan. The County offers an approved Medicare Part D Prescription Plan

**It is very important that you obtain both parts of Medicare for you or your spouse as soon as eligible, regardless of age. You must notify the Insurance Division as soon as you become eligible for Medicare.** Once eligible for Medicare, you, or your spouse, will be eligible to enroll in a Medicare Supplemental plan through Baltimore County. Please notify the Insurance Division as soon as you are enrolled in Medicare so that your records can be updated and no claim problems will result. Generally,

Medicare becomes effective the first day of the month in which you reach age 65 or otherwise become eligible due to disability. Contact your local Social Security office for further information regarding Medicare.

## What If My Spouse or I are Not Eligible for Medicare?

You may not be eligible for Medicare if you did not work the required number of quarters required by the Social Security Administration. If you do not qualify on your own, you may qualify for spousal coverage once your spouse is eligible for Medicare. You will need to contact your local Social Security office to determine whether you can enroll in Medicare.

Those few retirees not eligible for Medicare either on their own or through a spouse should contact the Insurance Division upon reaching their 65th birthday to discuss their options.

## What if I Become Eligible for Medicare but My Spouse is Not Yet Eligible?

You will be enrolled in a Medicare plan and your spouse can continue in non-Medicare plans until they are eligible for Medicare (same applies if spouse is eligible before retiree). You will pay for Individual coverage in each of the plans.

# Medicare Part D Prescription Plans

Federal legislation created prescription drug benefits for Medicare enrollees that took effect January 1, 2006. The new plans are called Medicare Part D plans.

Employers who cover prescription benefits for their Medicare retirees have a number of prescription plan options. Baltimore County offers their own approved Medicare Part D Plan for Medicare retirees and their dependents. **The benefits provided under the County Part D plan are at least as generous as those provided under the standard Medicare Part D plan and do not contain a “doughnut hole” provision.**

## How Does Medicare Part D Affect Pre-Medicare Retirees and Their Dependents?

If you and/or your dependents are not yet eligible to enroll in Medicare, you are also not eligible to enroll in a Medicare Part D plan. You will continue to receive the prescription benefits in the available pre-Medicare health plans.

## How Does Medicare Part D Affect Medicare Retirees and Their Dependents?

If you and/or your dependents are eligible for and enrolled in Medicare Parts A & B, you must enroll in either the CIGNA Medicare Surround Plan or the Kaiser Medicare Plus plan. **Both plans include prescription benefits that are at least as generous as the Medicare Part D standard benefits so it is not necessary to enroll in an Independent Medicare Part D plan.**

## Won't I Have to Pay a Penalty If I Don't Enroll in a Medicare Part D Plan When I'm First Eligible?

No – The plans offered by Baltimore County to its Medicare retirees are considered “creditable coverage” and as such, will protect you from paying a premium penalty in the future if you choose to enroll in an Independent Medicare Part D Plan.

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# Health Insurance For Retirees

## Retirees and/or Dependents Not Yet Enrolled in Medicare

Prior to enrolling in Medicare, Retirees and their eligible dependents can enroll in any medical plan offered to active employees at the time of their retirement.

If the County changes the benefit plans and/or the costs of the plans available to active employees, those same changes will affect retirees. Changes are announced during the Open Enrollment period and take effect January 1 of each year.

## Retirees and/or Dependents Enrolled in Medicare

Remember— you **must** obtain both Parts A & B of Medicare when eligible. Failure to enroll in Medicare Parts A & B when first eligible may mean a loss of benefits. You **DO NOT** need to enroll in a Medicare Part D plan. The County offers an approved Medicare Part D Plan.

For retirees/spouses enrolled in the CareFirst BlueCross BlueShield Triple Choice plan, or in the CIGNA Open Access PPO or HMO plans or Kaiser HMO plans, the move to the CIGNA Medicare Surround Plan will result in a change to your prescription benefit. If you choose the Kaiser Medicare Plus plan, you will continue to have prescription coverage for a small copay amount.

Medicare Part D Prescription coverage included with the CIGNA Medicare Surround Plan is administered by Express Scripts, Inc. (ESI). The plan requires the retiree and each covered dependent to meet a calendar year \$75 deductible beginning on January 1 of each year. Once the deductible is met, the member pays 20% for generic or 30% for brand name drugs, with a minimum \$10 co-pay. Your share of the cost is paid directly to the pharmacy. The remainder of the cost is paid by the County. ESI Participating pharmacies maintain records of your deductibles and the costs for your medications. ESI also provides the convenience of mail-order service for your maintenance medications.

## Dental Benefits for Retirees

Retirees may continue or enroll in the CareFirst BlueCross BlueShield Traditional Dental Plan, the CareFirst Preferred Dental PPO, or the CIGNA Dental Care DHMO.

The CareFirst Traditional Dental Plan has a national network of dentists with no need to select a primary dentist. If you use a non-participating provider, the dentist will bill you for any amount over the CareFirst allowed benefit. With this plan, each enrolled family member receives up to \$1,500 in paid benefits per calendar year. You will pay 100% of the premium with no County subsidy for enrollment in the CareFirst Traditional Dental Plan, Medicare or non-Medicare eligible.

The CareFirst Preferred Dental PPO also has a national network of dentists with no need to select a primary dentist. When you use a

Preferred Provider, you receive the highest level of coverage with the least amount of out-of-pocket expense. With this plan, each enrolled family member receives up to \$1,000 in paid benefits per calendar year.

The CIGNA Dental Care HMO (CIGNA DHMO) provides low out-of-pocket costs and no claim forms. With CIGNA, you will need to select a primary care dentist (PCD) from a National Network of DHMO providers. If no PCD is selected, one will be chosen for you. You are responsible for staying in the network.

Once retirees are eligible for Medicare or become Medicare age, the County no longer subsidizes the Dental plans. You may continue your plans at 100% of the premium with no County subsidy. These premiums will be automatically deducted from your pension check.

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## Vision Benefits for Retirees

Retirees not yet eligible for Medicare may continue (or enroll) in the CareFirst BlueVision plan (administered by Davis Vision) after retirement with Baltimore County subsidizing 90% of the cost. All other eligibility requirements must be met. Your share of the cost will be deducted separately from your pension check.

Once retirees are eligible for Medicare or become Medicare age, the County no longer subsidizes the Vision coverage. If you were enrolled in the Vision plan and become enrolled in Medicare, you may continue your plan at 100% of the premium with no County subsidy.

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## Life Insurance Benefits for Retirees

Only employees who were enrolled in life insurance benefits and who were hired prior to 7/1/1997 are allowed to carry life insurance into retirement.\* Life insurance can only be continued for those retirees immediately eligible to draw a pension from Baltimore County (i.e. if you retire at age 45 but are not eligible to receive a retirement check until age 55, you will not be allowed to enroll in life insurance benefits once you are receiving your retirement checks).

