



Howard County Public School System

Benefits Enrollment Guide for Active Employees

Plan Year January 1, 2012–December 31, 2012

Table of Contents

Open Enrollment Timeline	1
Letter from the Benefits Office	2
Important Things to Remember	6
Quick Enrollment Reference Guide	7
General Open Enrollment Information	8
Special Enrollment Period	11
Continuation of Coverage (COBRA)	13
“Old” Program	16
Employee Wellness Program	17
Virgin HealthMiles	19
Aetna Open Choice PPO Medical Plan	20
Open Access Aetna Select HMO Medical Plan	24
CareFirst BlueChoice HMO <i>Open Access</i> Medical Plan	28
Medical Benefits PPO Benefit Chart	31
Medical Benefits HMO Benefit Comparison Chart	35
Prescription Drug Coverage—Express Scripts	39
CIGNA Dental Care	42
Delta Dental PPO Plan	43
Vision Service Plan (VSP)	45
Life & Accidental Death & Dismemberment Insurance	49
Aflac Group Critical Illness Including Cancer	51
Short Term Disability Benefits	52
Long Term Disability Benefits	53
Flexible Spending Accounts (Dependent Care and Health Care)	54
Medical Rates	59
Dental and Vision Rates	61
Benefits Open House Dates	62
Notice of Privacy Policy and Practices	63
HCPSS Important Contacts	68
Benefits Plan Contact Information	69
Glossary of Terms	70

2012 Benefit Plan Choices

Medical Plans	Dental Plans	Vision Plans	Flexible Spending Accounts
Aetna Open Choice PPO	CIGNA DHMO	Vision Service Plan (VSP)	Health Care Account
Open Access Aetna Select HMO	Delta Dental PPO		Dependent Care Account
BlueChoice HMO Open Access			

ReliaStar	AFLAC	The Standard
Basic Life	Critical Illness including Cancer	Short Term Disability
Supplemental Life/AD&D		Long Term Disability
Whole Life/Long Term Care Rider		
Accident		

Open Enrollment Timeline

Important Dates	Open Enrollment Activity
October 3 – 31, 2011	Open Enrollment Period–All active employees must re-enroll in benefit programs (except for Basic Life, Supplemental Life, Whole Life with LTC, and LTD) online at https://hcpss.hrintouch.com .
October 12, 2011 October 18, 2011 October 26, 2011	Benefits Open House–Central Office in Board Rooms A&B from 12:30 p.m. – 6:00 p.m. Plan representatives and Benefits staff will be present to answer any questions.
October 31, 2011	Open Enrollment Ends–All benefit choices must be completed online.
January 1, 2012	Benefit Plan Elections Take Effect.
January 6, 2012	Payroll Deductions Begin – Deductions are taken over 20 pay periods.

The purpose of this Open Enrollment Guide is to give you basic information about your benefits 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 Certificates of Coverage provided by your health plan carriers for important additional information about the plans. Every effort has been made to make the information accurate; however, in the case of any discrepancy, the provisions of the legal documents will govern.

Letter From The Benefits Office

TO: HCPSS Employees Eligible for Benefits
FROM: Benefits Office
RE: Annual Open Enrollment for Group Benefit Plans—
Plan Year 2012
October 3, 2011 – October 31, 2011

It's open enrollment time! **The Annual Open Enrollment Period is October 3–October 31, 2011.** During this time, we recommend you review the benefits being offered by HCPSS and the plans you are enrolled in to determine if you should make any changes. The Benefits Enrollment Guide highlights the array of benefits available to employees.

Benefit Plan Changes *Choices Effective January 1, 2012*

Howard County Public School System is committed to offering quality health plans for HCPSS employees, retirees, and their families while considering the best value for Howard County. Recently, HCPSS conducted competitive bids for our medical, prescription, dental, and vision plans as well as voluntary benefits and wellness. The following describes the outcome of that process and provides a brief description of the plans that are effective January 1, 2012. The Open Enrollment for these plans will be October 3 through October 31, 2011. You will receive additional details regarding Open Enrollment including complete descriptions of each plan and monthly rates in the Open Enrollment Guide.

We are pleased to announce that Aetna, Inc. and Carefirst Blue Cross Blue Shield will remain plan options for Howard County Public School System. As an employee or retiree, you'll be offered a Health Maintenance Organization (HMO) and a Preferred Provider Organization (PPO) from Aetna and an HMO from Carefirst. All active employees and retirees can now enjoy two choices for open access medical coverage with no referral required to see a specialist. With Aetna and Carefirst you will get access to live customer service representatives and registered nurses. Nurses are available to talk with you twenty-four hours a day, seven days a week. In addition, you will have access to health and wellness programs including discounted services.

HCPSS will also change our online Benefits Administration System from Benelogic to Benefit Focus for the 2011 Fall Open Enrollment for all benefits effective January 1, 2012.

You will receive specific instructions in the Open Enrollment Guide on how to enroll in benefits through the Benefit Focus on-line system – HR Intouch.

All eligible employees **must re-enroll** in all of the benefit plans with the exception of Basic Life, Whole life with Long Term Care Rider, Supplemental Life Insurance and Long-term disability. **If you do not re-enroll, your coverage(s) will be considered waived.**

Learn More about AETNA and Carefirst below and at HR Intouch

You can learn more about Aetna and Carefirst by viewing informational videos and other benefits information by visiting our new on-line enrollment system <https://hcpss.hrintouch.com> beginning October 3, 2011.

Medical Plans

Open Access Aetna Select HMO and BlueChoice HMO Open Access

Aetna and Carefirst will remain our Open Access HMO providers. You will still enjoy the open access coverage you have come to enjoy with no need to get a referral to see a specialist. The plan co-pays will remain the same with a \$10 co-pay for primary care physicians and a \$15 co-pay for specialists. Over 96 percent of Aetna's nationwide provider network and Carefirst's regional provider network match the list of healthcare providers that our members currently use.

Aetna Open Choice PPO Plan

Aetna will remain the provider for our PPO. The PPO is very similar to the Open Access Aetna Select HMO with no need to select a primary care physician and no need to get a referral to see a specialist. However, the PPO allows for out-of-

Letter From The Benefits Office *(continued)*

network coverage should you need to see a doctor outside of the network. The plan co-pays will be \$15 for primary care and \$20 for a specialist. To view the Aetna provider directory, visit www.aetna.com, enter your doctor's name or zip code, and select Open Choice PPO for the type of plan.

To view the provider directory, visit www.aetna.com or www.carefirst.com.

Important: United Health Care, Kaiser, NCAS Traditional Plan, and NCAS Alternate medical plans will no longer be available.

Prescription Plan

Prescription Coverage for the Aetna Select Open Access HMO, Aetna Open Choice PPO, and Carefirst Open Access HMO Plan

Express Scripts will now be the Pharmacy Benefit Manager for HMO and PPO plans. The Prescription Drug co-pays for the HMO participants will remain at \$5 for generic, \$10 for Brand Formulary, and \$25 Brand Non-formulary for a one month supply. The Prescription copays for the Aetna PPO participants will remain at \$10 for generic, \$20 for Brand Formulary, and \$35 for Brand Non-formulary. If you would like to confirm the co-pays for your medication(s) you may call 1-877-866-5859.

Dental Plans

Delta Dental PPO

HCPSS will continue to offer the Delta Dental PPO Plan. The Delta Dental PPO has a national network of dentists with no need to select a primary dentist. With this plan each enrolled family member receives up to \$2,000 for PPO and Premier providers in paid benefits per calendar year. When you use a provider with in the PPO network, you receive the highest level of coverage with the least amount of out-of-pocket expenses. To view the Delta dental PPO provider directory visit www.deltadentalins.com, select Find a Doctor, select Dental, and select Preferred Dental PPO or contact Member Services at 1-800-932-0783. You may choose to use dentists outside of the network, but your costs may be higher.

CIGNA Dental Care HMO

HCPSS has added Cigna Dental Care HMO as a dental HMO option for HCPSS employees beginning January 1, 2012. This plan provides low out-of-pocket costs and no claim forms. You can get up to two free dental cleanings a year, and two more at a minimal co-pay. You'll also receive a Patient Charge Schedule, which lists all of the dental procedures covered by your plan, and any out-of-pocket costs you may run into. With CIGNA we will now enjoy National Network of DHMO providers. You will need to select a primary care dentist (PCD). If no PCD is selected one will be chosen for you. You are responsible for staying in the network. To view the CIGNA DHMO provider directory, visit www.cigna.com, select on the provider directory and indicate that you are looking for a Dentist. Enter your zip code, select the CIGNA Dental Care HMO as your plan and hit search. You may call the CIGNA pre-enrollment information line at 1-800-244-6224 for information on plans details and assistance in identifying dentists in the plan.

Important: NCAS dental plans will no longer be available. In addition, there will no longer be discounted dental available through the Carefirst Blue Choice Open Access HMO Medical plan option.

Vision Plan

VSP (Vision Service Plan)

VSP a leading administrator of vision benefits programs nationwide, will continue to provide HCPSS vision coverage. VSP has a strong network of VSP Preferred Providers. In addition, VSP has retail chain affiliate providers such as Costco Optical locations, Vision Eyecare Centers of America, and point-of-service retail centers (Wal-Mart). Should you choose to visit an eye care professional not in the network, you will still receive coverage; however, your out-of-pocket costs will be higher than if you had visited a network provider. To view the VSP provider directory visit www.vsp.com, select Find a Doctor, select Vision, select VSP Vision, and enter your zip code or contact or contact VSP vision at 1-800-877-7195.

Letter From The Benefits Office (*continued*)

Voluntary Benefits

Life Insurance

ReliaStar Life Insurance Company is the Life Insurance carrier for Basic and Supplemental Term Life Insurance. For a complete description of our Life Insurance plans, review the Life Insurance Section in the Open Enrollment Guide.

Whole Life Insurance with Long Term Care Rider

To enroll in Whole Life Insurance with Long-Term Care rider, please contact The Farmington Co at 1-800-621-0067. The open enrollment period for this benefit is October 3 through October 31, 2011.

Supplemental Life Insurance

Active employees may enroll, cancel, increase, or decrease the amount of supplemental term life insurance online through Benefitfocus during the 2011 Open Enrollment. All late applications and requests or increases in benefits are subject to medical underwriting approval.

Accident Coverage

For plan year 2012, accident coverage will be offered through ING. Employees currently enrolled in Aflac's accident coverage will no longer have payroll deduction starting the first pay in January 2012. Employees may enroll for accident coverage online through Benefitsfocus.

Short Term Disability

For plan year 2012, Short Term Disability coverage (STD) will be offered through The Standard. Employees who are currently enrolled in Aflac's STD coverage will no longer have payroll deductions starting the first pay in January 2012. If you enroll in STD coverage during the 2011 open enrollment period, there will be no medical underwriting. There is no 10-month waiting period to receive benefits. Employees may enroll for short-term disability coverage online through Benefitfocus.

Long Term Disability Coverage

If you did not enroll in Long-Term Disability (LTD) at the time of hire, you may choose to enroll in LTD coverage offered through The Standard during the annual open enrollment. However, you will be required to mail a completed Medical History Statement to The Standard by November 30, 2011.

Employees will be able to download/print the Medical History Statement when enrolling in LTD coverage online through Benefitfocus. Once your application has been processed and reviewed by The Standard, you will receive a notification of approval/denial of LTD coverage. The deduction for LTD coverage will begin the first of the month following notification of approval from The Standard.

Premiums/Board Contributions

Medical premiums have increased due to rising cost of healthcare and utilization. The premiums for all dental and vision plans will remain the same for plan year 2011. The Board will continue to pay 87% of the monthly health premium for benefits eligible employees with a hire date on or prior to 06/30/2011.

All benefits eligible employees with a hire date on or after 07/01/2011 will receive a board contribution of 85% towards their monthly health premium.

Dependent Eligibility Audit

Employees who add new dependent(s) to their health benefits plans during the open enrollment period and through out the benefits calendar year as a result of a qualifying event will be required to provide verification of their newly enrolled dependent(s). The verification of eligible dependent(s) will be conducted by an independent third party that specializes in dependent validation. You will receive an information packet with instructions on how to submit verification materials and how to access their call center after the open enrollment period. The call center representatives will be available to assist you with dependent eligibility questions or questions about removing coverage for ineligible dependents.

Letter From The Benefits Office *(continued)*

Insurance Cards

All employees will receive new ID cards for medical, dental (Cigna) and prescription cards by January 1, 2012. You will only receive a new card for Delta Dental if you made any changes to your name or coverage level. Please note that there is no vision insurance card for the Vision Service Plan (VSP).

Benefits Open House Events

To learn more about the health, dental, vision, flexible spending accounts (medical and dependent care), disability, voluntary benefits, 403(b) tax sheltered annuity programs, and 457(b) deferred compensation program, please attend one of the Benefits Open House Events on the dates listed below.

Date	Time	Location
Wednesday, October 12th, 2011	12:30pm–6:00pm	Board Rooms A & B (Central Office)
Tuesday, October 18th, 2011	12:30pm–6:00pm	Board Rooms A & B (Central Office)
Wednesday, October 26th, 2011	12:30pm–6:00pm	Board Rooms A & B (Central Office)

Representatives from all of our plan providers will be present at the Benefits Open House Events to provide information and answer questions. In addition, the Benefits Office staff will be onsite to answer questions or to assist with enrollment.

During the Benefits Open House Events, employees will also have the opportunity to enroll in voluntary benefit plans offered through Aflac and Reliastar.

**The effective date for all coverage(s) is January 1, 2012.
The first deduction will begin January 6, 2012.**

Gina Doyle: (410) 313-6710 gina_doyle@hcpss.org
Cynthia Harrison: (410) 313-1564 cynthia_harrison@hcpss.org
Jeeni Griffin: (410) 313-6713 jeeni_griffin@hcpss.org
Fax: (410) 313-1531

Please review the Benefits Enrollment Guide carefully, and if you have any questions contact the Benefits Office. We will be happy to assist you.

New!—Benefit Support Center

The HCPSS Benefit Support Center (BSC) is designed to be your first point of contact for all your benefits needs. The BSC benefit administrators are able to provide assistance in three main areas:

- Benefit Questions
- Technical/Application Support
- Transfer/Redirect Support

Call the HCPSS Benefit Support Center toll-free at 1-855-859-0971, Monday–Friday, 8:00am – 8:00pm.



Important Things to Remember

Reminder: Please review your Benefit Focus elections and print a copy for your records.

- Open Enrollment Period is October 3–31, 2011.
- Review the Benefits Enrollment Guide for Important information/changes.
- All eligible employees must re-enroll in all of the benefits except for Basic Life, Supplemental Life, Whole Life with LTC, and LTD online at <https://hcpss.hrintouch.com>.
- To learn more about the benefits offered by HCPSS for health, dental, vision, flexible spending accounts, disability, voluntary benefits, 403(b) tax sheltered annuity programs, and the 457(b) deferred compensation program, please plan to attend one of our planned Benefits Open House Events, held at the Central Office Board Rooms A & B between 12:30pm–6:00pm on the following dates.
 - › Wednesday, October 12, 2011
 - › Tuesday, October 18, 2011
 - › Wednesday, October 26, 2011Carrier representatives will be present to provide information and to answer any questions. In addition, the Benefits Office staff will be onsite to answer questions or to assist with enrollment.
- To enroll in Whole Life Insurance with Long Term Care Rider contact The Farmington Co. at 1-800-621-0067.
- If you are an existing employee and you wish to enroll in (LTD) coverage offered through The Standard during open enrollment, you will be required to mail a completed Medical History Statement to The Standard by November 30, 2011. New hires will not be subject to the medical history requirement if they enroll within the first 30 days of HCPSS employment.
- Short term disability coverage offered through The Standard. If you enroll during the Open Enrollment period, coverage is guarantee issue.
- You DO NOT have to select a Primary Care Provider (PCP) for Open Access Aetna Select HMO Plan
- You MUST select a PCP for the CareFirst BlueChoice HMO *Open Access*
- Enter your life Insurance Beneficiary designations on Benefit Focus.
- Review you personal information (name, address, phone number, date of birth, etc) and update information if necessary.
- All medical, dental, vision, flexible spending accounts, disability, and voluntary benefits deductions are based on 20 pays.
- Dependent eligibility verifications will be required for any new dependents added to your benefits during open enrollment. You will receive a package with instructions for providing documentation.
- All benefits elections take effect on January 1, 2012.
- Payroll deductions begin January 6, 2012.

