



2017 Retiree Benefits Enrollment Guide



Baltimore County Government

www.baltimorecountymd.gov/benefits

Effective January 1, 2017 - December 31, 2017

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Baltimore County Government

Important Contacts

Contact:	Regarding:
<p>Insurance Division, Office of Budget and Finance 400 Washington Ave., Rm 111 Towson, MD 21204 Phone: (410) 887-2568 or (800) 274-4302 Fax: (410) 887-3820 MAIL STOP 2105 Email: bcbenefits@baltimorecountymd.gov Internet: www.baltimorecountymd.gov/benefits</p>	<ul style="list-style-type: none"> ■ Who is eligible for County health plan coverage ■ General benefit questions ■ Changes in family status affecting benefits ■ Changes to life insurance beneficiaries ■ Assistance with benefits elections when retiring ■ Continuing benefits under COBRA if you or your dependent(s) lose County benefits ■ Enrollment and ESS questions ■ Life status changes – i.e. marriage, divorce, birth, adoption, death of dependents, loss of dependent status ■ Changes to your address
<p>Baltimore County Retirement Office 400 Washington Ave., Rm 169 Towson, MD 21204 Phone: (410) 887-8246 or (877) 222-3741</p>	<ul style="list-style-type: none"> ■ Questions about your pension benefits ■ Questions about who you designated as your retirement beneficiary ■ Requests for retirement conferences ■ Changes to your address or other retirement information on file ■ Life status changes – i.e. marriage, divorce, or death of dependent spouse or other retiree beneficiary ■ Changes to your direct deposit designation
<p>Baltimore County Employee Assistance Program (Administered by Cigna Behavioral Health)</p> <p>Phone: (888) 431-4334 www.cignabehavioralhealth.com (password: baltimore)</p>	<ul style="list-style-type: none"> ■ Assistance with short-term, confidential, no-cost counseling for mental health, substance abuse and/or other work or family issues
<p>Social Security Administration (SSA) Phone: (800) 772-1213</p>	<ul style="list-style-type: none"> ■ Change of address ■ General Medicare Part A or B eligibility or premiums
<p>Medicare Help Line Phone: 1-800-MEDICARE (633-4227) www.medicare.gov</p>	<ul style="list-style-type: none"> ■ Request new ID card ■ Ordering Medicare publications ■ General Medicare information

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.

General Enrollment and Eligibility Information

Open Enrollment Information

Benefits changes for all retirees must be completed between October 11, 2016 and November 11, 2016. Changes will be effective January 1, 2017.

Eligibility

- 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.

Dependent Eligibility

- **Spouse** (opposite and same sex marriage must be legally recognized)
- **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.

Including your dependent(s) on County benefit plans when they do not meet County eligibility requirements is fraudulent and subject to prosecution.

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

When You Must Contact Baltimore County's Insurance Division

It is your responsibility to notify the Insurance Office within 31 days each time you have a change in your Family Status. You must provide proof of the change requested (i.e. – a copy of the divorce decree, separation agreement 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.

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
- Marriage, Divorce or Legal Separation
- Loss of dependent child status – child is turning 26.
- Medicare eligibility due to age or disability
- Loss or gain of other coverage
- You move to a new residence outside Maryland that is not included in your current health plan's coverage area.

Online Information

- Information about Open Enrollment can be found on the County's internet website www.baltimorecountymd.gov/benefits.
- You can email the Insurance Division with benefits questions or requests for additional information – the email address is bcbenefits@baltimorecountymd.gov.
- Plan website addresses are found on the inside back cover for you to access information about providers and programs.

Basic Retiree Guidelines

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.

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 as Prescription Coverage is included with the county's supplemental plans.

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.

Medical Benefits for Non-Medicare Retirees

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. The three Medical Plans available to Non-Medicare Retirees are Cigna Open Access Plus (OAP), Cigna Open Access Plus In Network (OAPIN) and Kaiser Permanente Select HMO.

Medical Benefits for Medicare Retirees (Due to Age or Disability)

Baltimore County requires that as soon as a retiree or spouse of a retiree is eligible for Medicare due to age or disability, 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**
- **You do not need to enroll in an independent Medicare Part D Prescription plan. The County offers an approved Medicare Part D Prescription Plan; however, you have the right to opt out of the County's Medicare Part D Prescription Plan. Please see the rates provided to evaluate whether an independent Part D plan might be more cost effective for you. Please visit medicare.gov or call 1-800-633-4227 for details.**

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. The two Medicare Supplemental plans available to Medicare Retirees are Cigna Medicare Surround and Kaiser Medicare Plus.

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

Baltimore County offers their own approved Medicare Part D Plan for Medicare retirees and their dependents therefore, you do not need to enroll in an independent Medicare Part D Prescription Plan. However, you have the right to opt out of the County's Medicare Part D Prescription plan. This means that you may elect the Cigna Medicare Surround plan as a Medicare supplement only and you may purchase an independent Medicare Part D Prescription Plan. Kaiser Permanente Medicare members do not have the option to opt out of the County's Medicare Part D Prescription plan. Please see the rates provided to evaluate whether an independent Part D plan may be more cost effective for you. Please visit medicare.gov or call 1-800-633-4227 for details. Please Note: You are only allowed to be enrolled in one Medicare Part D Plan.

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 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.

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 nonparticipating 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.

Vision Benefits for Retirees

Retirees not yet eligible for Medicare may continue or enroll in the CareFirst BlueVision plan (administered by Davis Vision).

Once retirees are eligible for Medicare or become Medicare age, the County no longer subsidizes the Vision coverage. You may

continue your plan at 100% of the premium with no County subsidy. These premiums will be automatically deducted from your pension check.

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 by going online to www.standard.com/enroll.

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

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.

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. The widow/widower must be receiving a pension check

sufficient to cover their share of the health plan premium deductions. 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.

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.