Premiums are set up and automatically deducted from your retirement check. Premiums are subject to change annually if the rates for the entire group of County employees requires a change. Please be

sure to check your first retirement check to verify that life insurance deductions are being taken if you qualified to continue your life insurance benefits.

**Reminder: All retirees should be sure they have updated their beneficiary designation and notify the Insurance Division in the future if there is a change. Call (410) 887-2591 for the form.**

*\*Employees hired on/after July 1, 1997 are not eligible to continue their life insurance upon retirement except under Individual Conversion rights.*

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## Widow and Widower Benefits

Depending on the option chosen at the time of retirement and the classification of the retiree, health plan benefits may be available to a widow/widower with a subsidy from Baltimore County. For this reason, it is very important to give a great deal of consideration to your retirement option at the time you elect to retire. If you choose a pension option that will not provide payments sufficient to cover benefits for your spouse upon your death, your spouse will not be eligible for County subsidized benefits.

Baltimore County will subsidize the cost of coverage for a widow/widower whose spouse was killed in the line of duty

at the same level as active employees. Other widow/widower plan costs will be based on the date of retirement and the retiree's years of service to Baltimore County.

If a widow/widower remarries, the new spouse is not eligible for coverage under a County sponsored health plan. Widow/widowers not receiving a pension amount sufficient to cover benefits would be eligible for 36 months of COBRA coverage if necessary. COBRA coverage is not subsidized by the County and requires that the participant pay 102% of the actual plan premium.

# Employee Assistance Program – Non-Medicare Retirees

## 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 and retirees. The County has worked with ComPsych to develop a coordinated Managed Mental Health/Employee Assistance Program. These services have been designed to meet employee and retiree 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. 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](http://guidanceresources.com)

Your company Web ID: BALTIMORE

# Express Scripts Prescription Coverage

The prescription coverage included with the CIGNA Open Access Plus OAP, the CIGNA Open Access Plus In-Network OAPIN, 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 Plus Plans, 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](http://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](http://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
<b>Calendar Year Deductible</b>	\$100 Individual/\$200 Family	\$200 Individual/\$400 Family	\$300 Individual/\$600 Family
<b>Coinsurance</b>	95%/5%	85%/15%	75%/25%
<b>Calendar Year Out-of-Pocket Max</b>	\$500/\$1,000	\$1,000 \$2,000	\$1,500/\$3,000
<b>Lifetime Maximum</b>	Unlimited	%1,000,000 (Levels 2&3)	\$1,000,000 (Levels 2&3)
<b>Primary Care Office Visit</b>	In full after \$15 copay	In full after \$15 copay	75% AA after deductible
<b>Gynecology Office Visit</b>	In full after \$20 copay	In full after \$20 copay	75% AA after deductible
<b>Specialist Office Visit</b>	In full after \$20 copay	In full after \$25 copay	75% AA after deductible
<b>Physical/Speech/Occupational Therapy Office Visit</b>	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
<b>Room and Board-Pre-Auth REQUIRED if elective/Physician/Surgical Services</b>	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
<b>Medical Emergencies (use of ER): Accidental injury/Sudden and Serious Illness</b>	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
<b>Mental Health/Substance Abuse</b>	Outpatient \$15 copay	Outpatient \$15 copay	Outpatient 25%/75%
<b>Outpatient Prescription Drug Benefit</b>	Most drugs dispensed for up to 1 month supply		
<b>Dispensed at Pharmacy</b>	Covered by separate ESI prescription card; \$5 Generic/\$20 Brand Formulary/\$35 Brand Non-Formulary; One copay per monthly supply		
<b>Mail Order – Maintenance Medications</b>	\$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 – 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](http://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](http://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](http://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.

# CIGNA – 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.

# CIGNA Open Access Plus (OAP)

CIGNA's Open Access Plus OAP 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 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 Health<sup>SM</sup> Expense Tracker.

# CIGNA Open Access Plus (OAP) *(continued)*

## 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.

### 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.

### 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.

### 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.

### 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](http://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](http://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 (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 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 Health<sup>SM</sup> Expense Tracker.

# CIGNA Open Access Plus (OAPIN) *(continued)*

## 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.

### 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](http://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](http://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.

# 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 the above

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 practices 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 act 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 – 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](http://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

# Kaiser Permanente Select HMO *(continued)*

## Prescription Benefits

Prescriptions are \$5 per prescription for generic or \$15 for brand name drugs, if filled at a Kaiser Permanente medical center, or \$11 for generic \$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](http://www.kp.org).

## Wellness Services

Kaiser Permanente offers a variety of services aimed at preventing illness. Your PCP can encourage you to attend a variety of the “Be Well” classes offered in the Kaiser Permanente medical centers. The list of classes offered is printed in the provider directory and include 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](http://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](http://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](http://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](http://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](http://www.kp.org).

## Non-Medicare Plan Options

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

These plans are offered to pre-Medicare retirees and eligible dependents not yet eligible for Medicare.

Plan Facts	CIGNA Open Access Plus In-Network (OAPIN)
Member services	(800) 896-0948
Group Number	3333726
<b>COST SHARING LIFETIME LIMITS</b>	
Calendar Year Deductible	\$0 Individual / \$0 Family
Calendar Year Out-of-Pocket Maximum	\$1,100 Individual / \$3,600 Family
Lifetime Maximum	Unlimited
<b>PROFESSIONAL SERVICES</b>	
Primary Care Office Visit	You pay \$15 per visit
Gynecology Annual Office Visit	Primary Care Physician – You pay \$15 per visit Specialist – You pay \$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 \$15 / Specialist \$20 copay 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 / Specialist \$20 copay

## CIGNA Open Access Plus (OAP)

CIGNA Open Access Plus (OAP)		Kaiser Permanente HMO
In-Network	Out-of-Network	
(800) 896-0948	(800) 896-0948	(800) 777-7902
3333726	3333726	
\$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	\$10 copay – days/visits limits apply
PCP \$15 / 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
<b>Physician's Office</b> <b>Primary Care Physician</b> – You pay \$15 per visit <b>Specialist</b> – 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
<b>Independent X-ray or Lab Facility</b> <b>Outpatient Facility</b> 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
<b>Well Child Visit/Immunization</b> You pay 0% / Plan pays 100% No deductible	<b>Well Child Visit/Immunization</b> 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

## Non-Medicare Plan Options cont'd.

This chart summarizes the benefits for the CIGNA Open Access Plus PPO, CIGNA Open Access Plus In-Network and Kaiser Medical plans. These plans are offered to pre-Medicare retirees and eligible dependents not yet eligible for Medicare.