Please review the Benefits Enrollment Guide carefully, as it contains important information.

Quick Enrollment Reference Guide

To become covered by the plan, other than during Open Enrollment, **you must enroll online within 30 days from your hire date.**

Benefit options have changed for plan year 2012. All active employees MUST re-enroll in benefit programs (except for Basic Life, Supplemental Life, Whole Life with LTC, and LTD) online at <https://hcpss.hrintouch.com>.

How to Enroll in Benefits

- To enroll/waive/change/decline your benefits, go to <https://hcpss.hrintouch.com>.
- If you are logging in for the first time, you will need to register your account. To register, click on *Register or Reset Your Account* in the login box.
- If you have already registered, enter your User ID and password that you created upon registration to access, or choose *Register or Reset Your Account* if you have forgotten your login ID and password.
- After you have logged in to the site, click on *Enroll Now* to enroll in your benefits.
- You have completed your enrollment when you reach the big blue check mark.
- To view a summary of your elections, click on the *Employee Details Report*. This report is available to you online all the time simply by logging in and clicking on *Enroll Now*, or you may print it for your records.
- You may also print a beneficiary confirmation form for your records.



The Benefits Office staff is available to answer any questions and/or assist with online enrollment:

Monday–Friday 8:30 a.m.–4:00 p.m.

Phone: (410) 313-6710

(410) 313-1564

(410) 313-6713

HCPSS Benefits Support Center (BSC) representatives are available to help with online enrollment questions:

Monday–Friday 8:00 a.m.–6:00 p.m.

Phone Toll Free: 1-855-859-0971

Or visit us in the Benefits Office located at the Central Office.

General Open Enrollment Information

Eligibility

All Active Employees regularly scheduled to work at least 17.5 hours per week are eligible for the benefits. Food Service Workers regularly scheduled to work at least 15 hours per week are eligible. Any Employee working less than 15 hours per week is not eligible.

An Employee on an authorized leave-of-absence, as required by the Family and Medical Leave Act (FMLA) of 1993, shall be classified as eligible. The Employer will continue to pay its share of the premium as long as the Employee is on FMLA leave.

If an Employee qualifies as both an Employee and a Dependent, such person may be covered as an Employee or Dependent, but not as both. If both husband and wife are Employees, their children will be covered as Dependents of the husband or wife, but not of both.

Dependents

Eligible Dependents are:

- a. A Spouse—A husband or wife, of the opposite sex, under a legal marriage or qualified Same-Sex Domestic Partner;
- b. An unmarried/married Dependent child regardless of student status until the end of the birth month in which he or she reaches age 26;
- c. An unmarried/married Dependent child who is incapable of self-support because of mental retardation, mental illness, or physical incapacity that began before the child reached age 26. Proof of incapacity must be received by HCPSS within 30 days after coverage would otherwise terminate. Additional proof of disability may be required from time to time;
- d. Any child of a Participant who does not qualify as a Dependent under subsections b and c, solely because the child is not primarily dependent upon the Participant for support so long as over half of the support of the child is received by the child from the Participant pursuant to a multiple support agreement.

Dependent Eligibility Verification

Employees who add new dependent(s) to their health benefits plans during the open enrollment period and throughout the benefits calendar year as a result of a Qualifying Event, will be required to provide verification of their newly enrolled dependent(s). For a complete list of dependent verification documents/definitions of eligible dependent(s), please visit <https://hcpss.hrntouch.com>.

A Spouse or child in the armed forces of any country is not eligible for coverage.

If your dependent child is employed by HCPSS or any other company and is Benefits-Eligible, they must enroll for their own benefits. If they are currently enrolled on the employee's plan, they must be removed from coverage.

The term “**Dependent child**” means any of a Participant’s:

- a. Biological children;
- b. Legally adopted children or children placed in the Employee’s home pending final adoption;
- c. Stepchildren who permanently reside in the Employee’s household and are Dependent on the Employee for more than half of his or her support;
- d. Foster children (provided the foster child is not a ward of the state);
- e. Children who are under the legal guardianship of the Employee;
- f. Children for whom the Employee is required to provide health care coverage under a recognized Qualified Medical Child Support Order;
- g. Children of the Employee’s Same-Sex Domestic Partner who permanently reside in the Employee’s household and are Dependent upon the Employee for more than half of his or her support.

General Open Enrollment Information *(continued)*

The term “**Domestic Partner**” means a person of the same sex who:

- a. Has registered with the Employee as a Domestic Partner in a jurisdiction which allows for such registration; or
- b. Has shared the Employee’s permanent residence for no less than 12 months; and
- c. Is financially interdependent with the Employee and can provide documentation of at least two of the following: common ownership or lease-hold interest in property; common ownership of a motor vehicle; a joint bank or credit account, designation as a life insurance or retirement plan beneficiary, beneficiary in the Employee’s will; assignment of durable power of attorney; or any other proof deemed to show financial interdependence; and
- d. Is no less than 18 years old; and
- e. Is not a blood relative that would be prohibited by legal marriage; and
- f. Is not currently legally married to or separated from another person; and
- g. Has not applied under a health benefit program sponsored by any other Employer; and
- h. Would, if legally permissible, marry one another.

Cost of Coverage for Same-Sex Domestic Partnerships

The Employer portion of the premium for Domestic Partner coverage to coverage for a Domestic Partner is taxable income to the Employee and will be included as part of W-2 compensation and the Employee’s Domestic Partner’s portion of the premium will be paid with after tax dollars.

Age Limits

Dependent children are covered through the end of the birth month until age 26 for all medical, dental and vision plans. Please refer to page 8 for the definition of eligible Dependent.

Coverage Effective Date for Eligible Employees/Dependents

Coverage is effective on the first of the month following date of hire.

A Food and Nutrition service Employee’s coverage effective date is the first day of the month following the Employee’s completion of 30 days of continuous employment with HCPSS.

To become covered by the Plan other than during the Open Enrollment, **you must enroll online within 30 days from your eligibility date**. Please refer to page 7 for the Quick Enrollment Reference Guide.

Open Enrollment Information Online

Information about all benefit plans can be found on <https://hcpss.hrintouch.com>.

Changes to Benefits Coverage due to Qualifying Event

An Employee may change his election during the Plan Year when any of the following change in qualifying event:

- A change in employment status, including termination or commencement of employment the Employee, Spouse, or Dependent.
- The Employee or Spouse has a significant change in health coverage attributable to the Spouse’s employment.
- A reduction or increase in hours of employment by the Employee, Spouse, or Dependent, including a switch between part-time and full-time, a strike or lockout, or commencement or return from an unpaid leave of absence.
- A change in legal marital status, including marriage, death of Spouse, divorce, legal separation or annulment.
- A change in the number of Dependents, including birth, adoption, placement for adoption, or death of a Dependent.
- Your Dependent satisfies or ceases to satisfy the requirements for unmarried/married Dependents, due to attainment of age, or any similar circumstances as provided in the health plan under which the Employee receives coverage.

General Open Enrollment Information *(continued)*

- Health coverage is being offered through his/her employment.
- A change in the place of residence or work of the Employee, Spouse, or Dependent.
- A judgment, decree or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order) that requires accident or health coverage for an Employee's child. The Employee can change his election to provide coverage for the child if the order requires coverage under the Employee's plan; or, the Employee can make an election change to cancel coverage for the child if the order requires the former Spouse to provide coverage.
- Eligibility for Medicare or Medicaid (other than pediatric vaccines).

Employees must log on to the Benefit Focus website: <https://hcpss.hrintouch.com> to make any changes to existing coverage(s) due to a qualifying event, within 30 days of the qualifying event date.

Leave of Absence (FMLA)

If an eligible Employee takes FMLA leave, as defined by the Family and Medical Leave Act (FMLA), due to one or more of the following:

- a. The birth of a son or daughter of the Employee and in order to care for such son or daughter;
- b. The placement of a son or daughter with the Employee for adoption or foster care;
- c. To care for the Spouse, or a son, daughter, or parent, of the Employee, if such Spouse, son, daughter, or parent has a serious health condition;
- d. A serious health condition that makes the Employee unable to perform the functions of the position of such Employee;
- e. In addition, HCPSS will provide Military Family Leave in compliance with the National Defense Authorization Act. For more information contact Human Resources at (410) 313-6695.

If he or she terminates his or her coverage in the Plan due to "a"—"e", he or she will be able to re-enroll in the Plan within 30 days upon return to active employment at the conclusion of a period not to exceed that defined by the FMLA. This Employee will not be subject to Pre-Existing Waiting Period provisions.

Leave of Absence (Other than Family and Medical Leave Act Absence)

If an Employee does not qualify for FMLA and continues on an approved unpaid leave of absence, the Employee will be required to pay 100% of the Plan cost beginning the first of the following month after FMLA leave ends or the last day worked. Upon returning from an approved leave of absence, HCPSS will pay its share of the plan cost the first day of the month following the month in which you return to work.

Uniformed Service under USERRA

A Participant who is absent from employment with the Employer on account of being in "uniformed service" as that term is defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") may elect to continue participation in the Plan. The coverage period shall extend for the lesser of 24 months or until the Participant fails to apply for reinstatement or to return to employment with the Employer. The Participant shall be responsible for making the required contributions during the period in which he is in "uniformed service." The manner in which such payments are made shall be determined by the Plan Administrator in a manner similar to that of FMLA Leave.

Notwithstanding anything in this Plan to the contrary, with respect to any Employee or Dependent who loses coverage under this Plan during the Employee's absence from employment by reason of military service, no Pre-Existing Condition exclusion or Waiting Period may be imposed upon the reinstatement of such Employee's or Dependent's coverage upon reemployment of the Employee unless such Pre-Existing Condition exclusion or waiting period would have otherwise applied to such Employee or Dependent had the Employee not been on military leave of absence.

Special Enrollment Period

Special Enrollment Period means a period, other than an open enrollment period, during which an Employee or Dependent may enroll in the Plan. Special enrollment periods apply to Employees and Dependents that lose their medical coverage. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) contains a mandate that allows Employees and Dependents to enroll in a group health plan even if they elected not to enroll when they could have. It is called the special enrollment period.

Under this mandate, a plan must provide a special enrollment period when an individual who declined coverage when initially offered because he or she had other coverage, subsequently loses that coverage. This do-over scenario is also available to an individual who becomes a Dependent of an Employee through marriage, birth, adoption, or placement for adoption.

Conditions for Special Enrollment

An Employee or Dependent is eligible to enroll during a special enrollment period if each of the following applicable conditions is met:

- a. When the Employee declined enrollment for the Employee or the Dependent, the Employee stated in writing that coverage under another group health plan or other health insurance coverage was the reason for declining enrollment.
- b. When the Employee declined enrollment for the Employee or Dependent under the Plan, the Employee or Dependent had either:
 - › COBRA continuation coverage under another plan that has been exhausted, or other coverage that has been terminated as a result of loss of eligibility for the coverage or because employer contributions toward that coverage were terminated.

Note: For this purpose, loss of eligibility for coverage includes a loss of coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of the foregoing. Thus, for example, if an Employee's coverage ceases following a termination of employment and the Employee is eligible for but fails to elect COBRA continuation

coverage, this is treated as a loss of eligibility. However, loss of eligibility does not include a loss due to failure of the individual or the Participant to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). In addition, Employer contributions include contributions by any current or former Employer (of the individual or another person) that was contributing to coverage for the individual.

Length of Special Enrollment Period

The Employee is required to submit a Benefit Change Form and a written enrollment request (for the Employee or the Employee's Dependent) within 30 days after:

- The exhaustion of the other coverage;
- Termination of the other coverage as a result of the loss of eligibility for the other coverage;
- The termination of employer contributions toward that other coverage; or
- The date of marriage, birth, or adoption or placement for adoption.

Effective Date of Enrollment under Special Enrollment Period

The effective date of enrollment for an Employee and/or Dependent requesting coverage under a group health plan during a Special Enrollment Period will be as follows:

- a. In the case of a loss of alternative coverage or of a marriage, on a date specified by the Administrator that is not later than the first day of the month, on or after the date the completed request for enrollment is received in the Benefit Office.

Special Enrollment Period (*continued*)

- b. In the case of a Dependent's birth, adoption or placement for adoption, on the date of such birth, adoption or placement for adoption.

Health Insurance Portability Accountability (HIPAA)

The Health Insurance Portability and Accountability Act (HIPAA) places limitations on a group health plan's ability to impose pre-existing condition exclusions, provide special enrollment rights for certain individuals, and prohibit discrimination in group health plans based on health status. We are electronically transmitting data to our vendors for eligibility purposes. The vendors and Howard County Public Schools are in compliance with the HIPAA requirements. No personally identifiable information may be released to a third party.

When Coverage Terminates

Employee

Employee coverage shall automatically terminate immediately upon the earliest of the following dates, unless the covered Employee elects Continuation of Coverage:

- a. The last day of the month in which employment terminates;
- b. Except in the case of certain leaves of absence, the last day of the month in which the Employee ceases to be eligible, unless a later date applies under "c" below;
- c. With respect to any Employee whose employment terminates after he or she completes a school year, August 31 of the Plan Year in which that school year ends;
- d. The date this Plan is terminated (if Continuation of Coverage not available);
- e. The date the Employee receives the maximum lifetime benefits provided by the Plan;
- f. With respect to any coverage requiring Participant contributions, and with respect to which Participant contributions are discontinued, the period for which the Employee fails to make any required contribution;
- g. Except to the extent required by law, when the covered Employee enters the military, naval or air force of any country or international organization on a full-time active duty basis other than scheduled drills or other training not exceeding 1 month in any calendar year.

Dependent

Dependent coverage shall automatically terminate immediately upon the earliest of the following dates, unless the Employee or covered Dependent elects Continuation of Coverage:

- a. The last day of the month in which the Dependent ceases to be an eligible Dependent as defined in the Plan;
- b. The last day of the month in which the Employee's coverage under the Plan is terminated, unless a later date applies under "c".
- c. With respect to any unmarried/married child, living with the Employee, or who is more than 50% dependent upon the Employee for support, until the end of the birth month in which he or she reaches age 26.
- d. With respect to any coverage requiring Participant contributions, and with respect to which Participant contributions are discontinued, the period for which the Employee fails to make any required contribution;
- e. The date the Plan is terminated (Continuation of Coverage not available);
- f. Except to the extent required by law, when such Dependent enters the military, naval or air force of any country or international organization on a full-time active duty basis other than scheduled drills or other training not exceeding 1 month in any calendar year.

Certificate of Creditable Coverage

Each terminating Participant will receive a Certificate of Creditable Coverage, certifying the period of time the individual was covered under this Plan. For Employees with Dependent coverage, the certificate provided may include information on all covered Dependents. If you have any questions or need to request a Certificate of Creditable, please contact the insurance company for a copy.