Resources and Programs Available to All Cigna Participants

myCigna.com

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

On www.myCigna.com you can:

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

Register today. It's this easy:

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

Access to myCigna Mobile App

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

Health Matters - Confidential Health Assessment

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

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

Come play.

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

24 Hour Health Information Line

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

Discount Programs - Healthy Rewards

Save money when you purchase health and wellness products and services through the Cigna Healthy Rewards® program. Visit mycigna.com for online program information or call 1.800.870.3470.

Programs include:

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

ONE CONNECTION to total health and well-being



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

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

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

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

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

Here is one number you need to know:

1.877.459.6150 for your health needs or myCigna.com

GO YOU.



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

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Cigna OAP/OAPIN Prescription Drug Coverage

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

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

Co-payments – 30 day

- Generic drug- \$12.00 copay.
- Brand name drug on the Cigna Pharmacy formulary- \$30.00 copay.
- Brand name drug that is non-formulary- \$45.00 copay.
- Brand name drugs that have an FDA generic equivalent require a \$45 copay plus the cost difference between the brand name drug and its generic equivalent regardless of physician's instructions.

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

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

Acute Medications

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

Maintenance Medications

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

Cigna Home Delivery Pharmacy

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

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

Cigna Specialty Pharmacy Services

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

To start a new order, please call us at: 1.800.351.3606. You can manage delivery of your maintenance prescriptions online at www.myCigna.com.

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

Prior Authorization

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

Step Therapy

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

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

Cigna OAP/OAPIN Prescription Drug Coverage *(continued)*

Prescription Drug List

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

Your PDL splits medications into three categories, or tiers:

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

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

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

Cigna Open Access Plus (OAP)

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

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

■ 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 claim paperwork.

■ 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.

■ 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! Precertification may be necessary for hospitalizations and some types of outpatient care, but there is no paperwork for you.

■ Emergency and Urgent Care

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

■ Prescription Coverage with Cigna OAP

The prescription plan included in the premium cost for Cigna Open Access is administered by Cigna Pharmacy. See Cigna Pharmacy section for more information.

■ 24/7/365 Service. Call anytime (800) 896-0948

Whenever you need assistance, 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.

■ Online and on the go – myCigna.com and myCigna Mobile App.

- Use our award-winning directory of doctors, hospitals and facilities with cost, quality and patient experience* ratings
- Verify coverage details (copays, deductibles)
- Check claim activity and history
- Compare prescription drug prices, find generic options and enjoy convenience and savings by using Cigna Home Delivery PharmacySM*

Download your app now from the App StoreSM or Google PlayTM.

Frequently Asked Questions

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 Cigna's Provider list?

That means your doctor is not participating 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?

No. 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.

Cigna Open Access Plus (OAP) *(continued)*

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

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 “precertified.” This enables Cigna to determine if the services are covered. Precertification is not required for maternity stays of 48 hours for vaginal deliveries or 96 hours for cesarean sections. Depending on your plan, you may be eligible for additional coverage. Any hospital stay beyond the initial 48 or 96 hours must be approved.

Who is responsible for obtaining precertification?

Your doctor will help you decide which procedures require inpatient 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 precertification. If you use an out-of-network doctor, you are responsible for making the arrangements. Your plan materials will identify which procedures require precertification.

When do I need to submit a claim?

The timeframe to submit out-of-network claims is 180 days. Because Cigna does not have a contract with out-of-network doctors and facilities, Cigna cannot prevent them from billing you for payment of claims that Cigna denies because of late submission.

What is Case Management?

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

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

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

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

Call us at 1.800.896.0948

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

- Click on “Find a Doctor”
- Select a Directory
- Choose between “Doctor, Dentist, or Hospital, Pharmacy, Facility”
- Enter a “Location” (City and State OR Zip Code)
- Click “Select a Plan”
- Click “Open Access Plus, OA Plus, ChoiceFund OA Plus”
- Click “Choose”
- Click “A-Z” (for specialized doctors or search by name (optional))
- Click “Search”

Print and email options are available to save your results. After the plan effective date use www.mycigna.com.

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 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.

Cigna Open Access Plus In-Network (OAPIN)

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

■ 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 Coverage Only

For your health care to be covered by the plan, all health care professionals, providers, labs and other vendors must be part of the Cigna network.

■ No-Referral Specialist Care

If you need to see a specialist, you do not need a referral to see a doctor who participates in the Cigna network —just make the appointment and go!

■ 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.

■ Prescriptions

The prescription plan included in the premium cost for Cigna Open Access Plus In-Network is administered by Cigna Pharmacy. See Cigna Pharmacy section for more information.

■ 24/7/365 Service. Call anytime (800) 896-0948

Whenever you need assistance, 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.

■ Online and on the go – myCigna.com and myCigna Mobile App.

- Use our award-winning directory of doctors, hospitals and facilities with cost, quality and patient experience* ratings
- Verify coverage details (copays, deductibles)
- Check claim activity and history
- Compare prescription drug prices, find generic options and enjoy convenience and savings by using Cigna Home Delivery PharmacySM*

Download your app now from the App StoreSM or Google PlayTM.

Frequently Asked Questions

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 Cigna's Provider list?

That means your doctor is not participating 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 this plan.

Do I need a referral to see a specialist?

No. 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.

Cigna Open Access Plus In-Network (OAPIN) *(continued)*

How does my plan cover my care?

When you visit a doctor who participates in the Cigna network, you receive in-network coverage. Participating health care providers have agreed to charge lower fees, and your plan covers a 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 to determine if the services are covered. Precertification 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 precertification?

Your doctor will help you decide which procedures require inpatient care and which can be handled on an outpatient basis. If your doctor participates in the Cigna network, he or she will arrange for precertification. If you use an out-of-network doctor your care will not be covered. Your plan materials will identify which procedures require precertification.

What is Case Management?

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

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

Our dedicated Enrollment Information Line is available 24/7 to help you learn about the benefits and advantages of Cigna. Call today and a knowledgeable Enrollment Specialist will provide you with assistance in identifying participating providers.

