2017 Active Employee 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:
Insurance Division, Office of Budget and Finance 400 Washington Ave., Rm 111 Towson, MD 21204 **Phone: (410) 887-2568 or (800) 274-4302** **Fax: (410) 887-3820** **MAIL STOP 2105** **Email: bcbenefits@baltimorecountymd.gov** **Internet: www.baltimorecountymd.gov/benefits** **Intranet: bcnet**	■ Who is eligible for County health plan coverage ■ General benefit questions ■ Changes in family status affecting benefits ■ Changes to life insurance beneficiaries ■ Assistance with benefits elections when retiring ■ Continuing benefits under COBRA if you or your dependent(s) lose County benefits ■ Flexible Spending Accounts (FSA) ■ Enrollment and ESS questions ■ Life status changes–i.e. marriage, divorce, birth, adoption, death of dependents, loss of dependent status
Baltimore County Retirement Office 400 Washington Ave., Rm 169 Towson, MD 21204 **Phone: (410) 887-8246 or (877) 222-3741**	■ Questions about your pension benefits ■ Questions about who you designated as your retirement beneficiary ■ Requests for retirement conferences ■ Changes to your address or other retirement information on file ■ Life status changes - i.e. marriage, divorce, or death of dependent spouse or other retirement beneficiary
Baltimore County Pay Systems Administration 400 Washington Ave., Rm. 169 Towson, MD 21204 **Phone: (410) 887-2420**	■ Questions about your pay deductions ■ Changes to your tax withholding amounts ■ Changes to your direct deposit designation
Baltimore County Office of Human Resources 308 Allegheny Ave Towson, MD 21204 **Phone: (410) 887-3120** **Fax: (410) 887-6073** **MAIL STOP 62**	■ Coordination of leave status ■ Family and Medical Leave Act (FMLA) ■ Other Paid/Unpaid Leaves of Absence
Baltimore County Employee Assistance Program (Administered by Cigna Behavioral Health) **Phone: (888) 431-4334** **www.cignabehavioralhealth.com (password: baltimore)**	■ Assistance with short-term, confidential, no-cost counseling for mental health, substance abuse and/or other work or family issues

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
The Open Enrollment period is from October 11th through November 11th. Benefit changes and FSA re-enrollment must be completed on-line at **www.baltimorecountymd.gov/mybenefits** by November 11, 2016. Changes will be effective January 1, 2017.

Health Insurance Eligibility

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

Life Insurance Eligibility

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

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 employee or spouse's child by birth or legal adoption recognized under Maryland law
  - A child under testamentary or court appointed guardianship recognized under Maryland law who resides with the employee or spouse
  - A child who is the subject of a Qualified Medical Child Support Order (QMCSO) that creates the right of the child to receive health insurance benefits under an employee or retiree's coverage.

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

Coverage Changes During Open Enrollment

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

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

Open Enrollment Online Options

- Information about Open Enrollment can be found on the County's internet website **www.baltimorecountymd.gov/benefits** or the County's intranet **bcnet**.
- 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.

Family Status Changes

The County plans qualify for tax-favored treatment by the IRS. As such, the IRS requires that enrollment in the plans be in effect for the entire 12 month plan year. ***If you have a Family Status Change, you must notify the Insurance Division within 31 days of the event.***

Changes During the Year

Basic Rules of Baltimore County's Benefits Program

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

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

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

If you experience a qualifying family status change, any change you make to your benefits must be "on account of and consistent with the lifestyle change." For example, if you get married or have a child, you can add your new dependent to your plan and change the plan you chose during open enrollment.

When You Must Contact Baltimore County's Insurance Division

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

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

- Birth or adoption – children must be added to your coverage within 31 days of birth or adoption.
- Marriage, Divorce or Legal Separation
- Loss of dependent child status – child is reaching age 26
- Loss or gain of other coverage due to a change in employment status (i.e. changing from full-time to part-time status)
- You move to a new residence outside Maryland that is not included in your current plan's coverage area.
- If you or your dependents become eligible for Medicare contact the Insurance Division for coordination of benefits information.