Continuation of Coverage (COBRA)

A covered person may continue coverage for a period of 18, 29 or 36 months, at his/her own expense, pursuant to the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA), as amended, if coverage under the Plan would otherwise terminate because of a life event known as a “qualifying event”. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary” as follows:

1. Termination of Employment

A covered Employee, Spouse and Dependent child (qualified beneficiary) may elect to continue coverage under this Plan for up to 18 months, if their eligibility ends due to one of the following qualifying events:

- a. The covered Employee is terminated (for reasons other than Gross Misconduct*);
- b. The covered Employee’s number of hours of employment is reduced.
- c. The covered Employee resigns.

** Gross Misconduct is defined as the deliberate and willful violation of a reasonable rule or policy of the Employer, governing the Employee’s behavior in performance of his or her work, provided such violation has harmed the Employer or other Employees or has been repeated by the Employee despite warning or other explicit instruction from the Employer. Employees may also be terminated for cause, such as fraudulent claims submission.*

Disability Extension

A qualified beneficiary may elect to extend coverage an additional 11 months, up to a maximum of 29 months, for himself/herself and non disabled family members who are entitled to COBRA Continuation Coverage, if he is disabled (as defined by Title II or XVI of the Social Security Act) at the time of the qualifying event or at any time during the first 60 days of COBRA continuation coverage and is covered for Social Security Disability Income benefits.

The Qualified Beneficiary must send the COBRA Administrator a copy of the Social Security office’s disability determination letter within 60 days after the latest of (and in no event later than the end of the 18th month of COBRA coverage):

- a. The date of the Social Security Administration’s disability determination;

- b. The date on which the qualifying event occurs;
- c. The date on which the qualified beneficiary loses coverage; or
- d. The date on which the qualified beneficiary is informed of the obligation to provide the disability notice.

If the Social Security office determines that the qualified beneficiary is no longer disabled, the COBRA Administrator must receive a copy of the Social Security office’s letter within 30 days after it determines that he is no longer disabled. Please send the required documentation to the COBRA Administrator. Please contact the Benefits Office for the address of the COBRA Administrator.

2. Loss of Dependent Eligibility

A covered Dependent may elect to continue coverage under this Plan for up to 36 months, if his or her coverage ends due to any of the following qualifying events:

- a. The covered Employee dies;
- b. The covered Employee is divorced or legally separated;
- c. The covered Employee becomes eligible for and elects Medicare benefits;
- d. A Dependent child ceases to be a Dependent (as defined by the Plan).

The Employee or covered Dependent must notify the Plan Sponsor as follows:

Notice Obligations

A covered Employee, Spouse or Dependent is responsible for notifying Howard County Public School System of the Employee’s divorce or legal separation, or of the Employee’s child losing Dependent status. The qualified beneficiary

Continuation of Coverage (COBRA) *(continued)*

must notify the Plan Sponsor within 60 days of the date of the event or the date on which coverage would terminate, whichever is later. Written notification must be provided to the Benefits Office.

The qualified beneficiary may be required to complete a “COBRA Qualifying Event Notification Form” and attach official documentation, which substantiates the event. If you do not have access to a form, please provide the Howard County Public School System with the following information in writing and attach a copy of official documentation: Employee name, identification number, beneficiary name, address, telephone number, date of event, and description of event.

Failure to give notice within 60 days of the event can result in COBRA coverage being forfeited.

Multiple Event Extension

If a covered Dependent elects the 18 month continuation following an event shown in Part 1 and later becomes entitled to a 36 month continuation due to an event shown in Part 2, then that covered Dependent may continue coverage for up to 36 continuous months from the date of the first qualifying event.

For example, because the Employee is terminated, an 18-month continuation is elected for a covered Dependent. Before the 18-month period has ended, the covered Dependent reaches the maximum age to be covered under the Plan. This is a second qualifying event. In order to extend Continuation of Coverage up to 36 months from the original Continuation of Coverage effective date, the Dependent must notify the Benefits Office in writing, within 60 days of the second event or the date coverage ends (whichever is later). Written notification must include: beneficiary’s name, identification number, address, telephone number, date of event, description of event and a copy of official documentation substantiating the event (if divorce or legal separation.)

Election

A covered Employee can elect COBRA coverage for himself or herself and/or his or her covered Dependents. In the event that an Employee with family coverage does not elect COBRA coverage for his or her Dependents, such coverage may be elected by the Dependents. No Spouse or child is entitled to continuation coverage unless that individual was a covered Dependent under the Plan on the date before any of the above qualifying events except for the following:

- A Qualified Beneficiary includes a child born to or placed for adoption with a covered Employee during the period of COBRA coverage. An election on behalf of a minor child can be made by the child’s parent or legal guardian.

To continue coverage, the Employee or Dependent, hereinafter called a Continuee, affected by the qualifying event must make written election by the 60th day following:

- a. The last day of coverage; or
- b. The date he is sent notice of the right to continue coverage; whichever is later.

Within 45 days of the election date, the Continuee must pay the required monthly premium for the COBRA coverage period prior to the election. The 18 or 36 month continuation period will begin on the earliest of the above qualifying events.

Monthly Premium

The due date for the monthly premium is the first day of each coverage month and COBRA allows 30 days from the due date to send the premium to the COBRA Administrator, Jasper and Company.

The monthly premium will not exceed 102% of the total monthly cost (determined by the Plan on an actuarial basis) for coverage of a similarly situated active Employee. However, when a disabled Continuee extends coverage beyond 18 months, the monthly premium will increase to 150% of that total average monthly premium. The monthly premium is subject to change at the beginning of each Plan Year.

Continuation of Coverage (COBRA) *(continued)*

Payment of Claims

No claim will be payable under this COBRA provision, until the COBRA Administrator receives the applicable monthly premium for the Continuee’s coverage.

Termination

Coverage under the COBRA provision will terminate on the earliest of the following:

- a. The date on which the Employer ceases to provide a group health plan to Employees;
- b. The date the Continuee first becomes, after the date of the election, covered under any other group health plan (unless the plan contains pre-existing condition exclusions or limitations that are not reduced by creditable coverage);
- c. The date the Continuee first becomes, after the date of the election, covered for Medicare benefits;
- d. The date the Continuee fails to make timely payment of the monthly premium under the Plan;
- e. For a disabled Continuee who extends coverage beyond 18 months, the first of the month which begins 30 days after the Continuee is no longer considered disabled as defined by Social Security regulations;
- f. The end of the applicable 18, 29 or 36 month period. In no case will coverage continue beyond 36 months from the original qualifying event, even if a second qualifying event occurs during the COBRA coverage period;
- g. For cause, such as fraudulent claims submission, on the same basis that coverage could be terminated for similarly situated active Employees.

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	36 months

Old Program *(Only available to current Old Program Employees)*

The payroll deductions for health and dental benefits under the old program are after-tax purchases.

Once an employee elects to participate in the HCPSS Section 125 plan, he/she will not be allowed to participate in the old program.

Pre-Tax Contributions—A Way to Purchase Additional Benefits

If you add up the price tags for all the options you want and the total cost is greater than your Benefit Credits, you will make up the difference by using part of your salary to pay for benefits.

Benefit Credits

HCSPP employees that are not in the old plan electing a Medical Plan will receive benefit credits in the amount of \$420 per year. If an employee chooses to waive all Medical plans, they will receive benefit credits in the amount of \$750 per year.

Employee Assistance Program (EAP)

The Howard County Public School System has contracted with **Business Health Services (BHS)** as the service provider for all employees for the Employee Assistance Program. The EAP provides employees and their household members with free, confidential assistance to help with personal or professional problems that may interfere with work or family responsibilities and obligation. Services are available 24-hours a day, 7-days a week via a toll-free nationwide number, 1-800-327-2251. Employees and their household members can receive **up to three (3)** counseling sessions (which includes assessment, follow-up and referral services) per person, per problem episode, per year. Wellness resources and health tips are also available via the BHS website, www.bhsonline.com.



Employee Wellness Program

Introducing The Howard County Public Schools System (HCPSS)— Employee Wellness Program

Help and support for your journey to better health

We are pleased to announce that in addition to the physical activity tracking and rewards available through Virgin Health Miles, Aetna will also be a wellness partner for our HCPSS Employee Wellness Program.

HCPSS's new Employee Wellness Program will provide you with information, tools, resources and services to help you create and maintain a healthy lifestyle. The Employee Wellness Program is available to you regardless of the medical plan you select at enrollment.

Our vision is to begin and end each day with energy and vitality

We invite you to share our vision. With good health all things are possible. When we feel our best, we can do our best and serve as role models for the lives we touch. Our goal is to help you achieve your “personal best” health.

Get to know the HCPSS Employee Wellness Program

The HCPSS Employee Wellness Program can help you make lasting changes in your health—and your life. The program will:

- Help you know more about your personal health profile, including any risk factors.
- Empower you to address your health risks through simple lifestyle changes.
- Give you the information and support to better manage a chronic condition.
- Provide one-on-one coaching to help you set and achieve health-related goals.

Our mission is to create an environment that supports and celebrates each individual's lifelong journey toward optimal physical, social, intellectual, emotional and financial well-being by providing awareness, education, motivation and behavior change programs.

Remember the saying: An ounce of prevention is worth a pound of cure!

To protect against illness and uncover serious health conditions at their earliest stages, you will want to build a preventive care plan. Be sure to schedule your annual checkup, have any necessary immunizations and of course set up any necessary cancer screenings such as mammograms, colonoscopies and PSA (prostate-specific antigen), based on your age and health history.

Take action to know more about your health

One of the most important things you can do to protect your health is to know your risks. A great way to start is by completing the Health Assessment part of the *Simple Steps To A Healthier Life*® online wellness program.

Simple Steps To A Healthier Life supports Howard County Public School System and Aetna's commitment to good health. It's a step-by-step journey that helps you make gradual and lasting changes that fit into your life. Best of all, the program works at many different levels, so anyone can benefit from it.

The Health Assessment is a secure, confidential online questionnaire that covers topics such as lifestyle, health history, health screenings, and work and daily life. It's available to you 24/7 and only takes 15-20 minutes to complete. When you're done, you will know more about your personal health risks and what you can do about them.

It's easy to access the health assessment:

- Go to www.aetna.com.
- Register or log in to Aetna Navigator®, your secure member website.
- Under “I want to...,” click on *Take a Health Assessment*.

Employee Wellness Program (continued)

After you complete the Health Assessment, you will receive a health score, plus personalized health reports and an action plan. Your action plan will include recommendations for online wellness programs that are broken down into easy-to-complete modules that you can complete at your own pace.

Your action plan may include one or more of the following HealthMedia® programs:

- **Balance™**, for a healthier weight and healthier body.
- **Nourish™**, to get you in the habit of eating healthy.
- **Relax™**, for ways to manage everyday stress.
- **Breathe™**, for support to help you quit smoking.
- **Overcoming™ Depression**, to help you gain control over depression.
- **Overcoming™ Insomnia**, for a better night's sleep without medication.

You will also receive a follow-up email that tells more about your recommended program(s) and provides a link you can use to get started.

Information, inspiration and support to help you achieve your health goals

No matter what your health goals and challenges, it can help to have someone in your corner to encourage, advise and inform. With the Healthy Lifestyle Coaching program, you will have one-on-one support from a trained wellness coach to make the positive changes you've always wanted to make and live your healthiest life.

Through 30-minute private phone sessions with your coach, you can get help to:

- Lose weight
- Start a fitness program
- Eat healthy
- Quit smoking
- Manage stress
- Prevent illness and disease
- And more...

You will work with your coach at times that fit your schedule and together you will set goals, talk about habits and behaviors you want to change and work through the challenges that hold you back. When needed, your coach will direct you to other helpful resources and tools.

Start working with a coach today—it's confidential and free! It's all available at no additional cost to you and getting started is easy:

1. Just complete the Health Assessment and agree to be contacted for health coaching or,
2. Call 1-800-650-2747 and ask for the Healthy Lifestyle Coaching program.

Additional Tools to help you “Plan for your health”

Know more about health care benefits at all stages of life. To help you “plan for your health”, we invite you to visit, www.planforyourhealth.com, a public education campaign from Aetna and the Financial Planning Association. The site provides facts, tips and advice on choosing and using health and financial benefits at critical mileposts such as starting a first job, getting married, starting a family and planning for retirement.

Women's Health Online—Taking care of you

Aetna maintains a special website for women, called Women's Health Online. The site features information on heart health, breast health, migraines, depression, pregnancy and baby care, and preventive care guidelines, plus special information for ethnic and racial populations at risk for heart disease. There are also interactive tools, such as a body mass index (BMI) calculator, a pregnancy guide, “Choose My Plate” – a guide to healthy eating, and information on diet and nutrition. Visit the Women's Health Online website at <http://womenshealth.aetna.com>.

This is just the beginning! The Employee Wellness Program will continue to evolve with additional services to help us all reach our personal wellness goals. We've all made promises to ourselves about living healthier. Let's keep that promise together.

It's confidential

Your **HCPSS Employee Wellness Program** offers a variety of tools, programs and other resources to help you get on—and stay on—a healthy track. We want you to make the best use of these resources with full confidence that your information is safe and private.

Virgin HealthMiles

Get ready to think outside the gym.

The Virgin HealthMiles program makes getting active not just another to-do, but a fun and integral part of your world. And did we mention *rewards?!* Earn up to \$500 a year for getting active and participating in other healthy activities. And it's free; HCPSS is covering all of the costs for the program.



Here's what you get

- A GoZone pedometer
- Access to your own personal tracking site, the LifeZone
- Access to a HealthZone measurement station to check your weight, blood pressure, and body fat each month
- A fun way to get active with your colleagues!

Here's how it works

- Clip on your GoZone activity tracker each morning. Get active throughout the day and watch the steps stack up.
- Plug your GoZone into your computer to upload your steps.
- Track all your activity on the LifeZone, monitor your progress, watch your HealthMiles add up and spend your HealthCash

We'll keep you motivated all year long with challenges, contests, team competitions with your co-workers and more! Howard County Public School System will also give you opportunities to participate in healthy activities for even more HealthMiles.

Sign up for Virgin HealthMiles, a fun and rewarding way to get and stay active. The more you do, the better you feel, and the more rewards you can earn.

Go to www.virginhealthmiles.com/HCPSS to sign up today.

If you have any questions about the Virgin HealthMiles program, please contact Virgin Customer Services at 1-866-852-6898.

Aetna Open Choice[®] PPO

Featuring more freedom and more choice with a nationwide network of health care providers

With Aetna, you get a powerful health care resource. Aetna's nationwide Open Choice PPO network includes 934,260 health care providers; 159,100 of whom are Primary Care Providers (PCPs). This makes it easy to find a network doctor or a hospital, whether you are at home, work or traveling.

Your Aetna PPO Plan gives you more freedom of choice

When you need care, you have a choice. You can receive care within the network and pay less for your care. Or, you can choose to receive care outside the network and still receive benefits, but at a lower level.

Here's how the PPO Plan works:

In-Network	Out-of-Network
Visit any doctor in the network without a referral	Visit a doctor who is not part of the network
<ul style="list-style-type: none">■ You pay a flat copay for your care■ Your doctor will file your medical claims■ You do not need to get a referral to see a specialist■ You are not charged the difference between the doctor's charge and the amount that is covered by the plan	<ul style="list-style-type: none">■ You need to meet an annual deductible■ You pay for the full amount of the charge at the time you receive care■ You need to file a claim to be reimbursed for covered expenses■ You may also have to pay the difference between the doctor's charge and the amount covered by the plan

Find the right doctor

It's quick and easy with DocFind[®]

DocFind, Aetna's online provider directory at www.aetna.com, lists the doctors, hospitals, urgent care facilities and other health care providers that belong to Aetna's network. You can search by name or specialty, or do a geographic search to find all network providers within a given area. You can also get information about each provider's professional training and credentials, office hours, languages spoken, handicapped access, and more.