Plan Facts	CIGNA Open Access Plus In-Network (OAPIN)
<b>INPATIENT CARE HOSPITAL</b>	
<b>Room and Board</b> Preauthorization REQUIRED if elective	\$100 copay per admission, then You pay 0% / Plan pays 100%
<b>Physician/Surgical Services</b>	You pay 0% / Plan pays 100%
<b>Anesthesia Services</b>	You pay 0% / Plan pays 100%
<b>Medical Consultations</b>	You pay 0% / Plan pays 100%
<b>ICU/CCU</b>	\$100 copay per admission, then You pay 0% / Plan pays 100%
<b>Maternity/Nursery/Birthing Center</b>	<p><b>Initial Visit to confirm pregnancy</b>  <b>Primary Care Physician</b> – You pay \$15 per visit  <b>Specialist</b> – You pay \$20 per visit</p> <p><b>Global Maternity Professional Fees</b>            You pay 0% / Plan pays 100%</p> <p><b>Inpatient Facility</b>            \$100 copay per admission, then            You pay 0% / Plan pays 100%</p>
<b>Skilled Nursing/Rehab Facility Care</b>	You pay 0% / Plan pays 100% 100 days per calendar year
<b>Dialysis/Radiation/Chemotherapy</b>	\$100 copay per admission, then You pay 0% / Plan pays 100%
<b>Hospice</b>	You pay 0% / Plan pays 100%
<b>Physical/Speech/Occupational Therapy</b>	\$100 copay per admission, then You pay 0% / Plan pays 100%
<b>OUTPATIENT HOSPITAL SERVICES</b>	
<b>Surgical/Anesthesia Services</b>	You pay 0% / Plan pays 100%
<b>Dialysis/Radiation/Chemotherapy – Physicians Office</b>	PCP \$15 / Specialist \$20 copay
<b>Dialysis/Radiation/Chemotherapy – Outpatient Facility</b>	You pay 0% / Plan pays 100%
<b>Physical/Speech/Occupational Therapy</b> Preauthorization required after 10th visit	You pay \$20 per visit 40 days for each therapy per calendar year
<b>Outpatient Diagnostic Services</b>	You pay 0% / Plan pays 100%
<b>MATERNITY/INFERTILITY SERVICES</b>	
<b>1st prenatal visit</b>	<p><b>Initial Visit to confirm pregnancy</b>  <b>Primary Care Physician</b> – You pay \$15 per visit  <b>Specialist</b> – You pay \$20 per visit</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% 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
<b>Initial Visit to confirm pregnancy</b> <b>Primary Care Physician – You pay \$15 per visit</b> <b>Specialist – You pay \$25 per visit</b>  <b>Global Maternity Professional Fees</b> You pay 5% / Plan pays 95% after the deductible is met  <b>Inpatient Facility / Outpatient Facility</b> 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 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
PCP \$15 / Specialist \$25 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
<b>Initial Visit to confirm pregnancy</b> <b>Primary Care Physician – You pay \$15 per visit</b> <b>Specialist – You pay \$25 per visit</b>	You pay 25% / Plan pays 75% after the deductible is met	\$10 copay

## Non-Medicare Plans cont'd.

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

These plans are offered to pre-Medicare retirees and eligible dependents not yet eligible for Medicare.

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

CIGNA Open Access Plus (OAP)		Kaiser Permanente HMO
In-Network	Out-of-Network	
<b>Global Maternity Professional Fees</b> You pay 5% / Plan pays 95% after deductible is met  <b>Inpatient Facility / Outpatient Facility</b> You pay 15% / Plan pays 85% after the deductible is met	<b>Global Maternity Professional Fees</b> You pay 25% / Plan pays 75% after deductible is met  <b>Inpatient Facility</b> You pay 25% / Plan pays 75% after the deductible is met	Covered in full when authorized
<b>Inpatient Facility</b> You pay 15% / Plan pays 85% after the deductible is met	<b>Inpatient Facility</b> You pay 25% / Plan pays 75% after the deductible is met	Covered in full when authorized
<b>Primary Care Physician</b> – You pay \$15 per visit <b>Specialist</b> – You pay \$25 per visit  <b>Inpatient Facility / Outpatient Facility Physician's Services</b> 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
<b>Inpatient Facility / Outpatient Facility</b> You pay 15% / Plan pays 85% after the deductible is met	<b>Inpatient Facility / Outpatient Facility</b> You pay 25% / Plan pays 75% after the deductible is met	\$10 copay applies in outpatient setting
<b>Primary Care Physician</b> You pay \$15 per visit <b>Specialist</b> – You pay \$25 per visit  <b>Inpatient Facility / Outpatient Facility Physician's Services</b> 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
<b>Primary Care Physician</b> You pay \$15 per visit <b>Specialist</b> – You pay \$25 per visit  <b>Inpatient Facility / Outpatient Facility Physician's Services</b> 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 – 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 – copay waived if admitted
You pay \$50 per visit copay waived if admitted	You pay \$50 per visit copay waived if admitted	Coordinate w/ PCP – Office visit copays apply

## Non-Medicare Plans cont'd.

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

These plans are offered to pre-Medicare retirees and eligible dependents not yet eligible for Medicare.