Call us at 1.800.896.0948

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

- Click on “Find a Doctor”
- Select a Directory
- Choose between “Doctor, Dentist, or Hospital, Pharmacy, Facility”
- Enter a “Location” (City and State OR Zip Code)
- Click “Select a Plan”
- Click “Open Access Plus, OA Plus, ChoiceFund OA Plus”
- Click “Choose”
- Click “A-Z” (for specialized doctors or search by name (optional))
- Click “Search”

Print and email options are available to save your results. After the plan effective date use www.mycigna.com.

Kaiser Permanente Select HMO

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 at 1-800-777-7902.

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 \$12 for generic, \$30 for brand name drugs, and \$45 for brand-name non-formulary, if filled at a Kaiser Permanente medical center, or \$15 for generic, \$45 for brand drugs, and \$60 for brand-name non-formulary for up to a 30-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 two copays.

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

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

Wellness Services

Kaiser Permanente offers a variety of services aimed at preventing illness. Your PCP can encourage you to attend 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, 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.
- 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 1-866-530-8778 for assistance).
- Kaiser Permanente offers discounts to members on new health club membership when they join through Choose Healthy. Just go to www.kp.org/choosehealthy.
- When you get your care and services at a Kaiser medical center, My Health Manager becomes your one stop shop online resource 24 hours a day, 7 days a week. Features include: Email your doctor, view most lab test results, refill most prescriptions, schedule, cancel, or review routine appointments and much more. Go to www.kp.org/registernow to get connected.
- Download the Kaiser Permanente mobile app at no cost from your preferred app site. Use the convenient features of My Health Manager right from your smartphone or other mobile device. If you're already registered on kp.org, you're all set to start using your Kaiser Permanente app. If not, you'll need to go kp.org/registernow to set up your account from a computer. Then use your new user ID and password to activate the app.

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.
- The South Baltimore County Medical Center in Halethorpe, offers urgent care 24/7, 365 days per year.
- Now you can see your doctor face-to-face—without visiting the office. You can have a video visit with your personal doctor from home, work, or while on the go. Whether you want a future appointment or need to be seen right away, just visit kp.org or use our mobile app to schedule. You must be registered at kp.org to take advantage of this service. Not registered? Visit kp.org/register. You may also call Kaiser Permanente to schedule your video visit at 1-800-777-7904 (TTY 711).

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
COST SHARING LIFETIME LIMITS	
Calendar Year Deductible	\$0 Individual / \$0 Family
Calendar Year Medical Out-of-Pocket Maximum	\$1,100 Individual / \$3,600 Family
Calendar Year Prescription Out-of-Pocket Maximum	\$5,500 Individual / \$9,600 Family
Lifetime Maximum	Unlimited
OUTPATIENT PRESCRIPTION DRUG BENEFIT	
Dispensed at Pharmacy*	\$12 Generic / \$30 Brand Formulary / \$45 Brand Non-Formulary (copays apply for each 34 day supply)
Mail Order – Maintenance Medications* Mail order copays do not apply to Specialty Medications.	\$24 Generic / \$60 Brand Formulary / \$90 Brand Non-Formulary (you pay only 2 copays for each 102 day 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.	
PROFESSIONAL SERVICES	
Annual Adult Physical	You pay 0% / Plan pays 100%
Gynecology Annual Office Visit	You pay 0% / Plan pays 100%
Mammography Screening / PAP / PSA Testing (Routine)	You pay 0% / Plan pays 100%
Well Child Visit	You pay 0% / Plan pays 100%
Primary Care Office Visit	You pay \$15 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%

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
\$5,600 Individual / \$11,200 Family	N/A	N/A
Unlimited	Unlimited	Unlimited
\$12 Generic / \$30 Brand Formulary / \$45 Brand Non-Formulary (copays apply for each 34 day supply)		One copay for up to a 30 day supply. \$12 Generic / \$30 Brand Formulary / \$45 Brand Non-Formulary for Kaiser Facility \$15 Generic / \$45 Brand Formulary / \$60 Brand Non-Formulary at other network pharmacies
\$24 Generic / \$60 Brand Formulary / \$90 Brand Non-Formulary (you pay only 2 copays for each 102 day supply)		\$24 Generic / \$60 Brand Formulary / \$90 Brand Non-Formulary for mail order refills. Up to 90 day supply for maintenance medications
You pay 0% / Plan pays 100%	You pay 25% / Plan pays 75% after the deductible is met	100% Covered
You pay 0% / Plan pays 100%	You pay 25% / Plan pays 75% after the deductible is met	\$10 copay applies
You pay 0% / Plan pays 100% No deductible	You pay 0% / Plan pays 100% No deductible	100% Covered
You pay 0% / Plan pays 100%	You pay 25% / Plan pays 75% after the deductible is met	100% Covered
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 \$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

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)
PROFESSIONAL SERVICES (cont.)	
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%
INPATIENT CARE HOSPITAL	
Room and Board Preauthorization REQUIRED if elective	\$100 copay per admission, then You pay 0% / Plan pays 100%
Physician/Surgical Services	You pay 0% / Plan pays 100%
Anesthesia Services	You pay 0% / Plan pays 100%
Medical Consultations	You pay 0% / Plan pays 100%
ICU/CCU	\$100 copay per admission, then You pay 0% / Plan pays 100%
Maternity/Nursery/Birthing Center	Initial Visit to confirm pregnancy Primary Care Physician – You pay \$15 per visit Specialist – You pay \$20 per visit Global Maternity Professional Fees You pay 0% / Plan pays 100% Inpatient Facility \$100 copay per admission, then You pay 0% / Plan pays 100%
Skilled Nursing/Rehab Facility Care	You pay 0% / Plan pays 100% 100 days per calendar year
Dialysis/Radiation/Chemotherapy	\$100 copay per admission, then You pay 0% / Plan pays 100%
Hospice	You pay 0% / Plan pays 100%
Physical/Speech/Occupational Therapy	\$100 copay per admission, then You pay 0% / Plan pays 100%
OUTPATIENT HOSPITAL SERVICES	
Surgical/Anesthesia Services	You pay 0% / Plan pays 100%
Dialysis/Radiation/Chemotherapy – Physicians Office	PCP \$15 / Specialist \$20 copay
Dialysis/Radiation/Chemotherapy – Outpatient Facility	You pay 0% / Plan pays 100%
Physical/Speech/Occupational Therapy	You pay \$20 per visit 40 days for each therapy per calendar year
Outpatient Diagnostic Services	You pay 0% / Plan pays 100%