How to use DocFind

Visit www.aetna.com and look for the link on the home page to "Find a Doctor." You will provide some basic information to start your search, and choose a Provider Category (such as Medical Providers) and a Provider Type (such as Specialists). To Select a Plan, look under Aetna Standard Plans and select Open Choice[®] PPO.

You can then narrow your search by specialty, name and other criteria, or search for all network providers in your geographic area.

DocFind is updated three times a week, so it contains the most current information available. But if you aren't sure about a provider's network status, you can either call the provider's office or call Aetna Member Services at 1-888-502-3862.

Wherever you go, Aetna is there

If you're vacationing in Florida and need care while you're away, you can find network providers there as well. Do you have a child attending school in another state? Again, Aetna has network doctors available to provide their care. And finding them is easy with DocFind[®], the online provider directory available at www.aetna.com. You can even access DocFind with your smart phone!

Leaving the country?

If you are out of the country and need medical care, you can get the care you need then submit a claim to Aetna and be reimbursed at the out-of-network level of benefits. For help and assistance, call Aetna Member Services using the number on your Aetna ID card (1-888-502-3862).

A wide selection of mental health providers

When you or a covered family member needs counseling, therapy or other mental health services, Aetna can offer a large selection of network providers. Use DocFind to see for yourself. Just fill in the geographic information on the “General Search” page, then under Provider Category, select Behavioral Health. Look under Provider Type and select what you are looking for.

Online Tools & Resources

Look up claim information, research costs, go mobile—and more

In addition to the nationwide network, Aetna provides a wealth of information, tools, resources and services to help you manage your benefits and stay healthy.

It all starts with Aetna Navigator®

Aetna Navigator, your secure member website, is your prime resource for claim and benefits information, consumer tools, self-service convenience and so much more.

Once you register with Aetna Navigator at www.aetna.com, you will have a personal home page where you can access online tools and programs that include:

- **Access to claim information** that lets you look up the status of a claim and view your Explanation of Benefits statements (EOBs) online. You can also use the “send a message” feature to email Aetna Member Services with claim-related questions.

- **Benefit information** that includes a summary of your medical plan benefits, the names of your family members covered under the plan and a listing of health and wellness programs included with your plan.
- **Cost-of-care tools** that give you the estimated average costs of procedures and tests, treatments for diseases and conditions, and prescription drugs.
- Links to reliable, up-to-date health information through:
 - › **Aetna IntelliHealth®**, the award-winning health information website with the latest information from Harvard Medical School.
 - › **Healthwise® Knowledgebase**, an online reference and decision support tool that provides reliable information on a variety of health care topics and issues.
 - › **Aetna SmartSourceSM**, a tool that scans all of Aetna’s online resources to pull up health information tailored to your interests and needs.



Aetna Navigator is easy to use!

Once you’re enrolled with Aetna, you can visit www.aetna.com to register with Aetna Navigator. By registering, you set up your own password so that you, and only you, can access your personal health information. If you need help, Aetna’s virtual assistant, “Ann”, is there to guide you. Look for her on the home page. You will also see an invitation to “take a tour” of the site and discover how easy it is to find what you are looking for.

Your Personal Health Record

One secure and confidential place for all your health information

From Aetna Navigator, you can also link to your Personal Health Record (PHR). The PHR puts all of your claims-based information in one handy place so you can see medical procedures and services received, medications prescribed, and preventive and routine care provided—by whom and when.

Having trouble remembering when you had an exam or procedure? Want to find out when you started taking that new medication? Need to know which doctor you saw for a certain health problem or condition? It's all in your PHR. You can also enter your own information, such as over-the-counter drugs and nutritional supplements you use. You may want to print a copy of your PHR and share it with your doctor.

Go mobile with Aetna

Visit Aetna Navigator anytime, anywhere. You can log in using any mobile phone with web access. It's fast, easy and so convenient! Type www.aetna.com in your browser and you will be able to find in-network providers, view or show a virtual member ID card, check on claims, contact Aetna Member Services and much more.

Maternity Program

Give your baby a healthy start with Beginning Right®

If you or your covered spouse are planning to have or expecting a baby, you should enroll in Aetna's Beginning Right Maternity Management Program.

Beginning Right is part of your Aetna medical plan. When you enroll in the program, you will learn about prenatal care, labor and delivery, newborn care, breastfeeding and more. Plus, you also receive health coaching from registered nurses who can help you with any special health concerns.

Manage your health

With Aetna's Disease Management Program

Aetna's Disease Management Program provides one-on-one support, information and advice from a team of trained disease management nurses and other health professionals for more than 35 diseases and conditions, including diabetes, asthma, osteoporosis, heart disease and others.

When you agree to participate in the program, you get help with medical services and benefits relating to your health condition:

- You will talk with a trained nurse about the health concerns that matter to you.
- You receive help and guidance to follow your doctor's treatment plan, get important preventive care and manage your risks for other conditions.
- Your personal information is kept private and secure, in full compliance with federal and state law. It is not shared with HCPSS.

Aetna nurses will guide you through the maze of information and choices that come along with a health condition and its treatment.

Help and information is just a phone call away

Aetna Member Services: 1-888-502-3862

Aetna Member Services can help with questions about your plan and its benefits, claims and claim payments, ordering a new ID card and a host of other benefits needs. Aetna Member Services representatives are available from 8:00 a.m. to 6:00 p.m. EST, Monday through Friday. You also may access our voice-activated telephone system 24 hours a day, 7 days a week.

24-hour Nurse Line: 1-800-556-1555

Available 24 hours a day, 7 days a week, the toll-free Informed Health® Line gives you a quick, simple way to get answers to health-related questions. When you call, you will talk with a trained nurse who can provide information on hundreds of health topics, help you decide where to seek care, tell you how to take care of a health problem until you can get to the doctor, and much more.

Save money!

You and your enrolled family members can take advantage of these discount programs available through Aetna:

- **Aetna FitnessSM Discount Program**—Save on fitness club memberships, home exercise equipment and more. To find a participating fitness center, go to www.globalfit.com.
- **Aetna VisionSM Program**—Pay less for eyeglasses, contact lenses, sunglasses and LASIK surgery.
- **Aetna Natural Products and ServicesSM Discount Program**—Save on health services, like massage therapy, acupuncture, chiropractic care, nutritional counseling and other natural wellness products.
- **Aetna HearingSM Discounts**—You can save on the latest hearing aid styles and technology, and on the retail price of hearing exams.
- **Aetna Weight ManagementSM Discount Program**—Save on weight-loss programs and products from some of the world's leading weight-management firms, such as Nutrisystem®, Jenny Craig® and eDiets®.

You also get big savings on:

- Sonic toothbrushes and water-jet flossers from Waterpik®.
- Epic dental products, like gum, toothpaste, and mouth rinses.
- Books and other items from the American Cancer Society®, Bookstore and the MayoClinic.com Bookstore.
- ZAGAT.com membership (30% off a one-year membership)



Keep it simple!

You will enjoy the many conveniences of your Aetna Open Choice PPO Plan:

- You have access to a nationwide network of doctors, specialists, hospitals and other health care facilities to provide your care at home, at work, or traveling
- You pay a flat copay for your care
- You decide to receive care within the network, or out of the network
- You have access to a 24-hour nurse line service
- There are no referrals for in-network care
- There is no need to file claims for in-network care
- A deductible only applies to care received out-of-network

Open Access Aetna Select

An HMO Plan with a nationwide network of health care providers

With Aetna, you get a powerful health care resource. The Open Access[®] Aetna Select features a nationwide network that includes 870,652 health care providers; 159,819 of whom are Primary Care Providers (PCPs). This makes it easy to find a network doctor or a hospital, whether you are at home, work or traveling.

Your Aetna Select Plan gives you more freedom

There's no requirement to select a PCP, or obtain referrals for specialty care. When you need care, you're covered – no matter where you live. Our network of medical providers and facilities is *nationwide*, offering a full range of primary care doctors and specialists wherever you need them. When you visit a network provider, you will pay a flat copay for your care. There's no claim paperwork—your network provider will handle all claims for you. It's important to know that, under Open Access Aetna Select, you must see a network provider in order to receive benefits from the plan.

Wherever you go, Aetna is there

If you're vacationing in Florida and need care while you're away, you can find network providers there as well. Do you have a child attending school in another state? Again, Aetna has a network doctors available to provide their care. And finding them is easy with DocFind[®], the online provider directory available at www.aetna.com. You can even access DocFind with your smart phone!

Find the right doctor

It's quick and easy with DocFind[®]

DocFind, Aetna's online provider directory at www.aetna.com, lists the doctors, hospitals, urgent care facilities and other health care providers that belong to Aetna's network. You can search by name or specialty, or do a geographic search to find all network providers within a given area. You can also get information about each provider's professional training and credentials, office hours, languages spoken, handicapped access, and more.

How to use DocFind

Visit www.aetna.com and look for the link on the home page to "Find a Doctor." You will provide some basic information to start your search, and choose a Provider Category (such as Medical Providers) and a Provider Type (such as Specialists). To Select a Plan, look under Aetna Open Access Plans and select Aetna SelectSM (Open Access).

You can then narrow your search by specialty, name and other criteria, or search for all network providers in your geographic area.

DocFind is updated three times a week, so it contains the most current information available. But if you aren't sure about a provider's network status, you can either call the provider's office or call Aetna Member Services at 1-888-502-3862.

A wide selection of mental health providers

When you or a covered family member needs counseling, therapy or other mental health services, Aetna can offer a large selection of network providers. Use DocFind to see for yourself. Just fill in the geographic information on the "General Search" page, then under Provider Category, select Behavioral Health. Look under Provider Type and select what you are looking for.

Open Access Aetna Select (continued)

Online Tools & Resources

Look up claim information, research costs, go mobile—and more

In addition to the nationwide network, Aetna provides a wealth of information, tools, resources and services to help you manage your benefits and stay healthy.

It all starts with Aetna Navigator®

Aetna Navigator, your secure member website, is your prime resource for claim and benefits information, consumer tools, self-service convenience and so much more.

Once you register with Aetna Navigator at www.aetna.com, you will have a personal home page where you can access online tools and programs that include:

- Access to claim information that lets you look up the status of a claim and view your Explanation of Benefits statements (EOBs) online. You can also use the “send a message” feature to email Aetna Member Services with claim-related questions.
- Benefit information that includes a summary of your medical plan benefits, the names of your family members covered under the plan and a listing of health and wellness programs included with your plan.
- Cost-of-care tools that give you the estimated average costs of procedures and tests, treatments for diseases and conditions, and prescription drugs.

■ Links to reliable, up-to-date health information through:

- › **Aetna IntelliHealth®**, the award-winning health information website with the latest information from Harvard Medical School.
- › **Healthwise® Knowledgebase**, an online reference and decision support tool that provides reliable information on a variety of health care topics and issues.
- › **Aetna SmartSourceSM**, a tool that scans all of Aetna’s online resources to pull up health information tailored to your interests and needs.

Go mobile with Aetna

Visit Aetna Navigator anytime, anywhere. You can log in using any mobile phone with web access. It’s fast, easy and so convenient! Type www.aetna.com in your browser and you will be able to find in-network providers, view or show a virtual member ID card, check on claims, contact Aetna Member Services and much more.



Aetna Navigator is easy to use!

Once you’re enrolled with Aetna, you can visit www.aetna.com to register with Aetna Navigator. By registering, you set up your own password so that you, and only you, can access your personal health information. If you need help, Aetna’s virtual assistant, “Ann”, is there to guide you. Look for her on the home page. You will also see an invitation to “take a tour” of the site and discover how easy it is to find what you are looking for.

Your Personal Health Record

One secure and confidential place for all your health information

From Aetna Navigator, you can also link to your Personal Health Record (PHR). The PHR puts all of your claims-based information in one handy place so you can see medical procedures and services received, medications prescribed, and preventive and routine care provided—by whom and when.

Having trouble remembering when you had an exam or procedure? Want to find out when you started taking that new medication? Need to know which doctor you saw for a certain health problem or condition? It's all in your PHR. You can also enter your own information, such as over-the-counter drugs and nutritional supplements you use. You may want to print a copy of your PHR and share it with your doctor.

Manage your health

With Aetna's Disease Management Program

Aetna's Disease Management Program provides one-on-one support, information and advice from a team of trained disease management nurses and other health professionals for more than 35 diseases and conditions, including diabetes, asthma, osteoporosis, heart disease and others.

When you agree to participate in the program, you get help with medical services and benefits relating to your health condition:

- You will talk with a trained nurse about the health concerns that matter to you.
- You receive help and guidance to follow your doctor's treatment plan, get important preventive care and manage your risks for other conditions.
- Your personal information is kept private and secure, in full compliance with federal and state law. It is not shared with HCPSS.

Aetna nurses will guide you through the maze of information and choices that come along with a health condition and its treatment.

Maternity Program

Give your baby a healthy start with Beginning Right®

If you or your covered spouse are planning to have or expecting a baby, you should enroll in Aetna's Beginning Right Maternity Management Program.

Beginning Right is part of your Aetna medical plan. When you enroll in the program, you will learn about prenatal care, labor and delivery, newborn care, breastfeeding and more. Plus, you also receive health coaching from registered nurses who can help you with any special health concerns.

Help and information is just a phone call away

Aetna Member Services: 1-888-502-3862

Aetna Member Services can help with questions about your plan and its benefits, claims and claim payments, ordering a new ID card and a host of other benefits needs. Aetna Member Services representatives are available from 8:00 a.m. to 6:00 p.m. EST, Monday through Friday. You also may access our voice-activated telephone system 24 hours a day, 7 days a week.

24-hour Nurse Line: 1-800-556-1555

Available 24 hours a day, 7 days a week, the toll-free Informed Health® Line gives you a quick, simple way to get answers to health-related questions. When you call, you will talk with a trained nurse who can provide information on hundreds of health topics, help you decide where to seek care, tell you how to take care of a health problem until you can get to the doctor, and much more.

Open Access Aetna Select (continued)

Save money!

You and your enrolled family members can take advantage of these discount programs available through Aetna:

- **Aetna FitnessSM Discount Program**—Save on fitness club memberships, home exercise equipment and more. To find a participating fitness club, go to www.globalfit.com.
- **Aetna VisionSM Program**—Pay less for eyeglasses, contact lenses, sunglasses and LASIK surgery.
- **Aetna Natural Products and ServicesSM Discount Program**—Save on health services, like massage therapy, acupuncture, chiropractic care, nutritional counseling and other natural wellness products.
- **Aetna HearingSM Discounts**—You can save on the latest hearing aid styles and technology, and on the retail price of hearing exams.
- **Aetna Weight ManagementSM Discount Program**—Save on weight-loss programs and products from some of the world's leading weight-management firms, such as Nutrisystem[®], Jenny Craig[®] and eDiets[®].

You also get big savings on:

- Sonic toothbrushes and water-jet flossers from Waterpik[®].
- Epic dental products, like gum, toothpaste, and mouth rinses.
- Books and other items from the American Cancer Society[®], Bookstore and the MayoClinic.com Bookstore.
- ZAGAT.com membership (30% off a one-year membership)



Keep it simple!