Plan Facts	CIGNA Open Access Plus In-Network (OAPIN)
<b>MEDICAL EMERGENCIES (Use of Emergency Room) cont.</b>	
<b>Durable Medical Equipment</b>	You pay 0% / Plan pays 100% Unlimited Maximum per Calendar Year
<b>Diabetic Supplies</b>	Covered under DME or RX – copays may apply
<b>MENTAL HEALTH SUBSTANCE ABUSE</b>	
	Must contact CIGNA Behavioral Health at 800-896-0948
<b>Inpatient</b>	\$100 per admission, then You pay 0% / Plan pays 100%
<b>Outpatient</b>	Physician office visit \$25 per visit
<b>OTHER SERVICES</b>	
<b>Ambulance (Ground only)</b>	You pay 0% / Plan pays 100%
<b>Kidney, Cornea Bone Marrow Transplants</b>	<b>Primary Care Physician</b> You pay \$15 per visit <b>Specialist – You pay \$20 per visit</b> <b>Inpatient Facility</b> \$100 copay per admission, then You pay 0% / Plan pays 100% <b>Outpatient Facility – Physician’s Services</b> You pay 0% / Plan pays 100%
<b>Heart, Heart-Lung, Lung, Pancreas, Liver Transplants – Precertification Required</b>	<b>Primary Care Physician</b> You pay \$15 per visit <b>Specialist – You pay \$20 per visit</b> <b>Inpatient Facility</b> \$100 copay per admission, then You pay 0% / Plan pays 100% <b>Outpatient Facility – Physician’s Services</b> You pay 0% / Plan pays 100%
<b>Outpatient Cardiac Rehabilitation</b>	Limited to 40 days per calendar year \$15 PCP / \$20 Specialist copay
<b>Hearing Aids</b>	You pay 0% / Plan pays 100% of allowed benefit Limited to \$2,800 per 3 years
<b>OUTPATIENT PRESCRIPTION DRUG BENEFIT</b>	
	Most drugs dispensed for up to 1 month supply
<b>Dispensed at Pharmacy*</b>	Covered by separate ESI prescription card (copays apply for each one month supply) – \$5 Generic / \$20 Brand Formulary / \$35 Brand Non-Formulary
<b>Mail Order – Maintenance Medications</b> 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% after deductible Unlimited Maximum per Calendar Year	You pay 5% / Plan pays 95% after deductible 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
for authorization.		
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
Physician office visit \$25 per visit	You pay 25% / Plan pays 75% after the deductible is met	\$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
<b>Primary Care Physician</b> You pay \$15 per visit <b>Specialist – You pay \$25 per visit</b> <b>Inpatient Facility / Outpatient Facility Physician's Services</b> You pay 15% / Plan pays 85% after the deductible is met <b>(COVERED AT 100% AT LIFESOURCE CENTER)</b>	You pay 25% / Plan pays 75% after the deductible is met	Covered in full when authorized
<b>Primary Care Physician</b> You pay \$15 per visit <b>Specialist – You pay \$25 per visit</b> <b>Inpatient Facility / Outpatient Facility Physician's Services</b> You pay 15% / Plan pays 85% after the deductible is met <b>(COVERED AT 100% AT LIFESOURCE CENTER)</b>	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 deductible is met unlimited days per calendar year	\$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% 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 Plan – Highlights

## CIGNA Dental Care DHMO Plan

CIGNA Dental Care DHMO is a Dental Health Maintenance Organization. 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 [CIGNA.com/dental](http://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 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 \$1,500 in paid benefits per calendar year
- Flexibility to choose any dentist
- CareFirst's Participating Providers file claims for you and cannot balance bill

## CareFirst Dental 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.

### Dental 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](http://www.carefirst.com) or contact member services at 1-800-891-2802.

### 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

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

# 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](http://www.DavisVision.com) and select "Find a Provider" or call Davis Vision at (800) 783-5602. 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	
<b>Routine Eye Exam</b> (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.
<b>Tower Collection Frames</b> (Fashion)	\$10	N/A	
<b>Tower Collection Frames</b> (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)
<b>Non-Tower Frames</b>	Out-of-pocket costs varies**	Plan reimburses up to \$35*, you pay balance	
<b>Single Vision Lenses Only</b>	Included with frames	Plan reimburses up to \$40*, you pay balance	
<b>Bifocal/Trifocal Lenses Only</b>	Included with frames	Plan reimburses up to \$60/\$90*, you pay balance	
<b>Contact Lenses</b> (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)	<b>\$50 - \$20 = \$30 x 2 = \$60</b>

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](http://www.carefirst.com), or by calling Lens 123 at (800) 536-7123.

### Davis Providers

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

# 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 ZVision participating offices towards the purchase of items not covered, such as a second pair of glasses.

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

## Example Costs

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

	<b>You Pay:</b>
<b>Example 1</b>	
Single vision with Davis Fashion Frame	\$10
<b>Example 2</b>	
Single vision with Davis Designer or Premier Frame	\$30 (\$10 material copay + \$20 upgrade)
<b>Example 3</b>	
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) <b>\$50 - \$20 = \$30 x 2 = \$60</b>

## 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 (800) 783-5602, 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](http://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.**

# Life Insurance Benefits for Retirees

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 informational purposes only.

Only employees who were enrolled in life insurance benefits and who were hired prior to 7/1/1997 are allowed to carry life insurance into retirement.\* Life insurance can only be continued for those retirees immediately eligible to draw a pension from Baltimore County (i.e., if you retire at age 45 but are not eligible to receive a pension check until age 55, you will not be allowed to enroll in life insurance benefits once you are receiving your retirement checks.)

Premiums are set up and automatically deducted from your pension check. Premiums are subject to change annually if the rates for the entire group of County employees requires a change. Please be sure to check your first pension check to verify that life insurance deductions are being taken if you qualified to continue your life insurance benefits.

## What Is the Cost of Life Insurance Coverage?

The County pays 80% of the premium for Basic Coverage – employees pay the remaining 20% of the premium in effect each year. The County does not pay any part of the premium for Optional Life coverage. Please refer to the additional Life Insurance Communications for further information.

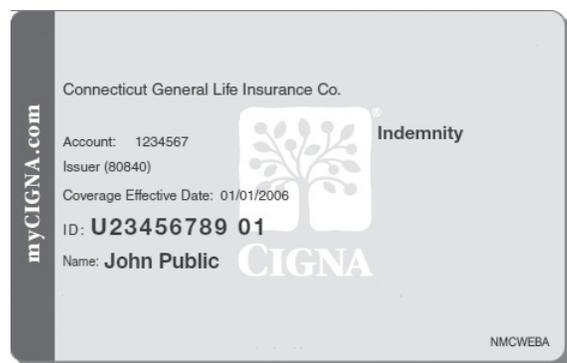
**Reminder: All retirees should be sure they have updated their beneficiary designation and notify the Insurance Division in the future if there is a change. Forms are available at [www.baltimorecountymd.gov/benefits](http://www.baltimorecountymd.gov/benefits) or by calling (410) 887-2568.**

## Life Insurance Conversion Right

*\*Employees hired on/after July 1, 1997 are not eligible to continue their life insurance upon retirement except under Individual Conversion rights. You must apply and begin paying for your conversion coverage within 31 days of your coverage end date. Please contact the Insurance Division for more information.*

# CIGNA Medicare Surround Plan

The CIGNA Medicare Surround® indemnity medical plan helps pay some of the health care costs that Medicare does not cover, such as your Medicare Part A and B deductibles and coinsurance.



*Note: When seeking medical care, please show both your Medicare card and your CIGNA Indemnity Medical ID card.*

- You will receive a CIGNA indemnity medical identification (ID) card. You should present this card along with your Medicare card when you receive care. The back of the ID card has the address for submitting claims along with the toll-free telephone number for CIGNA Customer Service.

- Be sure to give CIGNA your Medicare number found on your Medicare ID card. This is needed for Medicare to send us your claims. You can call CIGNA Customer Service at the number on the back of your CIGNA ID card.
- Expenses covered by your CIGNA Medicare Surround plan must be submitted to Medicare before being considered for payment. Hospitals, skilled nursing facilities, home health agencies and doctors are required by law to file Medicare claims for covered services and supplies that you receive.
- Once Medicare has paid your claim, they will forward it to CIGNA as your secondary payer. You will receive a Medicare Summary Notice (MSN) from Medicare. The MSN lists your Medicare claims information including a note if the information was sent to your private insurer (CIGNA) for additional benefits.
- To find doctors who accept Medicare, or to learn more about Medicare benefits and services, visit [www.medicare.gov](http://www.medicare.gov) or call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY/TDD users call 1-877-486-2048.