Cigna Open Access Plus (OAP)		Kaiser Permanente HMO
In-Network	Out-of-Network	
Physician's Office Primary Care Physician – You pay \$15 per visit Specialist – You pay \$25 per visit	You pay 25% / Plan pays 75% after the deductible is met	Tests covered in full on same day as office visit; \$10 copay applies unless on list of \$0 copayment preventive screenings
Independent X-ray or Lab Facility Outpatient Facility You pay 5% / Plan pays 95% after the deductible is met	You pay 25% / Plan pays 75% after the deductible is met	Approved tests covered in full
You pay 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
Initial Visit to confirm pregnancy Primary Care Physician – You pay \$15 per visit Specialist – You pay \$25 per visit Global Maternity Professional Fees You pay 5% / Plan pays 95% after the deductible is met Inpatient Facility / Outpatient Facility You pay 15% / Plan pays 85% after the deductible is met	You pay 25% / Plan pays 75% after the deductible is met	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% 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

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)
MATERNITY/INFERTILITY SERVICES	
1st prenatal visit	<p>Initial Visit to confirm pregnancy Primary Care Physician – You pay \$15 per visit Specialist – You pay \$20 per visit</p>
Pre- and Postnatal care and delivery	<p>Global Maternity Professional Fees You pay 0% / Plan pays 100%</p> <p>Inpatient Facility \$100 copay per admission You pay 0% / Plan pays 100%</p>
Routine nursery care	<p>Inpatient Facility \$100 copay per admission, then You pay 0% / Plan pays 100%</p>
Sterilization/Reverse Sterilization	<p>Physician's Office Primary Care Physician – You pay \$15 per visit Specialist – You pay \$20 per visit</p> <p>Inpatient Facility \$100 copay per admission, then You pay 0% / Plan pays 100%</p> <p>Outpatient Facility You pay 0% / Plan pays 100% Excludes reversal of sterilization</p>
Elective Abortions in inpatient or outpatient facility	<p>Inpatient Facility \$100 copay per admission, then You pay 0% / Plan pays 100%</p> <p>Outpatient Facility You pay 0% / Plan pays 100%</p>
Artificial Insemination (AI)	<p>Primary Care Physician You pay \$15 per visit Specialist – You pay \$20 per visit</p> <p>Inpatient Facility \$100 copay per admission, then You pay 0% / Plan pays 100%</p> <p>Outpatient Facility; Professional Services You pay 0% / Plan pays 100% Unlimited dollar maximum</p>
InVitro Fertilization (IVF)	<p>Primary Care Physician You pay \$15 per visit Specialist – You pay \$20 per visit</p> <p>Inpatient Facility \$100 copay per admission, then You pay 0% / Plan pays 100%</p> <p>Outpatient Facility; Professional Services You pay 0% / Plan pays 100% Unlimited dollar maximum</p>

Cigna Open Access Plus (OAP)		Kaiser Permanente HMO
In-Network	Out-of-Network	
Initial Visit to confirm pregnancy Primary Care Physician – You pay \$15 per visit Specialist – You pay \$25 per visit	You pay 25% / Plan pays 75% after the deductible is met	\$10 copay
Global Maternity Professional Fees You pay 5% / Plan pays 95% after deductible is met Inpatient Facility / Outpatient Facility You pay 15% / Plan pays 85% after the deductible is met	Global Maternity Professional Fees You pay 25% / Plan pays 75% after deductible is met Inpatient Facility You pay 25% / Plan pays 75% after the deductible is met	Covered in full when authorized
Inpatient Facility You pay 15% / Plan pays 85% after the deductible is met	Inpatient Facility You pay 25% / Plan pays 75% after the deductible is met	Covered in full when authorized
Primary Care Physician – You pay \$15 per visit Specialist – You pay \$25 per visit Inpatient Facility / Outpatient Facility Physician's Services You pay 15% / Plan pays 85% after the deductible is met Includes reversal of sterilization	You pay 25% / Plan pays 75% after the deductible is met Includes reversal of sterilization	\$10 copay applies, reversal not covered
Inpatient Facility / Outpatient Facility You pay 15% / Plan pays 85% after the deductible is met	Inpatient Facility / Outpatient Facility You pay 25% / Plan pays 75% after the deductible is met	\$10 copay applies in outpatient setting
Primary Care Physician You pay \$15 per visit Specialist – You pay \$25 per visit Inpatient Facility / Outpatient Facility Physician's Services You pay 15% / Plan pays 85% after the deductible is met Unlimited dollar maximum	You pay 25% / Plan pays 75% after the deductible is met \$100,000 lifetime maximum on all infertility	Covered at 50% of non-member rate when authorized
Primary Care Physician You pay \$15 per visit Specialist – You pay \$25 per visit Inpatient Facility / Outpatient Facility Physician's Services You pay 15% / Plan pays 85% after the deductible is met Unlimited dollar maximum	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