You will enjoy the many conveniences of your Open Access Aetna Select Plan:

- You have access to a nationwide network of doctors, specialists, hospitals and other health care facilities to provide your care at home, at work, or traveling
- You pay a flat copay for your care
- You have access to a 24-hour nurse line service
- There are no referrals
- There is no need to file claims
- There is no deductible

CareFirst BlueChoice HMO *Open Access*

CareFirst BlueChoice HMO Open Access, from CareFirst BlueChoice, Inc., (CareFirst BlueChoice) aims to keep you healthy by emphasizing prevention, early detection and early treatment. We work with you to help prevent illness and we encourage you to seek care when it is needed.

You can select your doctor from a regional network of physicians, Specialists and hospitals located throughout Maryland, Washington, D.C. and Northern Virginia—so now you can visit a doctor where you live, where you work or anywhere in between.



Open Access Means No Referrals

Traditional HMO plans require you to obtain a written referral from your PCP before seeing a Specialist. However, CareFirst BlueChoice has an *Open Access* feature. This means you have direct access to CareFirst BlueChoice Specialists without first obtaining a written referral from your PCP.

Large Regional Provider Network (Maryland, Washington, D.C., Northern Virginia)

The CareFirst BlueChoice provider network includes 17,000 doctors, Specialists and hospitals serving Maryland, Washington, D.C. and Northern Virginia, so you can choose a doctor where you live, where you work or anywhere in between.

Preventive Services

CareFirst BlueChoice HMO *Open Access* provides coverage for preventive services such as PAP tests and routine prostate screenings—all covered under your predictable copayment.

Emergency and Urgent Care

Each CareFirst BlueChoice doctor provides 24-hour-a-day availability so you are never out of reach of your PCP. If the condition is serious, but not life threatening, call your PCP and he or she will give you instructions on what to do next.

Your doctor may suggest that you visit an urgent care center. Urgent care centers are walk-in medical facilities equipped to handle minor emergencies. Urgent care centers allow you to be seen more quickly than emergency rooms and most have evening and weekend hours. A list of participating urgent care centers can be found in the Provider Directory or at www.carefirst.com.

In a life threatening emergency, such as chest pain, unconsciousness or severe bleeding, we encourage you to go immediately to the nearest emergency room or call 911.



Maternity and Well-Child Care

CareFirst BlueChoice HMO *Open Access* provides coverage for prenatal and postnatal visits as well as childhood immunizations and check-ups.

We aim to start your children on the road to good health before they are born. Our Great Beginnings program for expectant mothers is designed to complement the prenatal care and education you receive from your doctor. When you enroll in Great Beginnings you will receive information related to your condition and your baby's development. A Great Beginnings nurse will contact you during each trimester to see how you are feeling and to answer your questions.

We believe in giving baby and mother a healthy start, and want to encourage mothers to take advantage of these important services.

No Paperwork

CareFirst BlueChoice provides direct reimbursement to your doctor, which means no hassles or claims to file.

Coverage When You Travel

Out-of-area coverage is limited to emergency care only. However, members and their Dependents who plan to be out of the CareFirst BlueChoice service area for at least 90 consecutive days can take advantage of the Away from Home Care® Program, which allows temporary benefits through another Blue Cross and Blue Shield affiliated HMO. This special plan provides coverage for routine services and is perfect for extended out-of-town business or travel, semesters at school or families living apart. For more information on Away from Home Care, please call Member Services at (866) 520-6099.

CareFirst BlueChoice HMO Open Access (continued)

Your Primary Care Provider (PCP)

Establishing a relationship with one doctor is the best way for you to receive consistent, quality health care; therefore, **you must select a PCP at the time of your enrollment into CareFirst BlueChoice.**

Your PCP can:

- Provide basic medical care – treating illness and providing preventive care,
- Maintain your medical history,
- Work with you to determine when you should see a Specialist and assist in the selection of a Specialist.

You may choose a doctor who specializes in family practice, general practice, pediatrics or internal medicine as your PCP. Your entire family may select the same doctor, or each member may choose a different doctor, based on each person's age or medical needs. When completing your enrollment application, be sure to select a PCP for you and each of your family members. To ensure that you have the most current provider information, we encourage you to visit our online provider directory at www.carefirst.com.

No Referrals Needed for Specialists

You don't need a referral form if you visit a Specialist from among those listed in your CareFirst BlueChoice provider directory. (Please note, CareFirst BlueChoice approval is required for services like mental health and substance abuse treatments, non-emergency hospitalizations and outpatient hospital services, among others.)

Away from Home Care®

You have access to routine and urgent care when you're away from home for 90 consecutive days or more. Whether you're out of town on extended business, travel or attending school out of the area, you'll have access to your HMO benefits.

You'll have coverage when you see a provider of an affiliated Blue Cross and Blue Shield HMO (Host HMO) outside of the CareFirst BlueChoice, Inc. service area (Maryland, Washington, D.C., Northern Virginia). When you receive care, you'll be considered a member of the Host HMO and will be responsible for the copay benefits under that plan. Your copay benefits may be different than when you're in the service area.

You won't have to complete claim forms and are only responsible for out-of-pocket expenses such as copays, deductibles, coinsurance, and the cost of non-covered services. CareFirst BlueChoice, Inc. will communicate this information to you when your Away from Home Care application has been accepted.

Options

Save up to 50% on fitness club memberships, weight loss programs, hearing care services and laser vision correction, as well as alternative therapies such as acupuncture, nutrition counseling, massage therapy or yoga.



PPO Option January 1, 2012–December 31, 2012

Benefits	Aetna PPO	
	In-Network	Out-of-Network
COST SHARING LIFETIME LIMITS		
Calendar Year Deductible Individual Family	None None	\$100 \$300
Calendar Year Out-of-Pocket Maximum Individual Family	\$500 includes copays \$1500 includes copays	\$1,000 includes deductibles and copays \$3,000 includes deductibles and copays
Coinsurance	100%	80% after deductible
Lifetime Maximum	Unlimited	Unlimited
PROFESSIONAL SERVICES		
Primary Care Office Visit	\$15 copay	80% after deductible
Gynecology Office Visit	\$15 copay for Well Woman visit or \$20 copay for all other visits	80% after deductible
Specialist Office Visit	\$20 copay	80% after deductible
Physical Therapy Office Visit	100% (120 visits combined with Occupational Therapy). Visits beyond 25 will be reviewed for medical necessity.	80% after deductible 120 visits combined with Occupational Therapy. Visits beyond 25 will be reviewed for medical necessity.
Speech Therapy Office Visit	100% no copay 60 visits. Visits beyond 25 will be reviewed for medical necessity.	80% after deductible 60 visits. Visits beyond 25 will be reviewed for medical necessity.
Occupational Therapy Visit	100% (120 visits combined with Physical Therapy). Visits beyond 25 will be reviewed for medical necessity.	80% after deductible 120 visits combined with Physical Therapy. Visits beyond 25 will be reviewed for medical necessity.
Chiropractic Office Visit	100% (limited to 30 visit maximum combined in and out of network) Preauthorizat on not required.	80% after deductible (limited to 30 visit maximum combined in and out of network) Preauthorizat on not required.
Allergy Shots/Other Covered Injections	100% after copay	80% after deductible
Allergy Serum	100% after copay	80% after deductible
Allergy Testing	Covered as either a PCP or Specialist office visit	80% after deductible
Diagnostic tests	Included with PCP or Specialist copayment	80% after deductible
Diagnostic tests performed by lab or other testing facility and billed separately from office visit	100%	80% after deductible

PPO Option January 1, 2012–December 31, 2012 *(continued)*

Benefits	Aetna PPO	
	In-Network	Out-of-Network
PREVENTIVE CARE		
Well Child Visit / Immunization	\$15 copay	80% after deductible
Routine Adult Physical	\$15 copay	80% after deductible
Routine Gynecological Exam	\$15 copay, one exam per calendar year	80% after deductible, one exam per calendar year
Routine Pap Smear	100% when included with routine gynecological exam. One exam per calendar year.	80% after deductible, when included with routine gynecological exam. One exam per calendar year.
Routine Mammogram	100% . Baseline between age 35-39. One per calendar year age 40 and over.	80% after deductible. Baseline between age 35-39. One per calendar year age 40 and over.
PSA Testing	One per calendar year for males age 40 and over	80%, no deductible. One per calendar year for males age 40 and over
INPATIENT HOSPITAL CARE (Preauthorization Required)		
Room and Board	100% Pre-authorization required.	80% after deductible Pre-authorization required.
Physician / Surgical Services	100%	80% after deductible
Anesthesia Services	100%	80% after deductible
Intensive Care Unit / Critical Care Unit	100%	80% after deductible
Maternity/Nursery/Birthing Center	100%	80% after deductible
Skilled Nursing/Rehab Facility Care (Preauthorization Required??)	100% limited to 120 days per calendar year.	80% after deductible limited to 120 days per calendar year.
Dialysis/Radiation/Chemotherapy	100%	80% after deductible
Hospice	100%	80% after deductible
Physical/Speech/Occupational Therapy	100%	80% after deductible
OUTPATIENT HOSPITAL CARE		
Surgical/Anesthesia Services	100%	80% after deductible
Dialysis/Radiation/Chemotherapy	100%	80% after deductible
Outpatient Diagnostic Services	100%	80% after deductible
MATERNITY/INFERTILITY SERVICES		
1st prenatal visit	100% after copay	80% after deductible
Pre-and Postnatal care and delivery	100%	80% after deductible
Routine nursery care	100%	80% after deductible
Sterilization/Reverse Sterilization requires preauthorization	100% Reverse Sterilization is not covered	80% after deductible. Reverse Sterilization is not covered

PPO Option January 1, 2012–December 31, 2012 *(continued)*

Benefits	Aetna PPO	
	In-Network	Out-of-Network
Artificial Insemination (AI)	100%, (subject to applicable copay) preauthorization required. Limited to 6 courses of treatment per lifetime.	80% after deductible, preauthorization required. Limited to 6 courses of treatment per lifetime.
InVitro Fertilization (IVF)*– maximum of 3 IVF attempts/lifetime (Preauthorization Required)	100%, (subject to applicable copay) preauthorization required.	80% after deductible, preauthorization required.
MEDICAL EMERGENCIES (USE OF ER)		
Emergency Room	100% after \$50 ER copay (waived if admitted)	100% after \$50 ER copay (waived if admitted)
Urgent Care Center	100% after \$25 copay.	80% after deductible.
MEDICAL EQUIPMENT/SUPPLIES		
Durable Medical Equipment	100% \$10,000 calendar year max (includes foot orthotics)	80% after deductible \$10,000 calendar year max (includes foot orthotics)
Prosthetic Devices (Pre-authorization required)	100%	80% after deductible
Orthopedic Devices	100%	80% after deductible
Foot Orthotics (Subject to medical necessity)	100% Applies to Durable Medical Equipment Maximum	80% after deductible Applies to Durable Medical Equipment Maximum.
MENTAL HEALTH AND SUBSTANCE ABUSE (Preauthorization required for inpatient only)		
Mental Health: Inpatient Outpatient	100% \$20 copay	80% after deductible 80% after deductible
Substance Abuse: Inpatient Outpatient	100% \$20 copay	80% after deductible 80% after deductible
OTHER SERVICES		
Ambulance	Ground 100% Air 100%	Ground 100% no deductible. non-emergency use–80% after deductible Air 100% no deductible
Kidney, Cornea Bone Marrow Transplants	Covered in full. The National Medical Excellence (NME) unit will arrange transplant services by a facility that is part of the Institutes of Excellence (IOE) transplant network.	80% after deductible
Heart, Heart-Lung, Lung, Pancreas, Liver Transplants	Covered in full. The National Medical Excellence (NME) unit will arrange transplant services by a facility that is part of the Institutes of Excellence (IOE) transplant network.	80% after deductible

PPO Option January 1, 2012–December 31, 2012 *(continued)*

Benefits	Aetna PPO	
	In-Network	Out-of-Network
Cardiac Rehabilitation	100% if performed in an outpatient hospital setting; 100% after copay in office setting or freestanding cardiac rehabilitation center	80% after deductible
Hearing Aids	Hearing aids: 100% to a maximum of \$1,400 per ear during any 36 month period for a child up to age 19. Hearing exam: 100% after specialist copay. One exam every 12 months.	Hearing aids: 80% after deductible to a maximum of \$1,400 per ear during any 36 month period for a child up to age 19. Hearing exam: Not covered.
Acupuncture	Acupuncture therapy includes services provided by a licensed acupuncturist covered at 100% no copay subject to R&C	Acupuncture therapy includes services provided by a licensed acupuncturist covered at 100% no copay subject to R&C
Vision (Routine eye exam)	Routine eye exam covered at 100% after \$20 copay. One exam every 12 months.	Not covered.

HMO Options January 1, 2012–December 31, 2012

Benefits	Open Access Aetna Select HMO	CareFirst Open Access HMO
Network Coverage	Nationwide Network	Regional Network (MD, DC and Northern VA)
COST SHARING LIFETIME LIMITS		
Calendar Year Deductible Individual Family	None None	None None
Calendar Year Out-of-Pocket Maximum Individual Family	\$2,000 (includes copays) \$6,000 (includes copays)	\$2,000 \$6,000
Coinsurance	100%	100%
Lifetime Maximum	None	None
PROFESSIONAL SERVICES		
Primary Care Office Visit	\$10 copay	\$10 copay
Gynecology Office Visit	\$10 copay for Well Woman visit or \$15 copay for all other visits	\$10 for Well Woman visit or \$15 copay for all other visits
Specialist Office Visit	\$15 copay	\$15 copay
Physical Therapy Office Visit	100% (120 visits combined with Occupational Therapy). Visits beyond 25 will be reviewed for medical necessity.	100% after copay (30 visits per condition per calendar year)
Speech Therapy Office Visit	100% no copay 60 visits. Visits beyond 25 will be reviewed for medical necessity.	100% after copay (30 visits per condition per calendar year)
Occupational Therapy Visit	100% (120 visits combined with Physical Therapy). Visits beyond 25 will be reviewed for medical necessity.	100% after copay (30 visits per condition per calendar year)
Chiropractic Office Visit	100% (limited to 30 visit maximum combined in and out of network) Preauthorizat on not required.	100% after copay (limited to 20 visits per benefit period)
Allergy Shots/Other Covered Injections	100% after copay	100% after copay
Allergy Serum	100% after copay	100% after copay
Allergy Testing	Covered as either a PCP or Specialist office visit	Covered as either a PCP or Specialist office visit
Diagnostic tests	Included with PCP or Specialist copayment	100% after copay
Diagnostic tests performed by lab or other testing facility and billed separately from office visit	100%	100%

HMO Options January 1, 2012–December 31, 2012 *(continued)*

Benefits	Open Access Aetna Select HMO	CareFirst Open Access HMO
Network Coverage	Nationwide Network	Regional Network (MD, DC and Northern VA)
PREVENTIVE CARE		
Well Child Visit / Immunization	\$10 copay	\$10 copay
Routine Adult Physical	\$10 copay	\$10 copay
Routine Gynecological Exam	\$10 copay, one exam per calendar year.	\$10 copay, one exam per calendar year.
Routine Pap Smear	100% when included with routine gynecological exam. One exam per calendar year.	100% when included with routine gynecological exam. One exam per calendar year.
Routine Mammogram	100% . Baseline between age 35-39. One per calendar year age 40 and over.	100% unlimited visits
PSA Testing	Covered based on place of service. One per calendar year for males age 40 and over	Covered based on place of service. One per calendar year for males 40 and over
INPATIENT CARE (Pre authorization required)		
Room and Board	100% Pre-authorization required.	100% Pre-Authorization Required
Physician / Surgical Services	100%	100%
Anesthesia Services	100%	100%
Intensive Care Unit / Critical Care Unit	100%	100%
Maternity/Nursery/Birthing Center	100%	100%
Skilled Nursing/Rehab Facility Care	100% limited to 120 days per calendar year.	100% unlimited days
Dialysis/Radiation/Chemotherapy	100%	100%
Hospice (Preauthorization Required)	100%	100%
Physical/Speech/Occupational Therapy	100%	100%
OUTPATIENT HOSPITAL SERVICES		
Surgical/Anesthesia Services	100%	100%
Dialysis/Radiation/Chemotherapy	100%	100%
Outpatient Diagnostic Services	100%	100%
MATERNITY/INFERTILITY SERVICES		
1st prenatal visit	100% after copay	100% after copay
Pre-and Postnatal care and delivery	100%	100%
Routine nursery care	100%	100%
Sterilization/Reverse Sterilization requires preauthorization	100% Reverse Sterilization is not covered	100% Reverse Sterilization is not covered