The CIGNA Medicare Surround Plan offered through Baltimore County Government is health care coverage which will pay after Medicare. This plan requires you to have Medicare Part A & B in order to receive supplemental benefits. When treated in a doctor's office or a hospital, always present your Medicare card and your CIGNA card.

When seeking medical care, you will have the least out-of-pocket costs when you are seen by a physician who accepts Medicare assignment. Please note that all physicians must submit your claims to Medicare; however, not all physicians have to accept assignment. In other words, the physician that does not accept Medicare assignment may charge you up to 15% above the Medicare allowed amount for services, also defined as the limiting amount. You may be asked to pay the bill in full at the time of service.

Once you have been seen by the physician, the claim will be submitted to Medicare. After the claim is paid, you will receive a Medicare explanation of benefits. Since CIGNA is your supplemental or secondary insurance plan, the claim is then filed with us. CIGNA also sends an Explanation of Health Care

Benefits (EOHB) which states the amount the provider may bill if he accepts assignment. (See "How to file claims" that follows for more details.) The benefit chart within this booklet will show you the type of service, and how it is paid by Medicare and CIGNA.

As a member of CIGNA Medicare Surround Plan, you are covered for services in Maryland, in the United States, and even outside the U.S. You are also eligible to seek alternative therapies and wellness services at a discount rate through the CIGNA Healthy Rewards Program. For more information about the providers and services, you may call CIGNA's Member Services toll free number (800) 896-0948 or by visiting the online directory on CIGNA's Website [myCIGNA.com](http://myCIGNA.com).

Baltimore Government also offers a prescription plan through Express Scripts, Inc. (ESI). You will be enrolled in the prescription plan once you enroll in the CIGNA Medicare Surround Plan.

# How to File Medical Claims

## Questions and answers

### **Do I need to be enrolled in Medicare Part A and Part B?**

CIGNA Medicare Surround is available only if you and/or your eligible dependent qualify for Original Medicare benefits (Parts A and B). It is important for you to enroll in and maintain Part A and Part B Medicare coverage. That's because coverage under the CIGNA Medicare Surround indemnity medical plan depends upon you being covered by Medicare Parts A and B.

Medicare pays 80% for most expenses. CIGNA's benefit is based on the remaining 20%. If you do not enroll in Medicare, we will assume the amount payable under Part A and/or Part B has still been paid by Medicare. That means you will be responsible for the full amount that would have been paid by Medicare had you enrolled. Individuals are considered to be eligible for Medicare on the earliest date any coverage under Medicare could become effective for them.

### **What happens to my claim if my doctor participates in Medicare?**

In Medicare, participation means your doctor agrees to always "accept assignment of claims" for all services provided to you. By agreeing to always "accept assignment" your doctor agrees to accept Medicare-allowed amounts as payment in full. They can not collect more than the Medicare deductible and coinsurance from you. Your doctor is required to submit claims directly to Medicare. Medicare will send the claim to CIGNA and your CIGNA Medicare Surround plan may help pay for your Medicare deductible and coinsurance.

### **What if my doctor does not accept assignment from Medicare?**

Your doctor is classified as "non-participating" under the Medicare program and chooses to receive payment in a different method and amount than doctors who participate with Medicare. Your doctor may request payment directly from you. However, they are required to submit a bill to Medicare on your behalf so you may be reimbursed for the portion of the charges Medicare is responsible for. If you choose a doctor that does not accept assignment from Medicare, you may pay more out-of-pocket because the doctor will be allowed to bill you for additional costs up to the limiting charge.

### **What is a limiting charge?**

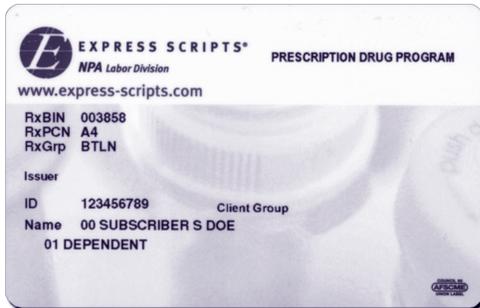
A "limiting charge" represents the maximum amount a non-participating doctor or supplier may bill you on unassigned claims. The limiting charge is 115% of the Medicare allowed amount. You cannot be billed for any charges over the 115% limit.

### **What if my doctor opts out of Medicare?**

If your doctor opts out of Medicare, you do have the option to continue seeing him or her under a "private contract." The Balanced Budget Act of 1997 defines a private contract as a contract between a Medicare beneficiary and a health care professional who has 'opted out' of Medicare for all covered items and services he or she provides to Medicare beneficiaries. In a private contract, the Medicare beneficiary agrees to give up Medicare payment for services provided by the health care professional and to pay the health care professional without regard to any limits that would otherwise apply to what he or she could charge. If you enter into a private contract with your doctor, they cannot submit the bill to Medicare. This means you or your doctor will need to submit the claim to CIGNA with a copy of the signed contract. Under your CIGNA plan, we will assume that Medicare has still paid the amount your doctor would receive in the absence of a private contract.

# CIGNA Medicare Surround Plan Coverage for Prescription Drugs

The CIGNA Medicare Surround Plan does provide coverage for outpatient prescription drugs. The prescription plan is administered through Express Scripts, Inc. (ESI). This Plan is an approved Medicare Part D Plan. **Therefore, Baltimore County retirees in the CIGNA Medicare Surround Plan do not need to enroll in an Independent Medicare Part D prescription plan.** Because you have employer-sponsored prescription benefits, late enrollment penalties will not apply if you need a Medicare prescription plan in the future. The customer service number is (866) 344-2922.



Use this card for prescriptions at  
any pharmacy displaying the ESI logo

The plan covers federal legend drugs prescribed for FDA and Manufacturer approved diagnoses. Diabetic supplies are also covered under the prescription plan.

Drugs that are excluded from coverage include over-the-counter medications, diet drugs, cosmetic drugs and drugs prescribed for a condition not approved by the FDA as appropriate for that condition.

Certain medications require that an appropriate diagnosis be submitted to ESI before they can be filled. Your physician can fax a request for prior authorization for these medications to ESI at (800) 417-8164. You or your physician can also contact ESI by phone or using the internet for a current listing of medications requiring prior authorization.

## Your Share of the Cost for Outpatient Prescriptions:

- An annual calendar year deductible of \$75/individual. Calendar years begin each January 1 and continues through December 31.