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)
MEDICAL EMERGENCIES (Use of Emergency Room)	
Accidental Injury	You pay \$50 per visit – copay waived if admitted
Sudden and Serious Illness	You pay \$50 per visit copay waived if admitted
Follow-up visits	You pay \$50 per visit copay waived if admitted
MENTAL HEALTH / SUBSTANCE ABUSE	
Inpatient	\$100 per admission, then You pay 0% / Plan pays 100%
Outpatient	Physician office visit \$20 per visit
OTHER SERVICES	
Ambulance	You pay 0% / Plan pays 100% <i>(Includes Air Ambulance when medically necessary)</i>
Kidney, Cornea Bone Marrow Transplants, Heart, Heart-Lung, Lung, Pancreas, Liver Transplants	Primary Care Physician You pay \$15 per visit Specialist – You pay \$20 per visit Inpatient Facility \$100 copay per admission, then You pay 0% / Plan pays 100% Outpatient Facility – Physician’s Services You pay 0% / Plan pays 100%
Outpatient Cardiac Rehabilitation	Limited to 40 days per calendar year \$15 PCP / \$20 Specialist copay
Hearing Aids	You pay 0% / Plan pays 100% of allowed benefit Unlimited dollar maximum, two hearing aids every three years You may use any provider including Amplifon.
Durable Medical Equipment	You pay 0% / Plan pays 100% Unlimited Maximum per Calendar Year
Diabetic Supplies	Covered under DME or RX – copays may apply

Cigna Open Access Plus (OAP)		
In-Network	Out-of-Network	Kaiser Permanente HMO
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
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 \$20 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
Primary Care Physician You pay \$15 per visit Specialist – You pay \$25 per visit Inpatient Facility / Outpatient Facility Physician's Services You pay 15% / Plan pays 85% after the deductible is met (COVERED AT 100% AT LIFESOURCE CENTER)	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 Unlimited dollar maximum, 2 hearing aids every three years You may use any provider including Amplifon.	You pay 0% / Plan pays 100% Unlimited dollar maximum, 2 hearing aids every three years You may use any provider including Amplifon.	One hearing aid for each hearing impaired ear every 36 months up to a \$1,000 maximum for adults and children
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

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. 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 or contact member services at 1-866-891-2802.

Out-of-Network Benefits

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

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

Baltimore County Dental Benefits Summary

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
Deductible per Calendar Year	\$100 Per person \$200 Per family	\$100 Per person \$200 Per family	\$100 Per person \$200 Per family	\$0
Maximum Benefit per Calendar Year	\$1500 Per person	\$1000 Per person		Unlimited
	Plan Pays	Plan Pays		Member Pays
Preventative Care, Exams, Cleanings, X-Rays, Fluoride	100% when using a participating provider (Non-participating providers can bill the balance)	100%	80%	\$5
Restorative Care, Fillings, Crowns, Root Canals	80% after deductible*	80% after deductible	60% after deductible	\$5 to \$225 See "Patient Charge Schedule" for details
Periodontal Services	50% for limited services after deductible; treatment plan required	80% for limited services after deductible; treatment plan required	60% for limited services after deductible; treatment plan required	\$5 to \$250 See "Patient Charge Schedule" for details
Prosthetic Services, Dentures, Bridgework	50% after deductible; treatment plan required	50% after deductible; treatment plan required	30% after deductible; treatment plan required	\$20 to \$625 See "Patient Charge Schedule" for details
Emergency Care	No additional emergency provisions provided	No additional emergency provisions provided		\$45 After regularly scheduled hours
Orthodontia Services	50% (\$2000 lifetime maximum) For dependent children only up to age 19	50% after deductible (\$1500 lifetime maximum) For dependent children only up to age 19	50% after deductible (\$1000 lifetime maximum) For dependent children only up to age 19	See "Patient Charge Schedule" for details

*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 and select “Find a Provider” or call Davis Vision at (800) 783-5602 (client code: 9002). Some offices participate for exams only and some provide significant discounts on lenses and frames. You will pay the least amount out-of-pocket by selecting a full-service office and choosing from the Davis tower of frames or Davis contact lens provider.

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

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

Davis Providers

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

Your CareFirst BlueVision Coverage

Out-of-Network Providers

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

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

BlueVision Discounted Rates on Special Services

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

- **Laser Vision correction** – entitled to a discount of up to 25% off providers usual and customary charge or a 5% discount from the Laser center’s advertised special at ZVision participating offices towards the purchase of items not covered, such as a second pair of glasses.

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

Example Costs

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

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

Does Davis Vision offer same-day service?

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

For more information call Davis Vision at (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 without being a current member of the plan. No ID name or Password is needed. Click on **Providers & Facilities** tab, then click “Search for Doctor/Facility. Click “Search Now” then click “Continue as Guest”. Select the type of provider you are looking for and follow prompts on screen.

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.

Employee Assistance Program – Non-Medicare Retirees

Baltimore County's EAP services are administered by Cigna, and are available to every employee of Baltimore County, and anyone who resides in the home of a Baltimore County Employee. Cigna EAP is available 24 hours a day, seven days a week, at 888.431.4334. Cigna EAP can also be accessed at: www.cignabehavioral.com employer id: baltimore

Commitment to Superior Mental Health and Work / Life Services

Baltimore County recognizes that the success of all County programs depends upon the well-being and commitment of Baltimore County employees. In order to support a healthy and productive workplace, the county has worked with Cigna to develop an integrated employee assistance and work / life support program. These services have been designed to meet employee needs, and to conform to the highest standards of quality.

Using your Baltimore County Employee Assistance Program

Baltimore County employees and under age 65 retirees, their household members (related or un-related) have access to the EAP program, provided by the professional counseling network of Cigna. The EAP can help if you, or a household member in need of assistance, with a wide variety of problems or concerns. EAP provides telephonic consultation, face to face counseling (up to 10 visits with a local EAP provider) per issue, per year, for every household member of a Baltimore County employee. EAP services are not tied to your selection of a County health plan. If you are an active employee, working 26+ hours per week, you and your household members have access to EAP services. There is no charge for EAP service. For more information, please contact Cigna EAP for Baltimore County at 888.431.4334.