Effective Dates For New Employees During the Plan Year

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

Continuation of Coverage While on an Approved Leave of Absence

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

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

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

Continuing Benefit Coverage When You Leave Baltimore County

Continuing Coverage After Employment Ends

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

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

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

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

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

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

Continuing Coverage Upon Retirement

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

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

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

Creditable Coverage for Medicare Eligible Active Employees

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

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

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 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.

Learn skills at your own pace online :

- Identify triggers to better cope with and reduce stress
- Improve your sleep
- Increase your physical activity and improve your nutrition.

One phone call lets you:

- Get information to better understand your treatment options - so you and your doctor can choose what works for you.
- Understand preventive screenings and annual exams to meet your needs and preferences.
- Know what to expect and how to prepare if you need to spend time in the hospital or need surgery.
- Get answers to questions about your benefits and finding your way through the health care system.
- Access support 24-hours-a-day when you need help understanding treatment options. For example, how to treat your child's high fever.

Here is one number you need to know:
1.877.459.6150 for your health needs or myCigna.com

GO YOU®

Cigna®

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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 – 34 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 34-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.

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

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.

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 Pharmacy℠. 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 Play™.

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 (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 Play™.

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 (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 practice exclusively in the Kaiser Permanente member centers or from a network of almost 12,000 community physicians who practice in the District of Columbia and Maryland, including Howard and Baltimore counties. It is important that you choose a PCP when you enroll, as this doctor will act as your good-health advocate and coordinate your care.

Kaiser Permanente Physicians

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

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

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

If you do not choose a PCP on your own when you enroll, Kaiser Permanente will choose one for you by selecting a physician from a medical center located close to your home. If you decide that you do not like the PCP selected for you or the one you have chosen for yourself, you may change your physician for any reason at any time. To change your physician, simply contact the Kaiser Permanente member services department 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).

Plan Options for Active Employees

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

Plan Facts	Cigna Open Access Plus In-Network (OAPIN)
Member services	**(800) 896-0948**
Group Number	**3333726**
COST SHARING LIFETIME LIMITS	
Calendar Year Deductible	$0 Individual / $0 Family
Calendar Year 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)		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

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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) In-Network	Cigna Open Access Plus (OAP) Out-of-Network	Kaiser Permanente HMO
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% per visit after the deductible is met	$10 copay applies
PCP $15 / Specialist $25 copay	You pay 25% / Plan pays 75% after the deductible is met	$10 copay applies
You pay 5% / Plan pays 95% after the deductible is met	You pay 25% / Plan pays 75% after the deductible is met	$10 copay applies
You pay $25 per visit	You pay 25% / Plan pays 75% after the deductible is met	$10 copay applies
You pay 5% / Plan pays 95% after the deductible is met	You pay 25% / Plan pays 75% after the deductible is met	$10 copay applies for office visit

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

Cigna Open Access Plus (OAP) In-Network	Cigna Open Access Plus (OAP) Out-of-Network	Kaiser Permanente HMO
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

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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% *(Includes Air Ambulance when medically necessary)*
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	Cigna Open Access Plus (OAP) 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 *(Includes Air Ambulance when medically necessary)*	You pay 5% / Plan pays 95% after the deductible is met *(Includes Air Ambulance when medically necessary)*	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 Options – Highlights

Cigna Dental Care is a Dental Health Maintenance Organization (DHMO).

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

Plan Highlights

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

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

CareFirst BlueCross BlueShield Traditional Dental Plan

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

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

CareFirst BlueCross BlueShield Preferred Dental PPO

The CareFirst BlueCross BlueShield Preferred Dental PPO Program offers two levels of benefits in one plan. When you need dental care, you may see the dentist of your choice. Benefit levels and out-of-pocket expenses are determined based upon whether you receive dental care from a preferred dentist. Some of the features include:

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

In-Network Benefits

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

Out-of-Network Benefits

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

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

Baltimore County Dental Benefits Summary

	CF Traditional Dental	CF Preferred Dental PPO		Cigna DENTAL DHMO
Covered Service	Participating or Non-Participating*	In-Network (Preferred)	Out-of-Network	In- Network Only
Deductible per Calendar Year	$100 Per person $200 Per family	$100 Per person $200 Per family	$100 Per person $200 Per family	$0
Maximum Benefit per Calendar Year	$1500 Per person	$1000 Per person		Unlimited
	Plan Pays	**Plan Pays**		**Member Pays**
Preventative Care, Exams, Cleanings, X-Rays, Fluoride	100% when using a participating provider (Non-participating providers can bill the balance)	100%	80%	$5
Restorative Care, Fillings, Crowns, Root Canals	80% after deductible*	80% after deductible	60% after deductible	$5 to $225 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.