After you have met your \$75 annual deductible, you will pay:

- The greater of \$10 or 20% of the cost for generic medications OR
- The greater of \$10 or 30% of the cost for brand name medications.

ESI also provides a convenient mail-order service for maintenance medications. These are medications you are using, in the same strength, for greater than a three month period. Contact Express Scripts at (866) 344-2922 for more information on mail order service, for order forms, and for a determination of what your medication(s) will cost using mail order.

# CIGNA Medicare Surround

Health Benefits Summary	Medicare Pays:
<b>Inpatient Hospital/Facility Services</b>	
Room & Board (ICU/CCU (other special care units), and Ancillary Services (including nursery charges))	100% of the Medicare approved amount after inpatient deductible
Extended Care Facility/Skilled Nursing Care	Days 1–20: 100% of the Medicare approved amount; Days 21–100: 100% of the Medicare approved amount after per day deductible
<b>Inpatient Professional/Practitioner Services</b>	
Physician Surgical Services	80% of the Medicare approved amount after annual deductible
Anesthesia, Assistant Surgeon	80% of the Medicare approved amount after annual deductible
Consultation (including follow-visits) & Physician Visits (Includes ECF)	80% of the Medicare approved amount after annual deductible
Radiation Therapy, Chemotherapy, and Renal Dialysis	80% of the Medicare approved amount after annual deductible
<b>Outpatient Hospital/Facility Services</b>	
Minor/All Surgery (includes hospital based and freestanding surgical enters)	80% of the Medicare approved amount after annual deductible
Preadmission Testing	80% of the Medicare approved amount after annual deductible
Radiation Therapy, Chemotherapy, and Renal Dialysis	80% of the Medicare approved amount after annual deductible
Physical & Speech Therapy	80% of the Medicare approved amount after annual deductible
Occupational Therapy	80% of the Medicare approved amount after annual deductible
Diagnostic Tests	80% of the Medicare approved amount after annual deductible. <i>Note: Medicare pays 100% of the Medicare approved amount for clinical laboratory services.</i>
<b>Outpatient/Office Professional Services</b>	
Minor/All Surgery	80% of the Medicare approved amount after annual deductible
Anesthesia, Assistant Surgeon	80% of the Medicare approved amount after annual deductible
Diagnostic Tests	80% of the Medicare approved amount after annual deductible. <i>Note: Medicare pays 100% of the Medicare approved amount for clinical laboratory services.</i>
Office Visit for Illness, Injury or consultation	80% of the Medicare approved amount after annual deductible
Allergy Tests	80% of the Medicare approved amount after annual deductible
Allergy and Other Covered Injections – administration of injections	80% of the Medicare approved amount after annual deductible
Acupuncture	Not covered
Physical therapy & Chiropractic	80% of the Medicare approved amount after annual deductible
Speech & Occupational Therapy	Speech therapy: 80% of the Medicare approved amount after annual deductible. <i>Note: Occupational therapy limited to \$1,860 per year. Speech &amp; physical therapy limited to \$1,860 per year.</i>
<b>Preventive/Well Care (Routine)</b>	
Annual Adult Physicals, Immunizations and Diagnostic Tests: age 18 & older	100% of the Medicare approved amount. One "Welcome" visit within 12 months of becoming eligible for Medicare – A & B deductibles and coinsurance apply.
Annual GYN Services (includes pap smear) rendered in the office	100% of the Medicare approved amount after annual deductible. <i>Note: Limited to one every two years and pap smear is not subject to annual deductible.</i>

## Baltimore County Government CIGNA Medicare Surround Plan Pays:

100% of inpatient deductible day 1-60; The benefit will reduce to 80% after day 61 unless a new benefit period begins

Day 1-20: Medicare covers at 100% - no CIGNA payment is necessary;  
Day 21 – 100: 100% of the per day deductible ;

100% of the balance due after Medicare including the Medicare deductible

100% of the balance due after Medicare including the Medicare deductible

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80% of the balance due after Medicare including the Medicare deductible

80% of the balance due after Medicare including the Medicare deductible

80% of the balance due after Medicare including the Medicare deductible

80% of the usual and customary rate; unlimited visits; services must be medically necessary

80% of the balance due after Medicare including the Medicare deductible

80% of the balance due after Medicare including the Medicare deductible

100% of the balance due after Medicare including the Medicare deductible

100% of the balance due after Medicare including the Medicare deductible

# CIGNA Medicare Surround *(continued)*

Health Benefits Summary	Medicare Pays:
<b>Preventive/Well Care (Routine) cont.</b>	
Mammography Screening (provider must be American College of Radiology [ACR] approved)	100% of the Medicare approved amount. <i>Note: Limited to one screening annually after age 40.</i>
Prostate Cancer Screening (including PSA test)	80% of the Medicare approved amount after annual deductible. <i>Note: Limited to one exam annually after age 50 and PSA is not subject to coinsurance or deductible.</i>
<b>Emergency Care</b>	
Accidental Injury/First Aid Medical Emergency or Life Threatening Event	80% of the Medicare approved amount after annual deductible
Follow-Up Visits to an Accidental Injury or Medical Emergency	80% of the Medicare approved amount after annual deductible
<b>Ambulance</b>	
Ground (public or private)	80% of the Medicare approved amount after annual deductible
<b>Mental Health</b>	
Inpatient Hospital/Facility and Professional Services	100% of the Medicare approved amount after inpatient deductible <i>Note: Coverage limited to 190 lifetime days.</i>
Outpatient Facility, Professional Services	55% of the Medicare approved amount after annual deductible
<b>Prosthetic Devices &amp; Orthopedic Braces</b>	
Purchase, repair or replacement	80% of the Medicare approved amount after annual deductible
Durable Medical Equipment	80% of the Medicare approved amount after annual deductible
Medical Supplies	80% of the Medicare approved amount after annual deductible
Hearing Aids	Not covered
<b>Home Health Care</b>	
Facility/Agency	100% of the Medicare approved amount
Outpatient Private Duty Nursing (Non-custodial; pre-authorization required)	100% of the Medicare approved amount
Hospice Care (Inpatient or At Home)	100% of the Medicare approved amount
Cardiac Rehabilitation	80% of the Medicare approved amount after annual deductible
<b>Organ Transplants</b>	
Kidney, Cornea, Bone Marrow	80% of the Medicare approved amount after annual deductible
Heart, Heart-Lung, Single or Double Lung, Pancreas, and Liver	80% of the Medicare approved amount after annual deductible
<b>Prescription Drugs</b>	
Outpatient Prescription Drugs	Not covered
Drugs dispensed by medical provider in office	80% of the Medicare approved amount after annual deductible
Routine Vision	Not covered
Dental	Not covered
<b>Additional Information</b>	
Deductible (Part A, Part B)	Verify with Medicare. Deductibles change yearly.
Out-of-Pocket Maximum	Not applicable
Lifetime Maximum	Not applicable