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

Work / Life Assistance

The County recognizes that the ability of its employees to be productive is impacted by life concerns that can often interfere with work. Therefore, the County provides work/ life support services for its employees, through the EAP program:

Child care, elder care and pet care referral services:

Whether an employee is seeking assistance with finding an in home daycare, a nanny, or a daycare center, summer camps, an adult daycare setting, or a pet sitter, etc Cigna EAP can assist with finding child care, elder care or pet care services that meet the particular needs of employees. By calling Cigna EAP at 888.431.4334, and asking to speak with a work/life specialist, Baltimore County

Employees and their household members can receive assistance with finding pre-screened referrals for a variety of work / life needs.

Legal and Identity Theft

Employees concerned with personal legal problems may be distracted at work, and spend time during the workday to manage those issues. Baltimore County employees and their household members can consult with an attorney, for 30 minutes, at no cost. This consultation can occur in person, or via the telephone, and includes consult for a wide range of legal concerns, with the exception of employment law.

In addition, County employees, and their household members can receive 60 minutes of telephonic support with a fraud resolution specialist, at no cost. Legal and identity theft consultation can be obtained by calling Cigna EAP at 888.431.4334.

Financial Consultation

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. Cigna EAP's Financial Consultants can assist you with the following financial matters, during a free 30 minute telephonic consultation:

- Managing Personal and Financial Challenges
- Credit Card and Debt Management
- Budgeting
- Tax Questions
- Financing for college
- Investment options
- Mortgage, loans, and refinancing
- Retirement planning
- Estate planning
- And more

Get the help you need: Here's how:

Call Cigna EAP 24 hours a day, seven days a week, at the toll free number listed below. You will be connected to a Personal Advocate, who will talk with you about your specific situation, and the resources available to you, at no cost, through your EAP program.

Cigna Employee Assistance Program

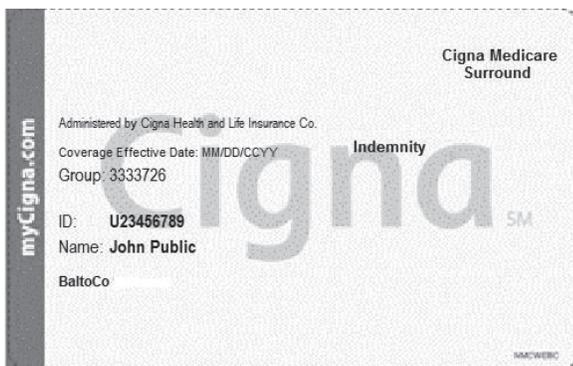
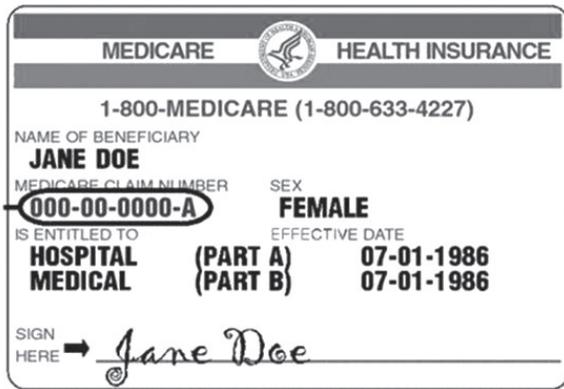
Call: 1.888.431.4334

Go online: www.cignabehavioral.com

Your Employer ID: baltimore

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 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.

Baltimore Government also offers a prescription plan through Cigna-HealthSpring. You will be enrolled in the prescription plan once you enroll in the Cigna Medicare Surround Plan.

Frequently Asked Medicare Questions

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 Cigna-HealthSpring. 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.** However, you have the right to opt out of the County's Medicare Part D Prescription Plan. This means you may elect the Cigna Medicare Surround plan as a Medicare supplement only and you may purchase an independent Medicare Part D Prescription plan. Please see the rates provided to evaluate whether an independent Part D plan might be more cost effective for you. Please visit medicare.gov or call 1-800-633-4227 for details. Please Note: You are only allowed to be enrolled in one Medicare Part D Plan.

Late enrollment penalties will not apply if you need to enroll in a Medicare Part D prescription plan in the future because you have employer-sponsored prescription benefits. The customer service number for Cigna-HealthSpring RX is 1-800-558-9562.



Use this card for prescriptions.

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 Cigna-HealthSpring RX (PDP) before they can be filled. You or your physician can contact Cigna-HealthSpring RX (PDP) at 1-800-558-9562.

Your Share of the Cost for Outpatient Prescriptions:

- An annual calendar year deductible of \$100/individual. Calendar years begin each January 1 and continues through December 31.

After you have met your \$100 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.

Cigna-HealthSpring RX (PDP) 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 Cigna Home Delivery at 1-855-401-9868 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:
Inpatient Hospital/Facility Services	
Room & Board (ICU/CCU (other special care units), and Ancillary Services (including nursery charges))	100% of the Medicare approved amount after inpatient deductible Days 1-60: 100% of the Medicare approved amount after the inpatient deductible per benefit period; Days 61-90: 100% of the Medicare approved amount after per day deductible per benefit period; After day 90: 100% of the Medicare approved amount after per day deductible (up to 60 days over your lifetime)
Extended Care Facility/Skilled Nursing Care	Days 1–20: 100% of the Medicare approved amount per benefit period; Days 21–100: 100% of the Medicare approved amount after per day deductible per benefit period
Inpatient Professional/Practitioner Services	
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
Outpatient Hospital/Facility Services	
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>
Outpatient/Office Professional Services	
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 \$1,960 per year (2016) Speech & physical therapy limited to \$1,960 per year (2016)</i>
Preventive/Well Care (Routine)	
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 and one annual wellness exam every 12 months thereafter.
Annual GYN Services (includes pap smear) rendered in the office	100% of the Medicare approved amount. <i>Note: Limited to one every two years.</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 ;
 Day 101-120: 100% of the allowed benefit