Employee Assistance Program (EAP)

Baltimore County's EAP services are administered by Cigna, and are available to County employees working 26+ hours per week and their household members. 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 eligible 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

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
Tower Collection Frames (Fashion)	$10	N/A
Tower Collection Frames (Upgrade)	$30	N/A
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)

*You are responsible for all charges for services received out-of-network and must file a claim for reimbursement to Davis Vision.

** 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)

$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	Retailers with selection of frames
Independent providers will offer the exclusive Tower Collection. You will pay: • $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	National retailers will offer their own selection of frames. • 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.
• 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.***

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**

BlueVision Discounted Rates on Special Services

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

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

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.

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.

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

Flexible Spending Accounts

Baltimore County uses the services of Benefit Strategies LLC to administer our Flexible Spending Accounts. There are two types of FSA accounts: Health Care Flexible Spending Account (Health FSA) for your out-of-pocket medical, prescription, dental, vision and hearing expenses and Dependent Daycare Flexible Spending Account (Dependent Care FSA) for your expenses related to dependent day care such as after school child care.

Why enroll in an FSA?

- **Give yourself a raise! Increase your spendable income by reducing the amount you pay in taxes.** FSA participants save approximately $27 in taxes for every $100 they set aside in an FSA.
- **Easily budget for the cost of health care expenses.**

Understanding the Health FSA

Health FSA funds can be used for health care expenses incurred by:

- You, your spouse, and your dependents up to age 26

Eligible expenses include associated costs with medical, prescription, dental, orthodontia, vision and hearing services. Refer to Health FSA Eligible Expense List later in this guide for a list of common eligible items, or view an expanded list on benstrat.com.

Understanding the Dependent Care FSA

Dependent Care FSA funds can be used for dependent care expenses you incur so that you (and your spouse if married) can be gainfully employed or attend school full-time.

To be eligible, the dependent must be your tax dependent who is:

- Under the age of 13
- Age 13 or older if physically or mentally incapable of self-care and residing in your home at least half the year

Eligible Providers and Settings:

- Day care centers and nursery schools
- Summer day camps
- Before/After school programs
- Babysitters including nannies, inside or outside the home (Relatives must be over 19 and not able to be claimed on your federal tax return. Non-relatives can be under the age of 19).
- Adult day care centers

Ineligible expenses include kindergarten, private school tuition, educational classes, and overnight camps.

As funds accumulate in your Dependent Care account through payroll deductions, you can submit for reimbursement.

Dependent Care FSA compared to IRS Child Care Credit:

- In most cases, a combined family Adjusted Gross Income of $40,000 and higher will see a greater tax savings through a Dependent Care FSA than the IRS Child Care Credit. A Dependent Care FSA and IRS Child Care Credit Comparison Chart can be found at benstrat.com. Consult with a tax advisor for details on your particular tax situation.

Example of Tax Savings Through a FSA	Before Enrolling in a FSA	After Enrolling in a FSA
Annual Earnings	$36,000	$36,000
Annual FSA Election Amount	-0-	-$1,500
Taxable Income	$36,000	$34,500
Approximate taxes paid (27.65%)	-$9,954	$9,539
Annual tax savings/increase in spendable income by enrolling in an FSA:		$415

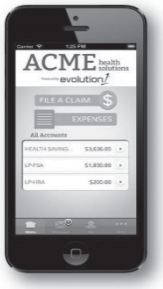
Flexible Spending Accounts – *continued*

Here's how it works:

1. **Decide if you want to enroll in the Health FSA, the Dependent Care FSA, or both.**
2. **Determine how much you spend annually on health care and dependent care expenses. (January 1st through December 31st and the grace period January 1st through March 15th of the following year).** Use the Election Worksheet and Eligible Expenses handout or the Tax Savings Calculator on www.benstrat.com to help determine your expenses.