HMO Options January 1, 2012–December 31, 2012 *(continued)*

Benefits	Open Access Aetna Select HMO	CareFirst Open Access HMO
Network Coverage	Nationwide Network	Regional Network (MD, DC and Northern VA)
Artificial Insemination (AI)	50% of Allowed Benefit (preauthorization; limited to 6 courses of treatment per lifetime)	50% of Allowed Benefit limited to 6 courses of treatment per lifetime
InVitro Fertilization (IVF)*– maximum of 3 IVF attempts/lifetime (Preauthorization Required)	50% of Allowed Benefit	50% of Allowed Benefit
MEDICAL EMERGENCIES (USE OF ER)		
Emergency Room	100% after \$50 ER copay (waived if admitted)	100% after \$50 copay (waived if admitted)
Urgent Care Center	100% after \$15 copay.	100% after \$15 copay
MEDICAL EQUIPMENT/SUPPLIES		
Durable Medical Equipment	100% \$10,000 calendar year max (includes foot orthotics)	100% \$7,500 calendar year max (includes foot orthotics)
Prosthetic Devices (Pre-authorization required)	100%	100%
Orthopedic Devices	100%	100%
Foot Orthotics (Subject to medical necessity)	100% Applies to Durable Medical Equipment Maximum	100% Applies to Durable Medical Equipment Maximum
MENTAL HEALTH AND SUBSTANCE ABUSE (Preauthorization required for inpatient only)		
Mental Health: Inpatient Outpatient	100% \$15 copay	100% \$15 copay
Substance Abuse: Inpatient Outpatient	100% \$15 copay	100% \$15 copay
OTHER SERVICES		
Ambulance	Ground 100% non-emergency not covered Air 100% non-emergency not covered	Ground 100% non-emergency not covered Air Covered 100% non-emergency not covered
Kidney, Cornea Bone Marrow Transplants	Covered in full. The National Medical Excellence (NME) unit will arrange transplant services by a facility that is part of the Institutes of Excellence (IOE) transplant network.	100%

HMO Options January 1, 2012–December 31, 2012 *(continued)*

Benefits	Open Access Aetna Select HMO	CareFirst Open Access HMO
Network Coverage	Nationwide Network	Regional Network (MD, DC and Northern VA)
Heart, Heart-Lung, Lung, Pancreas, Liver Transplants	Covered in full. The National Medical Excellence (NME) unit will arrange transplant services by a facility that is part of the Institutes of Excellence (IOE) transplant network. Performed at approved IOE facility. If non-IOE facility no coverage.	100%
Cardiac Rehabilitation	100% if performed in an outpatient hospital setting; 100% after copay in office setting or freestanding cardiac rehabilitation center	100% after \$15 copay
Hearing Aids	Hearing aids: 100% to a maximum of \$1,400 per ear during any 36 month period for a child up to age 19. Hearing exam: 100% after specialist copay. One exam every 12 months.	100% to a maximum of \$1,400 per ear during any 36 month period for a child up to the age of 18.
Acupuncture	Acupuncture therapy includes services provided by a licensed acupuncturist covered at 100% no copay subject to R&C	Not Covered
Vision (Routine eye exam)	Routine eye exam covered at 100% after \$15 copay. One exam every 12 months.	Routine eye exam covered at 100% after a \$10 copay. One exam per calendar year

Prescription Drug Coverage: Express Scripts

Express Scripts Welcomes Howard County Public School System Members

Express Scripts is the company chosen by Howard County Public School System to take care of your prescription benefit plan starting January 1, 2012. We're here to help you save money and get the best service on prescriptions for you and your family. Your Express Scripts plan includes:

- 24-hour, 365-day-a-year Patient Care Contact Center at 1-877-866-5859
- a national network of over 50,000 pharmacies
- Home Delivery for your medications from the Express



Copayments for Your New Prescription Program HMO

Prescriptions from a Pharmacy in-Network*	Prescriptions from the Express Scripts Pharmacy (Mail Order)
Up to a 30-day supply	Up to a 90-day supply
Generic Medication: \$5	Generic Medication: \$10
Preferred Brand-Name Medication: \$10	Preferred Brand-Name Medication: \$20
Non-Preferred Brand-Name Medication: \$25	Non-Preferred Brand-Name Medication: \$50

Copayments for Your New Prescription Program PPO

Prescriptions from a Pharmacy in-Network*	Prescriptions from the Express Scripts Pharmacy (Mail Order)
Up to a 30-day supply	Up to a 90-day supply
Generic Medication: \$10	Generic Medication: \$20
Preferred Brand-Name Medication: \$20	Preferred Brand-Name Medication: \$40
Non-Preferred Brand-Name Medication: \$35	Non-Preferred Brand-Name Medication: \$70

** To receive the in-network level of benefits, you must use a pharmacy in the Express Scripts network*

Scripts Pharmacy

How to Get Prescriptions from a Participating Pharmacy

You'll receive a card with your prescription ID number in your welcome package. You'll need to show this ID card to your pharmacist each time you get a prescription filled. To locate pharmacies near you that are in the Express Scripts network, visit our Web site at www.express-scripts.com.

How to Use Home Delivery

To take advantage of added savings and the convenience of our Home Delivery program for maintenance medications, just complete the New Patient Home Delivery Form that you will find in your plan's welcome package. You only need to fill out this form once for each family member. Mail each form, original prescription(s) and copayment(s) in the self-addressed envelope. Please allow 14 business days to

Prescription Drug Coverage: Express Scripts (*continued*)

receive your prescription.

How to Use CuraScript

CuraScript®, the Express Scripts Specialty Pharmacy, is a full service specialty pharmacy that provides personalized care to individuals with chronic, complex health conditions. CuraScript offers several comprehensive patient care management programs specific to major medical conditions such as cancer, hemophilia, hepatitis, multiple sclerosis, psoriasis, pulmonary arterial hypertension, respiratory syncytial virus, rheumatoid arthritis and more. Through the patient care management programs, You can receive a complete range of services and specialty medication—many of which are costly and often unavailable at retail pharmacies—through disease-specific management programs.

CuraScript provides:

- **Patient Counseling**—Convenient access to highly trained specialty experts, including pharmacists, nurses and patient care coordinators who provide the support you need to manage your condition.
- **Patient Education**—Clinicians and disease-specific educational materials available 24/7.
- **Convenient Delivery**—Coordinated delivery to your home, your doctor's office or any other approved location.
- **Refill Reminders**—Ongoing refill reminders from a patient care coordinator.
- **Language Assistance**—Translation services are available for non-English speaking patients.

To learn more, please call 866-848-9870.

How to Use Prior Authorization

Some prescription drugs require a Prior Authorization review in certain situations before being covered.

To initiate a Prior Authorization request, have your healthcare professional contact Express Scripts Prior Authorization at 800-417-8164.

How to Use Step Therapy

Step Therapy is a program designed for people who regularly take prescription drugs to treat ongoing medical conditions, such as arthritis, asthma or high blood pressure. Step Therapy is all about health and value—about getting the most effective medication for your money. That means getting a tried-and-true medication that's proven safe and effective for your condition at the lowest possible cost.

What is Step Therapy?

In Step Therapy, prescription medications are grouped into categories:

- Step 1 medications are generic drugs that have been rigorously tested and approved by the FDA. These medications should be prescribed first because generics can provide the same health benefit as more-expensive medications but a lower cost.
- Step 2 medications are brand-name drugs such as those you see advertised on TV. They're recommended for you only if a Step 1 medication doesn't work for you. Step 2 medications almost always cost more.

What if my doctor prescribes a Step 2 medication?

If your doctor prescribes a Step 2 medication, ask if a generic (Step 1) medication may be right for you. Please share your formulary—the list of prescription drugs covered by your plan—with your doctor. The pharmacy will not automatically change your prescription; your doctor must write a new prescription for you to change from a Step 2 medication to a Step 1 medication. If a Step 1 medication is not a good choice for you, then your doctor can request prior authorization to determine if a Step 2 medication will be covered by your plan.

Who decides which prescription drugs are included?

Step Therapy is developed under the guidance and direction of independent licensed doctors, pharmacists and other medical experts. Together with Express Scripts—the company chosen to manage your prescription-drug benefit—they review the most current research on thousands of prescription drugs tested and approved by the FDA for

Express Scripts (continued)

safety and effectiveness. Then they recommend appropriate prescription drugs for the Step Therapy Program, and the HCPS chooses the medications that will be covered in your pharmacy benefit plan.

For more information on Step Therapy, visit www.Express-Scripts.com or call 1-877-866-5859

24-Hour Customer Service

If you have questions about your prescription benefit plan, please call Express Scripts at the phone number on the back of your prescription card; the number will be effective starting January 1, 2012.

Have you ever had questions regarding your prescription-drug benefit plan—such as: Which drugs are covered? or How can I save money on my prescriptions?

Express Scripts, the company chosen to manage your prescription-drug plan, has the answers to these questions and more at www.express-scripts.com.

Express Scripts provides 24-hour online access to information regarding your prescription benefit. Visit the website today to:

- Learn how you could save money
- Order prescription refills and check order status*
- Renew expired prescriptions*
- Check the price of a drug
- View or print a list of drugs included in your formulary (drug list)
- Locate participating retail pharmacies near you
- View up to 24 months of your prescription history
- Better understand your benefit coverage

Register now at www.express-scripts.com.

Accessing your prescription benefit online is quick and easy; just go to www.express-scripts.com and complete our brief registration process to get started. You'll have the information you need about your prescription benefit right at your fingertips.



CIGNA Dental Care

HCPSS has added CIGNA Dental Care DHMO as a dental option for HCPSS employee and dependents for the 2012 plan year.

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 Web site at www.CIGNA.com/dental. Both resources are available 24 hours a day. You may change your primary dentist selection by calling Customer Service at **1-800-CIGNA24 (1-800-244-6224)**. 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.

Know what’s important to you
Programs and services that help you make the most of your CIGNA dental plan.

The tools you need for better oral and overall health

Nothing is more important than your health. That’s why there’s www.myCIGNA.com—your online home for assessment tools, plan management, dental health information and much more.

Once you’ve enrolled in a CIGNA dental plan, you can use www.myCIGNA.com to:

- Choose dentists and create, download, and print a personal directory.
- Verify plan details
- Print a dental ID card.
- Get the forms you need.
- Access dental health information through WebMD® Dental Health Resource Center.

Your Dental Benefits At-a-Glance

CIGNA Dental DHMO	
Covered Services	In-Network only
Deductible	\$0
Maximum Benefit per Calendar Year	Unlimited
Covered Services	Plan Pays:
Preventive Care Exams, Cleanings and Xrays	100%*
Restorative Fillings	Copayments for covered procedures range from \$23–\$135*
Crowns and Bridges	Copayments for covered procedures range from \$425–\$520*
Endodontic–Root Canals	Copayments for covered procedures range from \$375–\$680*
Periodontics	Copayments for covered procedures range from \$70–\$640*
Prosthetics	Copayments for covered procedures range from \$43–\$780*
Orthodontics	Copayments vary from case to case. Maximum benefit of 24 months. *
Emergency Care	\$65 (\$74 after regularly scheduled hours)

* To view patient charge schedule, go to <https://hcpss.hrntouch.com>. Click on *Dental*, select *CIGNA Dental DHMO*.

Delta Dental PPO Plan

Benefit Highlights For Delta Dental PPOSM

Delta Dental offers you what no other dental plan can—The Delta Dental Difference[®]. Here’s what makes us a leading provider of dental benefits:

- **Exceptional Cost Savings**—Our networks protect enrollees from balance billing and prevent dentists from charging more by “unbundling” services that should be billed as one service. Your costs are usually lowest when you visit a Delta Dental dentist.
- **Guaranteed Coinsurance/Copayment**—Delta Dental dentists agree to accept our determination of fees. They won’t balance bill over Delta Dental’s approved amount.
- **Professional Treatment Standards**—Delta Dental reviews utilization patterns and office practices to ensure that Delta Dental dentists meet professional standards for safety and quality of care.

	In PPO Network	Out of PPO Network	
Sample Claims Savings	Delta Dental PPO Dentists	Delta Dental Premier Dentists	Non-Delta Dental Dentists
Dentist bills	\$180.00	\$180.00	\$180.00
Dentist accepts as payment in full	\$90.00 (Delta Dental’s agreed-upon fee)	\$130.00 (Delta Dental’s agreed-upon fee)	\$180.00 (No fee agreement with Delta Dental)
Delta Dental’s payment 50%	\$45.00	\$45.00	\$45.00
Patient share*	\$45.00	\$85.00	\$135.00
Patient savings	\$90.00	\$50.00	\$0.00

The Delta Dental PPO program allows you the freedom to visit any licensed dentist, including a dentist from our Delta Dental Premier indemnity network. However, there are advantages to visiting a Delta Dental PPO network dentist instead of a Premier or non-Delta Dental dentist. Consider the information below:

In-PPO Network Delta Dental PPO Dentists	Out-of-PPO Network Delta Dental Premier [®] Dentists & Non-Delta Dental Dentists
You will usually pay the lowest amount for services when you visit a Delta Dental PPO dentist. PPO dentists agree to accept a reduced fee for PPO patients.	You are responsible for the difference between the amount Delta Dental pays and the amount your non-Delta Dental dentist bills. You will usually have the highest out-of-pocket costs when you visit a non-Delta Dental dentist. Premier dentists may not balance bill above Delta Dental’s approved amount, so your out-of-pocket costs may be lower than with non-Delta Dental dentists’ charges.
You are charged only the patient’s share* at the time of treatment. Delta Dental pays its portion directly to the dentist.	Non-Delta Dental dentists may require you to pay the entire amount of the bill in advance and wait for reimbursement. Premier dentists charge you only the patient’s share* at the time of treatment.
Premier dentists will complete claim forms and submit them for you at no charge.	You may have to complete and submit your own claim forms, or pay your non-Delta Dental dentist a service fee to submit them for you.* Premier dentists will complete claim forms and submit them for you at no charge.

* Patient’s share is the coinsurance/copayment, any remaining deductible, any amount over the annual maximum and any services your plan does not cover.

** If you visit a non-network dentist, Delta Dental will send the benefit payment directly to you. You are responsible for paying the non-network dentist’s total fee, which may include amounts in excess of your share of your plan’s contract allowance.

Delta Dental PPO Plan (continued)

Program Overview

The following information is not intended or designed to replace or serve as an Evidence of Coverage or Summary Plan benefit structure, limitations or exclusions, consult your company's benefits representative for the provisions specified in your Group Dental Contract.