## Baltimore County Government CIGNA Medicare Surround Plan Pays:

100% of the balance due after Medicare including the Medicare deductible
100% of the balance due after Medicare including the Medicare deductible
100% of the balance due after Medicare including the Medicare deductible
80% of the balance due after Medicare including the Medicare deductible
80% of the balance due after Medicare including the Medicare deductible
100% of the balance due after Medicare including the Medicare deductible
80% of the balance due after Medicare including the Medicare deductible
100% of the balance due after Medicare including the Medicare deductible
80% of the balance due after Medicare including the Medicare deductible
80% of the balance due after Medicare including the Medicare deductible
Not covered
Medicare covers 100% of the Medicare allowed amount – no CIGNA payment necessary
Medicare covers 100% of the Medicare allowed amount – no CIGNA payment necessary
Medicare covers 100% of the Medicare allowed amount – no CIGNA payment necessary
80% of the balance due after Medicare including the Medicare deductible
100% of the balance due after Medicare including the Medicare deductible
100% of the balance due after Medicare including the Medicare deductible
Coverage through Express Scripts (ESI)
80% of the balance due after Medicare including the Medicare deductible
Not covered
Not covered
Not applicable
\$2,000
\$300,000 (applies to Part B expenses)

# Kaiser Permanente Medicare Plus

## Summary of Benefits 2011

This plan is offered by the Kaiser Foundation Health Plan of the Mid-Atlantic States. This Summary outlines some of the Plan features. It does not list every service that is covered or every limitation of coverage. For a comprehensive description of benefits contact Kaiser and request an "Evidence of Coverage" booklet. The contact # is (301) 468-6000 or (800) 777-7902. Hours are Monday through Friday from 7:30 a.m. to 5:30 p.m.

### Where is the Kaiser Medicare Plus Plan Available?

You can enroll in this plan if you live in the following areas:

- District of Columbia
- Maryland: Baltimore City, Anne Arundel County, Baltimore County, Carroll County, Hartford County, Howard County, Montgomery County, Prince Georges County, Calvert County\*, Charles County\*, Frederick County\*  
*\*Partial coverage in these counties*
- Virginia: Alexandria, Arlington, Fairfax City, Fairfax, Falls Church, Loudoun, Manassas City, Manassas Park City and Prince William County

### Physician and Hospital Choices

#### In-Network

You must go to network doctors, specialists and hospitals. You'll need a referral from your Primary Care Provider for specialist visits and for hospital-based care.

### Non-Emergency Out of Network Care

If you have Medicare Parts A & B, your Coverage will be the same as the Original Medicare Plan. You will be responsible for Medicare deductibles and coinsurance amounts.

### Inpatient Hospital Care

You have 100% coverage for approved Inpatient care. The number of days covered is unlimited.

### Doctor Office Visits

You pay \$5 for each visit to your Primary Care Provider. You also pay \$5 for approved Specialist Visits.

### Diagnostic tests, X-rays, Lab Services

There is no copay for Medicare covered x-rays and diagnostic lab services. There is a \$5 copay for each Medicare Covered radiation therapy service.

### Emergency Care

You pay \$50 for each Medicare covered Emergency room visit. The copay is waived if you are admitted to the hospital within 48 hours of the emergency room visit for the same condition.

### Urgent Care

You pay \$5 for urgent care visits.

### Dental and Vision Services

Your copay is \$30 for a preventive care dental visit every six months. You pay \$5 for a routine eye exam and receive a 25% discount on the cost of glasses.

## Outpatient Prescription Drugs

The Kaiser plan uses a formulary, which is a preferred list of drugs selected to meet patient needs at a lower cost. If the formulary changes, you will be notified in writing before the change. To view the plan's formulary, go to [www.kp.org](http://www.kp.org) on the web.

### Your Out-of-Pocket Costs

You will not have a deductible with the Kaiser plan. Before your out-of-pocket drug costs reach \$3,600, you pay:

#### Kaiser Permanente Mail Delivery Services:

Generic or Brand: \$3.00 (up to a 60-day supply)

#### Kaiser Permanente Medical Center Pharmacy:

Generic or Brand: \$5.00 (up to a 60-day supply)

#### Kaiser Permanente Affiliated Network Pharmacy:

Generic or Brand: \$10.00 (up to a 60-day supply)

#### Out-of-Network Pharmacy:

Generic or Brand: \$5.00 (up to 30-day supply)

After your yearly out-of-pocket drug costs reach \$3,600, you pay:

### Kaiser Permanente Mail Delivery, Medical Center

**or Affiliated Network Pharmacy: Generic:** \$1.00 **Brand:** \$2.50

**Out-of-Network Pharmacy: Generic:** \$1.00 **Brand:** \$2.50

*Please note that certain prescription drugs will have maximum quantity limits.*

### Out-of-Network Pharmacies

We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care. In this situation, you will have to pay the full cost (rather than paying just your copayment) when you fill your prescription.

You can ask us to reimburse you for our share of the cost by submitting a paper claim form. To learn how to submit a paper claim, please refer to the paper claims process described in the Evidence of Coverage. You will be responsible for paying applicable cost-shares and all amounts over and above the amount Kaiser Permanente would have paid to an in-network non-preferred pharmacy (Kaiser Permanente Affiliated Network Pharmacy).

# Kaiser Permanente Medicare Plus

## Health Benefits Summary

<b>Inpatient Hospital/Facility Services</b>	
Room & Board ICU/CCU (other special care units), and Ancillary Services (incl. nursery charges)	100% Covered
Extended Care Facility/Skilled Nursing Care (medically necessary care—non custodial)	100% Covered
<b>Inpatient Professional/Practitioner Services</b>	
Physician Surgical Services	100% Covered
Anesthesia, Assistant Surgeon	100% Covered
Consultations (including follow-visits) & Physician Visits (includes ECF)	100% Covered
Radiation Therapy, Chemotherapy, and Renal Dialysis	100% Covered
<b>Outpatient Hospital/Facility Services</b>	
Minor/All Surgery (includes hospital based and freestanding surgical centers)	\$5 Copay
Preadmission Testing	\$5 Copay
Radiation Therapy, Chemotherapy, and Renal Dialysis	\$5 Copay
Physical & Speech Therapy	\$5 Copay
Occupational Therapy	\$5 Copay
Diagnostic Tests	100% Covered
<b>Outpatient/Office Professional Services</b>	
Minor/All Surgery	\$5 Copay
Anesthesia, Assistant Surgeon	\$5 Copay
Diagnostic Tests	100% Covered
Office Visit for Illness, Injury or Consultation	\$5 Copay
Allergy Tests	\$5 Copay
Allergy and Other Covered Injections—administration of injection	\$5 Copay
Physical Therapy & Acupuncture	\$5 Copay
Speech & Occupational Therapy	\$5 Copay
<b>Preventive/Well Care (Routine)</b>	
Annual Adult Physicals, Immunizations and Diagnostic Tests: Age 18 & older	\$5 Copay
Annual GYN Services (includes pap smear) rendered in the office	\$5 Copay
Mammography Screening (Provider must be American College of Radiology [ACR] approved)	\$5 Copay
Prostate Cancer Screening (including PSA test)	\$5 Copay