   Note: The maximum Healthcare election for the upcoming plan year is $2,550. The maximum Dependent Care election for the upcoming plan year is $5,000.

   Important: Because you are receiving pre-tax treatment on the FSA funds, IRS regulations require that funds be spent within the time frame your plan specifies or you lose access to them. Make a conservative election; only consider expenses you and your family expect to incur.
3. **Enroll online at www.baltimorecountymd.gov/mybenefits by entering the total amount of your election on the appropriate enrollment screen. Your biweekly deduction will be calculated for you based the remaining pay periods in the plan year.** This amount is payroll deducted each pay period on a pre-tax basis throughout the year. **You are required to re-enroll during open enrollment each year if you want to participate in one or both FSA plans for the new benefit year.**
4. **Access your FSA funds throughout the plan year to pay for eligible expenses.**
   - Use the FSA debit card
   - Submit for reimbursement through the quick and convenient reimbursement methods. Reimbursements are made payable to you, either by paper check or direct deposit.



Use It or Lose It Rule

The amount you elect in your FSA account(s) must be spent for qualified expenses you have during the plan year plus an additional 2½ month period after the plan year ends. **(January 1st through December 31st and the grace period January 1st through March 15th of the following year).** Claims for expenses incurred during the allowed period must be submitted for reimbursement no later than April 30th following the plan year.

Coverage upon Termination of Employment

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

Annual Enrollment Required

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

Flexible Spending Accounts – *continued*

Using Your FSA Funds

Health FSA Funds: Your full election amount is available on the first day of the plan year.

Dependent Care FSA Funds: Your funds are available as they accumulate through payroll deductions.

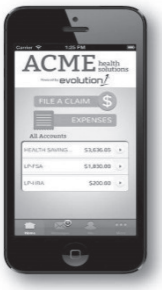
The FSA Card

It may look like a typical debit or credit card, but the FSA card is a special benefits card pre-loaded with your full annual Health FSA election amount. You use the card to pay for IRS qualified expenses directly at the point of sale or when paying a bill. The card works in settings such as physician offices, dental and orthodontic offices, optometrists, pharmacies, chiropractors, urgent care centers, and hospitals*.

- Two identical cards are mailed to your home address and additional sets of cards can be ordered.
- The IRS requires you keep all original documentation** for purchases associated with the FSA debit card. Benefit Strategies may also request copies of your documentation to verify a debit card purchase.

**If you are enrolled in the Dependent Care FSA, the card can also be used in dependent care settings. Just remember that the card will only work for an amount that does not exceed the available balance in your Dependent Care FSA account on that day.*

Electronic and Paper Reimbursement Methods – 3 to 5 day typical turnaround time

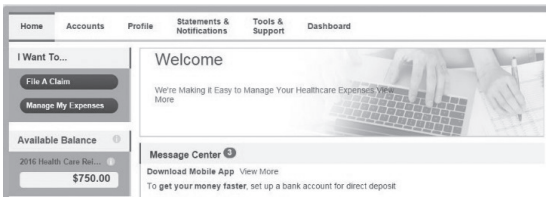


Reimbursements are made payable to you, either by paper check or direct deposit. All reimbursement methods require you to submit documentation.**

- Submit on-line through your secure account at benstrat.com
- Download the Benefit Strategies mobile application to submit through your mobile device
- Complete a paper claim form to submit via fax, secure email, or mail

***To be valid, documentation must include: date the expense was incurred, patient name (if applicable), amount of the expense after any insurance adjustment, provider name, service/product description.*

FSA Account Resources



Your on-line account at benstrat.com

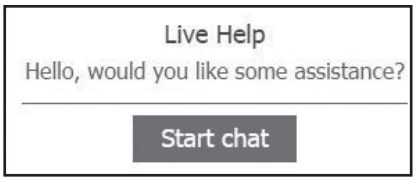
Through your secure on-line account at benstrat.com you can file for reimbursement, upload documentation, set up text message alerts, view claims history, account balances, filing deadlines, participate in Live Chats, and more.

Benefit Strategies Mobile Application

Download our mobile application for iPhone, Android and tablet devices to access account information on the go, including filing claims. Use your device's camera to photograph your documentation and upload it through the application!