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
 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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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
 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

Cigna Medicare Surround *(continued)*

Health Benefits Summary	Medicare Pays:
Preventive/Well Care (Routine) cont.	
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)	100% 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>
Emergency Care	
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
Ambulance	
Ground (public or private)	80% of the Medicare approved amount after annual deductible
Mental Health	
Inpatient Hospital/Facility and Professional Services	Same as medical <i>Note: Coverage limited to 190 lifetime days.</i>
Outpatient Facility, Professional Services	80% of the Medicare approved amount after annual deductible
Prosthetic Devices & Orthopedic Braces	
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
Home Health Care	
Facility/Agency	100% for covered home health services, 80% for durable medical equipment
Outpatient Private Duty Nursing (Non-custodial; pre-authorization required)	100% of the Medicare approved amount for covered home health services by a Medicare covered Home Health Care Agency
Hospice Care (Inpatient or At Home)	100% of the Medicare approved amount except \$5 per outpatient prescription and 5% of inpatient respite care
Cardiac Rehabilitation	80% of the Medicare approved amount
Organ Transplants	
Kidney, Cornea, Bone Marrow	Same as medical
Heart, Heart-Lung, Single or Double Lung, Pancreas, and Liver	Same as medical
Prescription Drugs	
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
Additional Information	
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
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
Same as medical
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 home health services at 100% – no Cigna payment necessary, Cigna pays 80% of the balance due after Medicare for durable medical equipment
80% for medically necessary services not covered by Medicare
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 Cigna-HealthSpring Rx (PDP)
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

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 at 1-888-777-5536 and request an “Evidence of Coverage” booklet.

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.

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 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 \$4,850, you pay:

Kaiser Permanente Mail Delivery Services:

Generic or Brand: \$3.00 (up to a 90-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 \$4,950, you pay:

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 twice per year. You pay \$5 for a routine eye exam and receive a 25% discount on the cost of glasses.

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

Inpatient Hospital/Facility Services	
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
Inpatient Professional/Practitioner Services	
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
Outpatient Hospital/Facility Services	
Minor/All Surgery (includes hospital based and freestanding surgical centers)	100% Covered
Preadmission Testing	100% Covered
Radiation Therapy, Chemotherapy	\$5 Copay
Renal Dialysis	100% Covered
Physical & Speech Therapy	\$5 Copay
Occupational Therapy	\$5 Copay
Diagnostic Tests	100% Covered
Outpatient/Office Professional Services	
Minor/All Surgery	100% Covered
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	\$5 Copay
Speech & Occupational Therapy	\$5 Copay
Preventive/Well Care (Routine)	
Annual Adult Physicals, Immunizations and Diagnostic Tests: Age 18 & older	100% Covered
Annual GYN Services (includes pap smear) rendered in the office	100% Covered
Mammography Screening (Provider must be American College of Radiology [ACR] approved)	100% Covered
Prostate Cancer Screening (including PSA test)	100% Covered

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)	100% Covered
Mental Health	
Inpatient Hospital/Facility and Professional Services	100% Covered 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
Mail Order – maintenance medications only	\$3 mail order – up to 90 days supply for maintenance drugs
Drugs dispensed by medical provider in office	Included in office visit
Vision	
Routine Vision	\$5 Copay
Dental	
Dental	Preventive dental and 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.

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?

Retirees will receive the same subsidy for Basic Life as they received while they were actively working. 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.

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.*

How Do I Change My Life Insurance Beneficiary?

You may designate or update your life insurance beneficiary information quickly and easily at www.standard.com/enroll. If you have not already established an online account, simply click “Need A Login?” and follow the instructions to create your account with The Standard. To begin the designation process, select “Start Here – Change My Benefits”, “Life Event,” “Change of Beneficiary (Use Today’s Date)”. If you have any questions about The Standard’s web site or need additional assistance, contact The Standard’s Customer Service at 866-623-0622, Monday-Friday, 8:30 am - 6:30 pm EST. Retirees who do not have access to the internet may contact the Insurance Division to request a “Change of Beneficiary” form.

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

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

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

This flyer contains important information you should read before you enroll in Cigna Medicare Surround®. If you have any questions about this information, please contact your plan.

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 your employer 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 employer 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 employer 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.

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-Cigna24 (1-800-244-6224).

Together, all the way.®



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 employer 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-Cigna24 (1-800-244-6224).



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BALTIMORE COUNTY GOVERNMENT RETIREE HEALTH INSURANCE APPLICATION

1- Applicant's Personal Information							To Be Completed by the Insurance Division	
Name		Street					Ben Eff Date:	DPOL:
SSN		City		State		Zip	Date of Event:	Retirement Date:
DOB		Primary Phone		Email			Benefit Basis:	Entity:
If Widow or Spouse is Applicant: _____							Years of Creditable Service:	
Retiree Name				Retiree SSN			Completed by: _____ Date: _____	
							IMPORTANT – Please provide address for person(s) being removed: _____	

2- Enrollment Type		
Type of Event	Add Dependent(s)	Remove Dependent(s)
<input type="checkbox"/> New Applicant	<input type="checkbox"/> Loss of other coverage	<input type="checkbox"/> Marriage*
<input type="checkbox"/> Eligible for Medicare: <input type="checkbox"/> Self <input type="checkbox"/> Spouse	<input type="checkbox"/> Gain of other coverage	<input type="checkbox"/> Legal Separation / Divorce*
<input type="checkbox"/> Retirement	<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Child over qualifying age
	<input type="checkbox"/> Other (please explain)	<input type="checkbox"/> Other (please explain)
* If adding or removing dependent(s), please attach documentation within 31 days of event *Please provide address for person(s) being removed		