Who's Eligible	Primary enrollee, Spouse or Domestic Partner and eligible Dependent children to the end of the month that Dependent turns 26.
Deductibles	\$25 per person / \$75 per family (per calendar year)
Deductible Waived For Diagnostic, Preventive, Basic Restorative and Orthodontics?	Yes
Annual Maximum	The maximum benefit paid per calendar year is \$2,000 for premier and PPO/\$1,500 for non-participating dentists per person

Contact Information

Delta Dental of Pennsylvania

Customer Service

deltadentalins.com

800-932-0783

(Business Hours: 8 a.m. – 8 p.m. EST)

Claims Address

P.O. Box 2105, Mechanicsburg, PA 17055

* Limitations or waiting periods may apply for some benefits; some services may be excluded. Please refer to your Evidence of Coverage or Summary Plan Description for waiting periods and a list of benefit limitations and exclusions.

** Fees are based on PPO fees for PPO dentists and PPO fees for out-of-PPO

Benefits and Covered Services*	In-PPO Network**	Out-of-PPO Network**
Diagnostic and Preventive Benefits Oral examinations, routine cleanings, x-rays, fluoride treatment, space maintainers, sealants	100%	100%
Basic Benefits Fillings, posterior composites	90%	90%
Major Benefits Inlays, onlays and cast restorations	50%	50%
Endodontics Root canals	80%	80%
Periodontics Gum treatment	80%	80%
Oral Surgery Incisions, excisions, surgical removal of tooth including simple extractions	80%	80%
Prosthodontics Bridges, dentures, implants	50%	50%
Crowns	60%	60%
Orthodontic Benefit children only to the end of the calendar year they reach age 19	50%	50%
Orthodontic Maximum	\$1,200 Lifetime	\$1,200 Lifetime
Other Denture Repair	Service covered at 80%	Service covered at 80%

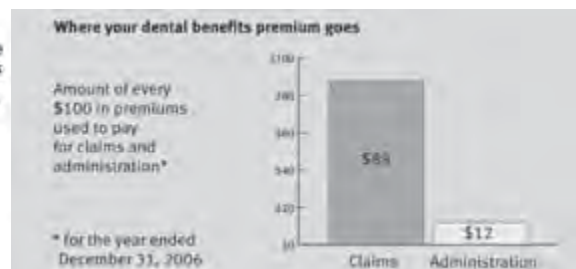
dentists. Reimbursement is paid on Delta Dental contract allowances and not necessarily each dentist's actual fees.

Maryland law requires we make the following statement:

Our compensation to physicians who offer health care services to our insured members or enrollees may be based on a variety of payment mechanisms such as fee-for-service payments, salary or capitation. Bonuses may be used with these various types of payment methods. If you desire additional information about our methods of paying physicians, or if you want to know which method(s) apply to your physician, please call Delta Dental at 800-932-0783 or write to: Delta Dental of Pennsylvania, One Delta Drive, Mechanicsburg, PA 17055.

Please note that the benefit payments made by Delta Dental to dentists, other dental care providers or enrollees are based on fee-for-service payment mechanisms and do not include salary, capitation or bonuses.

In Maryland, Delta Dental PPO and Delta Dental Premier are underwritten by Delta Dental of Pennsylvania, a not-for-profit dental service company.



Vision Service Plan (VSP)

Vision Service Plan doctors take the time to get to know you and your eyes. Through a WellVision Exam[®], our doctors look for more than just vision problems. They can detect signs of serious health conditions like diabetes, high blood pressure, and high cholesterol too. VSP doctors are located nearby and most offer weekend and evening appointments. Plus, all of our doctors offer eyewear choices you'll love. Before selecting your eyewear, ask your doctor what is fully covered by your VSP plan. The following chart summarizes the main benefits of your plan:

Your Vision Plan Coverage from a VSP Doctor

Benefits	Copay	Frequencies
WellVision Exam[®] focuses on your eye health and overall wellness	No copay	Every calendar year
Prescription Glasses Lenses <ul style="list-style-type: none"> ■ Single vision, bifocal, trifocal, lenticular Frame ■ \$120 allowance for frame of your choice ■ 20% off amount over your allowance 	\$20 copay	Every calendar year
Contact Lens Care* <ul style="list-style-type: none"> ■ Medically necessary ■ Elective—\$120 allowance for contacts and the contact lens exam (fitting and evaluation). This additional exam ensures proper fit of contacts. 	\$20 copay No copay	Every calendar year Every calendar year

Extra savings and discounts

Prescription Glasses	<ul style="list-style-type: none"> ■ Average 30% savings on lens options like progressives and scratch-resistant and anti-reflective coatings ■ 20% off additional glasses and sunglasses, including lens options**
Contacts**	<ul style="list-style-type: none"> ■ 15% off cost of contact lens exam (fitting and evaluation)
Laser Vision Correction***	<ul style="list-style-type: none"> ■ Average 15% off the regular price or 5% off the promotional price from contracted facilities. ■ After your surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor.

* Patients choosing contacts use their eligibility for a frame and lenses. Materials are provided at the customary fees. Your VSP doctor must get prior approval from VSP for medically necessary contact lenses. Current contact lens users may qualify for a special program that includes a contact lens evaluation and initial supply of replacement lenses.

** Available from any VSP doctor within 12 months of your last eye exam.

*** Laser vision correction (PRK and LASIK surgery) is available through contracted laser centers. Must see a VSP doctor. For a referral. Call 888-354-4434 for information.

Vision Service Plan (VSP) (continued)



Getting started is a breeze.

- **Find the right VSP doctor for you.** You'll find plenty to choose from at www.vsp.com or by calling (800) 877-7195.
- **Already have a doctor?** Make an appointment and tell them you're a VSP member.
- **Check out your coverage and savings.** Visit www.vsp.com to see your benefits anytime and check out how much you saved with VSP after your appointment.

That's it! We'll handle the rest—**no ID card** or claim forms to complete.

You're free to choose.

You'll find a big selection of VSP doctors and a get better value by staying in-network. If your doctor isn't in our network, you can choose to see a non-VSP provider. You'll pay the provider in full and have six months to submit a claim to VSP for partial reimbursement. Before seeing a non-VSP provider, contact us at (800) 877-7195.

Open Access

You get the best value from your benefit when you see a VSP doctor. If you see a non-VSP provider, you'll typically pay more out of pocket. You'll pay the provider in full and must submit a claim to VSP for partial reimbursement less copays. Before seeing a non-VSP provider, call us first at (800) 877-7195.

Service	Covered up to
Exam	\$52
Single Vision Lenses	\$55
Bifocal Lenses	\$75
Trifocal Lenses	\$95
Lenticular Lenses	\$125
Frame	\$70
Medically Necessary Contacts	\$210
Elective Contacts	\$105

For non-VSP doctor appointments only:

Sign on to www.vsp.com, select the *VSP Member Reimbursement Form* and follow the instructions. If you don't have Internet access, send the following to VSP:

- Itemized receipt listing services received
- Name, address and phone number of the non-VSP provider
- Insured member's name, unique ID number, address and phone number
- Patient's name, date of birth, address, phone number and relationship to insured member
- Reference Howard County Public Schools

Submit your claims to VSP within six months. Keep copies of the claims and send the originals to:

VSP Open Access
Attn: Out of Network Claims
P.O. Box 997105
Sacramento, CA 95899-7105

Questions? Please call VSP at (800) 877-7195 or visit www.vsp.com.

Vision Service Plan (VSP) (continued)

How the VSP Works

To Use a Vision Service Plan Provider...

Step 1:

Call VSP at (800) 877-7195 or visit VSP's website at www.vsp.com to locate a participating optometrist or ophthalmologist.

Step 2:

When making an appointment, identify yourself as a VSP member. The participating doctor will also need the last 4 digits of your social security number and last name so that your eligibility may be verified with VSP.

Important Note: The vision plan is offered through VSP. No identification card is necessary. Do not offer your medical health insurance identification card to a VSP provider.

Step 3:

At your appointment, the participating doctor will provide an eye examination and determine if eyewear is necessary. Simply pay your copayment(s) listed on page 45.

To Use a Non-Participating Provider...

Step 1:

Select any licensed vision care provider of your choice.

Step 2:

Pay for the services when they are rendered.

Step 3:

Submit a claim to VSP for reimbursement within 6 months. The reimbursement schedule does not guarantee full payment when services are provided by a non-participating provider. Your claim must include your name, address, social security number, group name (i.e. the name and relationship of the patient, the itemized bill and receipt). Please keep a copy of the information for your records and send the originals to the following address:

**Vision Service Plan
Attn: Out-of-network Claims
P.O. Box 997105
Sacramento, CA 95899-7105**



Vision Service Plan (VSP) (continued)

More Choice and Convenience with VSP® Vision Care

Beginning January 1, 2012, you'll have more eyecare providers to choose from with VSP. Finding the right eyecare provider for you is important to your eye health and overall wellness. That's why you can choose to see a VSP doctor, retail chain affiliate (including Costco and Eye Care Centers of America (ECCA)), or any other provider.

Below is a high-level summary of your coverage with VSP doctors and Costco or ECCA. Beginning on January 1, 2012, you can visit www.vsp.com for a complete descriptions of your benefits.

Using your VSP benefit is easy

Whether you choose to see a VSP doctor, retail chain affiliate, or any other provider using your vision coverage is simple and convenient.

- **Find an eyecare provider who's right for you.** To find a VSP doctor or an affiliate provider, visit www.vsp.com or call 800-877-7195.

- **Review your benefit information.** Visit www.vsp.com to review your plan coverage along with the details about how your coverage differs with retail chain affiliates and other providers.

- **At your appointment, tell them you have VSP.** There's no ID card necessary.

That's it. VSP will handle the rest—there are no claim forms to complete when you see a VSP doctor or retail chain affiliate.

If you choose to see a provider other than a VSP doctor or retail chain affiliate, you may need to submit a claim form to VSP for reimbursement. Some providers, such as WalMart, submit your claim to VSP for you. Visit www.vsp.com for more details.

VSP has made getting your benefit information and finding a doctor easier and more convenient through your smartphone. Simply register and log on to www.vsp.com and you'll be able to access information on the go—when you need it.

See well and stay well with VSP.

Benefit	Coverage with VSP Doctors	Coverage with Costco or ECCA
Eye Exam	Fully covered after a \$20 copay	Fully covered after a \$20 copay
Prescription Glasses	\$20 copay	\$20 copay
Frame	\$120 allowance; 20% discount on amount over your allowance	Special pricing on frames up to a \$70 allowance
Lenses	<ul style="list-style-type: none"> ■ Single Vision, lined bifocal, and line trifocal lenses ■ Polycarbonate lenses for dependent children 	<ul style="list-style-type: none"> ■ Single Vision, lined bifocal, and line trifocal lenses ■ Polycarbonate lenses for dependent children
Lens Options	Average 35%–40% off lens options	Check with Costco or ECCA for member pricing on lens options
Contacts (instead of glasses)	\$120 allowance for contacts and contact lens exam	\$120 allowance for contacts; your contact lens exam is not covered
Extra Savings and Discounts	Available through VSP doctors only	Not available

Life & Accidental Death & Dismemberment Insurance

Offered through ReliaStar Life Insurance Company

HCPSS offers eligible employees life insurance & accidental death and dismemberment (AD&D) insurance at no cost to the employees through ReliaStar Life Insurance Company.

The amount of life insurance is equal to the employees' current annual salary.

Voluntary Life Insurance Coverage

HCPSS offers two types of Life Insurance that employees may purchase through the convenience of payroll deductions:

- Premier Whole Life Insurance with optional Long Term Care Rider with Restoration and Extension of Benefits.
- Supplemental Group Term Life Insurance with Portability

Premier Whole Life Insurance with optional Long Term Care Rider with Restoration and Extension of Benefits

This is a policy that is very well suited for long term insurance needs and final expenses. Your spouse and children/grandchildren may also be covered. There is an optional Long Term Care rider available.

- Employees may apply for the amount of coverage that \$20 per week will purchase for their age up to \$100,000 with only two health questions asked. An employee may apply for more coverage, but additional underwriting will be required.
- Spouses may apply for the amount of coverage that \$5 per week will purchase for their age with a minimum coverage of \$5,000 with only two health questions asked. A spouse may apply for more coverage but additional underwriting will be required.
- Children/grandchildren may apply for an individual policy in amounts of \$12,500, \$15,000, \$20,000 or \$25,000 with only two health questions asked.
- Your spouse and children/grandchildren may apply for coverage even if you are not applying for coverage yourself.
- Premiums are guaranteed to be fixed for the life of the policy.

- The policy builds guaranteed cash value.
- Coverage is Portable. Therefore, if you retire or leave employment, the policies may be taken with you.

To apply for Premier Whole Life Insurance with optional Long Term Care Rider with Restoration and Extension of Benefits you must contact The Farmington Co at 1-800-621-0067.

Premier Whole Life Insurance is issued and underwritten by ReliaStar Life Insurance Company, Policy Form Number RL-WL2-POL-07, form number may vary by state.



Life & Accidental Death & Dismemberment Insurance (*continued*)

Supplemental Group Term Life Insurance with Portability

This is group term life insurance that provides affordable protection for short term needs. Coverage may be taken with you if you leave or retire.

- You may elect Supplemental Life coverage in amounts of 1, 2 or 3 times your annual salary.
- You must provide Evidence of Insurability subject to approval by ReliaStar Life Insurance Company.
- New Hires are eligible for the guaranteed issue amount of one times salary up to \$50,000 if enrolled within 30 days of date of hire.
- Coverage is portable. Therefore, if you change jobs or retire, you can keep coverage to age 70.
- Rates are based on five-year age bands, and the rate will be based on your age as of January 1, 2012 and every January 1st thereafter. The rate will change when you reach the next age band.
- You may elect Dependent Life coverage on your family, if you elect Supplemental Life coverage for yourself. Your spouse will be covered for \$10,000 and each child will be covered for \$5,000 for \$2.00 a month.
- If you elect Dependent Life when you are first eligible, Evidence of Insurability on your spouse and children is not required. If you elect Dependent Life after you are first eligible then you must provide Evidence of Insurability on your dependents, subject to approval by ReliaStar Life Insurance Company.

This is a summary of benefits only. A complete description of the benefits and limitations will be provided in the Certificate of Coverage. Policy form LP00GP.

Accident Insurance, a limited benefit policy

For plan year 2012, Accident coverage will be offered through ReliaStar Insurance Company.

You cannot anticipate what one accident could mean to your financial stability. Accident insurance benefits are paid directly to you. You can use the money however you wish. The benefits are paid in addition to other medical coverage.

Accident Insurance can help cover the unexpected costs related to accident expenses. This policy pays a specified benefit amount for:

- Initial care such as ambulance, emergency room and initial doctor visit.
- Follow-up care such as outpatient doctor's treatment and medical appliances.
- Injuries, including burns, dislocations and fractures
- Catastrophic accident
- Accidental death
- You are eligible to apply if you are 18 years old or older, you are a permanent benefits eligible employee who meets the requirements and you are actively at work on the enrollment date.
- You may also apply for coverage on your spouse and dependent children.
- Coverage is available to you without answering health questions.
- Coverage is portable. Therefore, if you retire or leave, policies can be taken with you.

This is a summary of benefits only. A complete description of the benefits and limitations will be provided in the policy or Certificate of Coverage.

Accident Insurance is issued and underwritten by ReliaStar Life Insurance Company, Policy Form Number RL-ACC2005-POL, form number may vary by state.

Aflac Group Critical Illness including Cancer

Aflac's Group Critical Illness product provides a lump-sum benefit upon the diagnosis of not only one covered illness, but for each diagnosed covered illness, including Cancer.

Group Critical Illness insurance provides a lump-sum benefit payment to cover out-of-pocket medical expenses and the costs associated with life-changes following a covered critical illness. Cancer, Heart Attack, Stroke, or Renal Failure (end stage) are all life-changing events.