Customer Relations Team

- 1-888-401-FLEX (3539) or info@benstrat.com
- Monday - Thursday 8:00 AM - 6:00 PM ET; Friday 8:00 AM - 5:00 PM ET
- Automated system available through our toll free number at all times
- Please visit our website at benstrat.com



Flexible Spending Accounts – *continued*

Health FSA Eligible Expense List

Visit benstrat.com for an expanded list of eligible expenses. If you have questions on what constitutes an FSA eligible expense, please contact our Customer Relations Team: 1-888-401-FLEX (3539) or info@benstrat.com.

Ace bandages
Acne treatments*
Acupuncture
Allergy and sinus medicine*
Antacids and digestive aids*
Antibiotic ointments*
Antifungal and anti-itch*
Aspirin and other pain relievers*
Asthma medicine*
Athletic treatments*
Band-aids
Blood pressure monitors
Canker and cold sore remedies*
Chest rubs*
Chiropractic care
Cholesterol meter test kit and supplies
Cold and fl u medicines*
Contact lenses
Contact lens cleaning solution
Coinsurance
Copays
Corn and callus removers*
Cough medicine*
CPAP machine
Crutches, canes and walkers
Deductibles
Dental care (routine and corrective)
Dentures
Diabetic monitors and supplies
Diaper rash ointments*
Eye exams
Eye glasses
Eye related equipment
Fertility monitors
First aid kits
Gastrointestinal medication*
Genetic testing**
Glucosamine*
Group therapy
Hearing aids and batteries
Hearing care
Herbal medicine**
Hospitalization costs
Hypnosis – treatment of illness
Immunizations
Imaging scans
Incontinence supplies
Individual therapy
Laboratory fees
Lasik eye surgery
Laxatives*
Lice treatments*
Massage therapy**
Medical equipment
Medical monitoring and testing
Mileage to receive medical care
Motion and nausea medicine*
Nutritional supplements**
Orthodontia
Orthopedic and surgical supports
Orthotics
Physical exams
Physical therapy
Physician services
Pregnancy tests
Prescription drugs
Psychoanalysis and mental health therapy
Reading glasses
Sleep aids*
Smoking deterrents*
Sunscreen (SPF 30 and higher)
Thermometers
Toothache gels*
Urological products
Vision care
Vitamins**
Wart removal treatment*
Weight loss drugs and programs**
Wheelchairs and repairs

Examples of ineligible expenses include: Cosmetic surgery and procedures (including teeth whitening); Custodial nursing care; Dental hygiene products; Health club dues; Insurance premiums.

** Although Over-The-Counter (OTC) medicines and drugs do not need a prescription to be purchased, one is needed for an OTC medicine/drug to be FSA eligible. See note below.*

***Dual Use items and services are those that can be used for general health as well as to treat an illness or physical defect. If the item/service is prescribed to treat an illness or physical defect, a Physician Statement form needs to be submitted to Benefit Strategies for it to be FSA eligible. This form can be found on benstrat.com, or by contacting our Consumer Relations team. See note below.*

NOTE: *OTC Medicines/drugs and Dual Use items/services will not work with the FSA card. You will need to pay with another means and submit for reimbursement through one of our reimbursement methods. Remember to submit the prescription or Physician Statement, along with the purchase documentation.*

Life Insurance

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

Eligibility

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

Basic Life Insurance

Effective January 1, 2014, all eligible employees were automatically enrolled in Basic Life Insurance. New hires will be automatically enrolled with The Standard effective the 1st of the month following date of hire. You may decline this coverage at any time by visiting **www.standard.com/enroll.** Please note that once you decline the Basic Life Insurance, you will need to provide Evidence of Insurability if you decide to re-enroll at a later date.

Additional Life Insurance

Employees may enroll, cancel, increase, or decrease the amount of Additional Life Insurance by completing an enrollment online at **www.standard.com/enroll**. New employees that would like to enroll in the Additional Policy may do so within the first 31 days of hire without proof of Evidence of Insurability. All late applicants and requests for increases are subject to medical underwriting approval after providing Evidence of Insurability.

Basic Life Insurance

Benefit Amount

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

Employee Rate / County Subsidy

The cost is shared by you and the County. The County subsidizes the Basic Life Insurance as outlined below. Effective 01/01/2017, the total premium is $.55 per $1,000 of coverage.