# Kaiser Permanente Medicare Plus

## Health Benefits Summary

Emergency Care	
Accidental Injury/First Aid and Medical Emergency or Life Threatening Event	\$50 emergency copay; waived if admitted
Follow-up Visits to an Accidental Injury or Medical Emergency	\$5 office visit copay
Ambulance	
Ground (public and private)	Covered in full
Mental Health	
Inpatient Hospital/Facility and Professional Services	Covered in full up to 190 lifetime days in psychiatric hospital
Outpatient Facility, Professional Services	\$5 Copay
Prosthetic Devices & Orthopedic Braces	
Purchase, repair or replacement	100% Covered (Medicare Guidelines)
Durable Medical Equipment	100% Covered (Medicare Guidelines)
Medical Supplies	100% Covered (Medicare Guidelines)
Home Health Care	
Facility/Agency	100% Covered (Medicare Guidelines)
Outpatient Private Duty Nursing (non-custodial; pre-authorization required)	100% Covered up to 100 days per benefit period
Hospice Care (inpatient or at home; pre-authorization required)	100% Covered (Medicare Certified Hospice)
Cardiac Rehabilitation	\$5 office visit copay
Organ Transplants	
Kidney, Cornea, Bone Marrow	100% Covered (Medicare Guidelines)
Heart, Heart-Lung, Single or Double Lung, Pancreas, and Liver	100% Covered (Medicare Guidelines)
Prescription Drugs	
Outpatient prescription drugs	60 day supply: \$3 mail order, \$5 Kaiser Center, \$10 Kaiser network pharmacy
Drugs dispensed by medical provider in office	Included in office visit
Vision	
Routine Vision	Discounts at participating providers
Dental	
Dental	Discounts at participating providers

Note: All services through Kaiser Permanente require coordination or authorization from the Plan or the member's Primary Care Physician.

This benefit matrix is intended for comparison/informational purposes and is not meant to be a binding contract. Specific benefit inquiries or quotes for benefits should be directed to the appropriate customer service department.

# 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.

# Important Notice

## Special Enrollment Requirements from CIGNA HealthCare

This flyer contains important information you should read before you enroll in this CIGNA Medicare Surround<sup>®</sup>. If you have any questions about this information, please contact your plan sponsor.

### If You Are Declining Enrollment

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if:

- You or your dependents are eligible under the plan, and
- You or your dependents lose eligibility for that other coverage (or if the plan sponsor stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the plan sponsor stops contributing toward the other coverage). If the other coverage is COBRA continuation coverage, you and your dependents must complete your entire COBRA coverage period before you can enroll in this plan, even if your plan sponsor stops contributions toward the COBRA coverage.

In addition, if you have a new eligible dependent as a result of marriage, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, adoption, or placement for adoption.

Effective April 1, 2009 or later, if you or your dependents lose eligibility for state Medicaid or Children's Health Insurance Program (CHIP) coverage or become eligible for assistance with group health plan premium payment under a state Medicaid or CHIP plan, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the state Medicaid or CHIP coverage ends or you are determined eligible for premium assistance.

**To request special enrollment or obtain more information, contact our Customer Service Team at 1.800.896.0948**

### Other Late Entrants

If you decide not to enroll in this plan now, then want to enroll later, you must qualify for special enrollment. If you do not qualify for special enrollment, you may have to wait until an open enrollment period, or you may not be able to enroll, depending on the terms and conditions of your benefit plan. Please contact your plan sponsor for more information.

### Women's Health and Cancer Rights Act (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain coverage under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related coverage, it will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

This coverage will be provided subject to the same deductibles and coinsurance or copays applicable to other medical and surgical benefits provided under this plan as shown in the Summary of Benefits. If you would like more information on WHCRA benefits, call our Customer Service Team at 1.800.896.0948.

# Protecting Your Confidentiality

## **Protection of Your Confidential Information**

At CIGNA, we are committed to maintaining the confidentiality of your health information. We have established policies and safeguards to protect oral, written and electronic information across our organization.

## **Information about CIGNA Privacy Practices**

Our Notice of Privacy Practices is given to everyone enrolling in a medical insurance policy. Individuals covered under self-insured medical plans will receive notices from their plan sponsor and can obtain a copy of CIGNA's notice by calling our Customer Service Team.

## **Release of Confidential Information**

We will not use or disclose your confidential information for any purpose other than the purposes permitted by the HIPAA Privacy Rule without your written authorization. For example, we will not supply confidential information to another company for its marketing purposes or to a potential plan sponsor with whom you are seeking employment unless you authorize it.

## **Access to Your Medical Records**

You may ask to inspect or to obtain a copy of your confidential information that is included in certain records we maintain. We may charge you copying and mailing costs. Under limited circumstances, we may deny you access to a portion of your records. Instructions on how to obtain a copy of your records will be included in the privacy notice you receive from CIGNA or your plan sponsor after you enroll.

## **Information to Plan Sponsors**

We may disclose your confidential information to your plan sponsor or to a company acting on your plan sponsor's behalf so that it can monitor, audit and otherwise administer the health plan in which you participate. Your plan sponsor is not permitted to use the confidential information we disclose for any purpose other than administering your health plan.

# 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, Open Access Plus In-Network (CIGNA 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](http://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 Dates, 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) <i>PCP Required for Kaiser Only.</i>	Primary Care Dentist ID Number and Name (ex. 1234 Smith) <i>PCP Required for CIGNA DHMO Only.</i>
	/ /			
	/ /			
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	/ /			
	/ /			
	/ /			
<b>Active Employees Only</b>				\$
<b>FSA Dependent Daycare Contribution Amount for plan year 1/1/2012 through 12/31/2012</b>				\$
<b>FSA Health Care Contribution Amount for plan year 1/1/2012 through 12/31/2012</b>				\$

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](http://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](http://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.

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.

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

# 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
- PEPSCO 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 2<sup>nd</sup> Shawan Rd exit. Follow Shawan Rd to 1<sup>st</sup> 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 3<sup>rd</sup> light after circle onto Towsontowne Blvd. Make 1<sup>st</sup> 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