3- Benefit Options			
Non-Medicare Retirees / Spouses	Medicare Retirees / Spouses	Dental Plans	Vision Plan
<input type="checkbox"/> Cigna Open Access Plus (OAP – In and Out of Network)	<input type="checkbox"/> Cigna Medicare Surround	<input type="checkbox"/> CareFirst BCBS Traditional Dental	<input type="checkbox"/> CareFirst Davis Vision
<input type="checkbox"/> Cigna Open Access Plus In-Network Only (OAPIN)	<input type="checkbox"/> Kaiser Medicare Plus HMO	<input type="checkbox"/> CareFirst BCBS Preferred PPO	<input type="checkbox"/> Waive Coverage
<input type="checkbox"/> Kaiser Permanente Select HMO	<input type="checkbox"/> Cigna Medicare Surround No Rx	<input type="checkbox"/> Cigna Dental Care HMO	
<input type="checkbox"/> Waive Coverage	<input type="checkbox"/> Waive Coverage	<input type="checkbox"/> Waive Coverage	
Coverage Level : <input type="checkbox"/> IND <input type="checkbox"/> Ret+Sp <input type="checkbox"/> P/C <input type="checkbox"/> FAM		Coverage Level : <input type="checkbox"/> IND <input type="checkbox"/> Ret+Sp <input type="checkbox"/> P/C <input type="checkbox"/> FAM	Coverage Level : <input type="checkbox"/> IND <input type="checkbox"/> Ret+Sp <input type="checkbox"/> P/C <input type="checkbox"/> F/

4- Dependent(s) Being Added or Removed (Rem)									
Name	Add	Rem	Relationship	Gender	Social Security #	Date of Birth	Disabled Y/ N	Primary Care Doctor (Kaiser ONLY)	Primary Care Dentist (CIGNA ONLY)
RETIREE			SELF						

5- Medicare Information (if applicable)			
Are you eligible for Medicare? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, attach copy of Medicare card	If yes, Medicare No: _____	Part A Effective Date: _____	Part B Effective Date: _____
Spouse eligible? <input type="checkbox"/> YES <input type="checkbox"/> NO Child eligible? <input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, Medicare No: _____	Part A Effective Date: _____	Part B Effective Date: _____

All information I have given on this application is true to the best of my knowledge. I agree to follow the Retiree guidelines and eligibility rules set forth in the Retiree enrollment guide.

Applicant Signature

Date

Return to: Baltimore County Insurance Division
400 Washington Ave Room 111
Towson, MD 21204
FAX: 410-887-3820 PH: 410-887-256

How to Contact Your Benefit Plans Directly

	Plan Name	Customer Service Number	Website
MEDICAL	Cigna Open Access Plus OAP Cigna Open Access Plus OAPIN Cigna Medicare Surround	1-800-896-0948	www.mycigna.com
	Kaiser Permanente Select HMO/Prescription	1-800-777-7902	www.kaiserpermanente.org
RX	Cigna Pharmacy Prescription Coverage for Cigna OAP and Cigna OAPIN Non-Medicare Plans	1-800-896-0948	www.mycigna.com
RETIREE MEDICARE SUPPLEMENTAL/RX	Cigna-HealthSpring Rx (PDP) Cigna Medicare Surround Medicare Part D Prescription Drug Plan	1-800-558-9562	www.mycigna.com
	Kaiser Permanente Medicare Plus/Prescription	1-888-777-5536	www.kp.org
DENTAL	CareFirst BCBS Traditional Dental CareFirst BCBS Dental PPO	1-866-891-2802	www.carefirst.com
	Cigna Dental Plan (DHMO)	1-800-896-0948	www.mycigna.com
EAP	Cigna Behavioral Health	1-888-431-4334	www.cignabehavioral.com (Employer ID: baltimore)
VISION	CareFirst BCBS Davis Vision	1-800-783-5602	www.carefirst.com
LIFE INSURANCE	The Standard	1-866-623-0622	www.standard.com/enroll
Baltimore County	Baltimore County Insurance Division	410-887-2568 1-800-274-4302	www.baltimorecounty.md.gov/benefits

2017 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 Sponsors and Representatives from the County Insurance Division. The meetings will also include plan materials and promotional items as well as healthy lifestyle information.

- CIGNA HealthCare
- Kaiser Permanente
- CareFirst BlueCross BlueShield Dental/Vision
- Benefit Strategies LLC
- CIGNA Behavioral Health EAP
- Nationwide Retirement Solutions

The Open Enrollment Meetings listed below are for benefits effective January 1, 2017 and will take place at the following locations and times:

LOCATIONS	TIMES
Wednesday, Oct 12, 2016 – Historic Courthouse 1st Floor	10:00 a.m. to 2:00 p.m.
Thursday, Oct 13, 2016 – CCBC Dundalk Campus	10:00 a.m. to 2:00 p.m.
Thursday, Oct 13, 2016 – Oregon Ridge Lodge	10:00 a.m. to 2:00 p.m.
Friday, Oct 14, 2016 – Public Safety Building, 4th Floor	10:00 a.m. to 2:00 p.m.
Tuesday, Nov 1, 2016 – Historic Courthouse 1st Floor	10:00 a.m. to 2:00 p.m.
Wednesday, Nov 2, 2016 – Oregon Ridge Lodge	10:00 a.m. to 2:00 p.m.
Thursday, Nov 3, 2016 – Public Safety Building, 4th Floor	10:00 a.m. to 2:00 p.m.

Meeting Location Addresses:

Historic Courthouse: 400 Washington Ave, 1st Floor, Towson, MD 21204

Public Safety Building: 700 E. Joppa Rd, 4th Floor, Towson, MD 21286

Oregon Ridge Lodge: 13401 Beaver Dam Road, Cockeysville, Maryland 21030

CCBC Dundalk Campus: 7200 Sollers Point Road, Baltimore, MD 21222
(Wellness & Athletics Center- Building H)



Baltimore County Office of Budget and Finance

Insurance Division

400 Washington Avenue, Towson, MD 21204