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

Example of employee with 80% Subsidy

80% Subsidy – Employee Rate = $.11 per $1,000

$50,000 salary / $1,000 =	**50**
$.55 rate x 20% EE share =	**x $.11**
Monthly Payroll Deduction	**$5.50**

Additional Life Insurance Plans

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

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

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

Additional Life Insurance with Age-Banded Rates

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

Additional Life Insurance Rates

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

Features of All County Life Insurance Plans

- **Accelerated Death Benefit:** If you become terminally ill as a result of an illness or physical condition which is reasonably expected to result in death within 12 months, you may have the right to receive a portion of your insurance as an accelerated benefit within your lifetime. You must apply and may receive up to 75% of your insurance. The minimum accelerated benefit is $5,000 or 10% of your insurance, whichever is greater. There are no restrictions on how this money can be spent, and no fees will be charged.
- **Portability:** If your coverage ends because your employment terminates, you may buy a term life policy. You must be under age 65, able to be gainfully employed and meet minimum coverage requirements. You must

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

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

How Do I Change My Beneficiary Election?

You may designate or update your life insurance beneficiary information quickly and easily at **www.standard.com/enroll**. If you have not already established an online account, simply click "**Need A Login?**" and follow the instructions to create your account with The Standard. To begin the designation process, 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 888-623-0622, Monday-Friday, 8:30 am-6:30 pm EST.

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

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

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

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

You do not have to enroll. As a participant in your Baltimore County's Group Life insurance coverage from The Standard, you and your family members are automatically covered. All services are provided by Standard Travel Assistance and are available 24 hours a day, every day. Contact Standard Travel Assistance at 1.800.527.0218.

Standard Travel Assist offers the following services:

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

Deferred Compensation for Baltimore County Employees

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

What is Deferred Compensation and how can it benefit me?

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

How a little can mean a lot

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

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

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

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

Participating is easy

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

- Visit **www.baltimorecountydc.com** to enroll, change your deferral allocation or current investment, and receive financial information and education.
- Contact a Direct Access Retirement Specialist between 8 a.m. and 11 p.m. EST at (877) NRS-FORU (677-3678).
- Use the NRS automated telephone service anytime day or night to process an exchange or allocation change, and check your account balance: 877-NRSFORU (877-677-3678).

For more information

Contact Kevin McQuarrie, your local Retirement Specialist, at (410) 519-3416 or email mcquark@nationwide.com.

Securities offered through Nationwide Investment Services Corporation, member NASD. In Michigan only: Nationwide Investment Svcx. Corporation.
Information provided by retirement specialists is for education purposes only and is not intended as investment advice NRS00677 (03/02)

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
- 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 gaveauthorization, 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:

Rebecca Ellis
Health Insurance Administrator
400 Washington Ave, Rm 111
Towson, MD. 21204
410-887-2568

Effective Date.

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

How to Contact Your Benefit Plans Directly

	Plan Name	Customer Service Number	Website
MEDICAL	Cigna Open Access Plus (OAP) Cigna Open Access Plus In-Network (OAPIN) Cigna Medicare Surround	1-800-896-0948	www.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	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	1-800-777-7902	www.kp.org
DENTAL	CareFirst BCBS Traditional Dental CareFirst BCBS Dental PPO	1-866-891-2802	www.carefirst.com
	Cigna Dental Plan (DHMO)	1-800-896-0948	www.mycigna.com
MENTAL HEALTH	Cigna Open Access Plus OAP and OAPIN	1-800-896-0948	www.mycigna.com
	Kaiser Permanente HMO	1-866-530-8778	www.kp.org
EAP	Cigna Behavioral Health	1-888-431-4334	www.cignabehavioral.com (password: baltimore)
VISION	CareFirst BCBS Davis Vision	1-800-783-5602	www.carefirst.com
FSA	Benefit Strategies LLC Health and Dependent Care Flexible Spending accounts	1-888-401-FLEX (3539)	www.benstrat.com
LIFE INSURANCE	The Standard	1-866-623-0622	www.standard.com/enroll
Deferred Compensation	Nationwide Retirement Solutions Kevin McQuarrie	410-519-3416	www.baltimorecountydc.com

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

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