This product is available to employees 18-69 years of age. Plan benefits include but are not limited to:

- Lump-sum paid directly to the insured (unless otherwise assigned) following the diagnosis of each covered critical illness.
- Guaranteed Issue—available for employee at \$15,000 and \$7,500 spouse coverage.
- Benefit amounts available for \$5,000 up to \$50,000 for employees and \$25,000 for spouse.
- Each dependent child is covered at 25% of the primary insured amount at no additional charge.
- Additional Benefit Rider includes Coma, Paralysis, Burns, Loss of Sight, Loss of Hearing and Loss of Speech.

Coverage Availability:

- Individual
- Spouse
- Dependent child, under age 26, at no additional cost at 25% of the employee benefit amount.

Plan Features:

- Annual health screening benefits included.
- The plan is portable, with certain stipulations.
- Level premium rates based upon the applicant's age as of the time of application. Rates cannot be individually increased on a particular insured due to a change in age, health or individual claim.

Coverage is underwritten by Continental American Insurance Company.

For specific program and rate information contact Pam Dinterman at (410) 207-5341 or pamela_dinterman@us.aflac.com.



Short Term Disability—The Standard

Short-term disability (STD) insurance helps to replace your income if you are sick or injured and cannot work. It is designed to begin after you have been disabled for a predetermined waiting period, known as the elimination period. You have a choice of elimination periods with this plan: 7 days, 14 days or 30 days.

Important Note:

Coverage elected during the 2011 open enrollment will require no medical underwriting approval. Any election made after the 2011 open enrollment will be subject to medical underwriting approval from Standard.

Eligibility

All active full-time employees who work 30 hours per week on a regularly scheduled basis for HCPSS.

Eligibility Waiting Period

First day of the month following your date of hire. Coverage elected during the 2011 open enrollment begins on January 1st, 2012.

Elimination Period

The elimination period will run for 7, 14 or 30 days depending on the option you choose. During this time you will not receive any short-term disability benefits, but you may receive sick leave.

Maximum Benefit Period

The benefit period will last until you are no longer disabled, or 3 months, whichever is shorter. If you have also purchased long-term disability coverage from Standard they will automatically transition your claim and review whether benefits will continue.

Benefit Percentage and Maximum Benefit

The benefit percentage is 60% of your regular weekly pay. The maximum weekly benefit is \$2,500.

The chart below will help you determine the cost of STD insurance. The cost will automatically calculate when you select this coverage online.

Per Payroll Rates Based on 20 Annual Deductions				
	<39	40-49	50-59	60+
7 Day EP Rate	\$.29	\$.22	\$.28	\$.40
14 Day EP Rate	\$.25	\$.17	\$.22	\$.32
30 Day EP Rate	\$.17	\$.12	\$.16	\$.22

$$\frac{\text{Annual Salary}}{52} = \text{Weekly Salary (less than or equal to \$4,167)} \times .06 \times \text{Rate Above} = \$ \text{Pay Period Cost}$$

Your cost may change if your salary changes within the benefit's plan year.

Long Term Disability

Long-term disability (LTD) insurance helps to replace your income if you are sick or injured and cannot work. It is designed to begin after you have been disabled for a predetermined waiting period, known as the elimination period, of 90 days.

Important Note:

If you are enrolling in long-term disability (LTD) coverage offered through The Standard via on-line, other than the period that you were initially eligible to enroll, you will be required to **mail a completed Medical History Statement to The Standard by November 30, 2011**. Once your application has been processed and reviewed by The Standard, you will receive a notification of approval / denial of LTD coverage.

The deduction for LTD coverage will begin the first of the month following notification of approval from The Standard.

Eligibility

All active full-time Employees who work 30 hours per week on a regularly scheduled basis for HCPSS.

Eligibility Waiting Period

First day of the month following your date of hire.

Elimination Period

90 days

Benefit Percentage/ Maximum & Minimum Benefit

You have a choice of choosing a plan which can replace 25%, 40% or 50% of your monthly income loss to a maximum of \$6,500.

The chart below will help you determine the cost of LTD insurance. The cost will automatically calculate when you select this coverage online.

Per Payroll Rates Based on 20 Annual Deductions									
Age	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60+
Option 1 Rate	\$.0414	\$.0414	\$.0666	\$.0864	\$.1356	\$.1842	\$.2796	\$.3642	\$.3642
Option 2 Rate	\$.0360	\$.0360	\$.0582	\$.0774	\$.1218	\$.1650	\$.2496	\$.3270	\$.3270
Option 3 Rate	\$.0342	\$.0342	\$.0552	\$.0696	\$.1110	\$.1524	\$.2322	\$.3018	\$.3018

If I Elect:	My LTD Benefit Will Be:	Annual Salary Maximum
Option 1	LTD coverage of up to 50% of my regular pay to maximum of \$6,500	\$156,000
Option 2	LTD coverage of up to 40% of my regular pay to maximum of \$6,500	\$195,000
Option 3	LTD coverage of up to 25% of my regular pay to maximum of \$6,500	\$312,000

$$\frac{\text{Annual Salary}}{\div 12} = \frac{\text{Monthly Salary}}{\div 100} = \text{Rate Above} \times \text{Pay Period Cost} = \$$$

Your cost may change if your salary changes within the benefit's plan year.

Flexible Spending Accounts (FSAs)

Plan Administrator

HCPSS will continue to use the services of HFS Benefits (HFS) to administer our Flexible Spending Accounts. The online address is www.hfsbenefits.com.

HFS Benefits

4 North Park Drive, Suite 500

Hunt Valley, MD 21030-1550

Email: customerservice@hfsbenefits.com

Local Phone: **410-771-1331**

Toll-Free Phone: **888-460-8005**

Local Fax: **410-771-5533**

Toll-Free Fax: **1-888-510-4218**



Who should consider using Flexible Spending Accounts?

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

Why you should consider using Flexible Spending Accounts?

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

Flexible Spending Accounts (FSAs) (continued)

Rules for Dependent Care Flexible Spending Accounts

Dependent Care FSAs are used to reimburse you for expenses you have for dependent daycare only. Do not use the Dependent Care FSA for anticipated medical expenses for your dependents—those expenses are reimbursed through the Health Care FSA. The IRS requires the following conditions to be met.

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

How Dependent Care FSAs work

- Estimate what you think you will spend for dependent care expenses in the upcoming Plan Year (January 1, 2012–December 31, 2012).
- Enroll online by entering the amount you expect to spend this year on the Flexible Spending Accounts page. The annual minimum contribution is $\$100/20 = \$5/\text{pay}$ and the annual maximum contribution is $\$5,000/20 = \$250/\text{pay}$
- Beginning with the first paycheck in January, 2011, you will see a deduction for your Dependent Care Account. That amount will be credited to your Dependent Care Account each pay period. You can reimburse yourself with the money in your account bi-weekly, monthly, or even annually if you prefer.
- You submit your receipts for dependent care to HFS with a simple claim form.
- You have the option of receiving your reimbursement either by check or by direct deposit to your bank account.
- If the claims you submit are more than the balance in your account, any excess amount will carry over to the next pay date and be paid at that time.

Some services such as nursing home expenses and overnight expenses do not qualify for Dependent Care FSA reimbursement—consult IRS Publication #503 for more information or visit the HFS website at www.hfsbenefits.com.

Dependent Care FSA Savings Example:	Without FSA	With FSA
Gross Annual Salary	\$24,000	\$24,000
Pre-Tax Dependent Care Cost	—	\$3,900
Taxable Income	\$24,000	\$20,100
Federal Tax (15%)	\$3,600	\$3,015
Local Tax (7.5%)	\$1,800	\$1,508
FICA/Medicare (7.65%)	\$1,836	\$1,538
After-tax Dependent Care Cost	\$3,900	—
Net Annual Salary	\$12,864	\$14,039
Annual Savings	—	\$1,175

Flexible Spending Accounts (FSAs) (continued)

Rules for Health Care Flexible Spending Accounts

The Health Care FSA is used to reimburse your predictable out-of-pocket medical expenses. If you expect to spend \$100 or more this year on medical expenses for yourself or your spouse and/or dependent children, you should consider participating in a Health Care FSA. Examples of expenses allowed by the IRS include:

- Copayments or coinsurance amounts that you must pay for doctor's office visits, diagnostic tests or prescriptions.
- Your share of the cost for orthodontia treatment for yourself, spouse or your children.
- Medical or dental services not covered by your benefit plans (i.e., laser vision correction)
- The cost of some over-the-counter medical products as allowed by the IRS (medical equipment, bandaids, bandages)

How the Health care FSAs work

- Estimate what you think you will spend for predictable health care expenses in the upcoming Plan Year (January 1, 2012–March 15, 2013)
- Enroll online at www.hcpss.benelogic.com by entering the amount you expect to spend this year in the Flexible Spending Account section. The annual minimum contribution is $\$100/20 = \$5/\text{pay}$ and the annual maximum contribution is $\$3500/20 = \$175/\text{pay}$.
- Beginning with the first paycheck in January, 2012, you will see a deduction for your Health Care Account. That amount will be credited to your Health Care Account each pay period.
- Health Care Accounts are pre-funded – that means you have access to the entire election amount for the plan year at any time during the plan year. You can use your pre-funded debit card or submit your receipts and claim requests can be reimbursed for the full amount you spend for qualified services or purchases up to your annual amount at any time during the plan year.

- Over-the-counter (OTC) medications such as antacids, allergy medicines, pain relievers and cold medicines, will require a prescription from a health care provider to qualify for reimbursement. Because OTC medications will be removed from the approved list of reimbursable items, the FSA debit card will not be accessible for these purchases. You will be required to use another form of payment and submit a claim for reimbursement.

Options for receiving Health Care FSA Reimbursements

- **For Health Care FSAs only, participants will receive a debit card** that has been credited with the annual amount you elected for this plan year. The debit card can be used at numerous medical, dental and vision care practices for copays or coinsurance amounts as well as for qualified purchases. You may use your debit card at retail locations that comply with the IRS mandated Inventory Information Approval System (IIAS). Medical, Dental and Prescription plan copays will not require receipts. However, please retain all receipts when using your debit card as HFS may need to obtain a copy of your receipt to verify the eligibility of the expense.
- If you do not use the debit card, you can file claims with HFS using one of the following methods:

HFS Benefits

4 North Park Drive, Suite 500

Hunt Valley, MD 21030-1550

Local Fax: 410-771-5533

Toll-Free Fax: 1-888-510-4218

By Email: claims@hfsbenefits.com

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

Flexible Spending Accounts (FSAs) (continued)

Health Care FSA Savings

As with the Dependent Care FSA, you will save money because you are paying qualified Health Care expenses with pre-tax money instead of after tax money.

Use It or Lose It Rule

Any amount that remains in your account after April 30, 2013 must be forfeited. Keep in mind that you save at least 28% on every dollar you set aside and use to pay for qualified expenses—if you have a small balance at the end of the year, you will still have saved more in taxes than you lose if you didn't have enough expenses to claim all your money. Plus you can use the funds for certain over the counter supplies to avoid forfeiture of the money.

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

- For the plan year that begins January 1, 2012 you must incur expenses between January 1, 2012 and March 15, 2013.
- The last day for submitting claims for expenses incurred between January 1, 2012–March 15, 2013 is April 30, 2013.

Annual Enrollment Required

Because your anticipated expenses can change from year to 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. This applies even if you want to elect the same amount you have in the current plan year. **If you do not enroll online during the Open Enrollment period, you will not be able to have an FSA in the new benefit year.**

Things to know when using your Flexible Spending Account Debit Card

Your FSA debit card allows you to directly pay for your eligible FSA expenses at the point of services. This allows you to avoid the traditional hassles, such as paying out of pocket for services and then filling out and submitting a claim form and waiting for a reimbursement check. Your cards can be used at any authorized Medical provider who accepts MasterCard. A list of authorized retail outlets is available at www.hfsbenefits.com. The payment that you make to the provider of services will be deducted directly from your FSA account.

- Your FSA debit card can only be used to pay for eligible expenses. Examples include:
 - Eligible Medical, Dental and/or Vision expenses not covered by your insurance plan (i.e. copays and deductibles)
 - Prescription copays
 - Contact lenses, eyeglasses and other vision care expenses
 - Alternative healing (acupuncture and chiropractic visits)
 - The debit card system is coded to only accept charges from qualified merchants (i.e. doctor's office, dentist's office, pharmacy, etc). Please do not use your FSA debit card to pay for your prescription(s) at the same time you purchase non-eligible items like toothpaste, shampoo, vitamins, etc.
- Your FSA debit card transaction will be denied if the amount of your transaction is greater than the balance in your FSA account.
- Your FSA debit card offers 24/7 online access to real-time account balances plus other vital information. Go to www.hfsbenefits.com to review your account status.
- Please retain all receipts for goods and services that are purchased with your FSA debit card. HFS will request to review receipts for charges which cannot be determined to be an exact copayment match or previously substantiated recurring expense. If you cannot provide a receipt to prove that your purchase is an eligible charge, you will be asked to reimburse your FSA for the amount of the purchase.

Flexible Spending Accounts (FSAs) *(continued)*

- When using your FSA debit card, please be sure to notify the merchant to process the transaction as a “credit”. If “debit” is selected in error, the transaction will be declined as there is no PIN number associated with the card.
- Be sure that you are using your FSA Debit card to pay for current plan year expenses. You will be asked to reimburse the plan if you pay for any expenses that were incurred in the previous plan year. The date that the service was rendered is considered to be the date the expense was incurred.

Very important

HFS will email and/or mail you a request for receipt for all transactions that do not match a copay or do not match a previously substantiated expense. If you do not respond to the first request, a second request will be emailed/mailed 30 days after the first notification. If HFS does not receive substantiation of the full expense within 30 days, a third and final notification will be generated. Any transactions that are not substantiated within 90 days from the date of transaction swipe will be deemed ineligible and your card will be temporarily deactivated.

Substantiation receipts must be generated from the provider and include the following information:

- Name of Provider,
- Date of Service,
- Description of the Service,
- Amount of the service, and
- The patient’s name.

Please note that credit cards receipts do not meet this requirement.

For more information about the plan and online account inquiry please visit: www.hfsbenefits.com or contact:

HFS Benefits

**4 North Park Drive, Suite 500
Hunt Valley, MD 21030-1550**

Local Phone: 410-771-1331

Toll-Free Phone: 1-888-460-8005

Toll-Free Fax: 1-888-510-4218



HCPSS Annual Medical Costs

Rate Chart for Active Full-Time/Part-Time Employees with a Hire Date on or Before 6/30/2011

	Total Cost 1/1/12–12/31/12 (For Information Only)	Your Cost 1/1/12–12/31/12	Benefit Credits
No Medical Coverage Through the School System			
No Coverage		\$-	\$750

With Medical Coverage Through the School System	Deductions are based on 20 pay periods		
Aetna Open Choice PPO			
Individual	\$6,071	\$871	\$420
Parent/Child(ren)	\$13,053	\$1,697	\$420
Husband/Wife	\$14,690	\$1,910	\$420
Family	\$21,009	\$2,731	\$420
Open Access Aetna Select HMO			
Individual	\$5,326	\$692	\$420
Parent/Child	\$10,377	\$1,349	\$420
Husband/Wife	\$11,677	\$1,518	\$420
Family	\$16,700	\$2,171	\$420
BlueChoice HMO Open Access			
Individual	\$5,391	\$701	\$420
Parent/Child	\$10,530	\$1,369	\$420
Husband/Wife	\$11,865	\$1,542	\$420
Family	\$17,004	\$2,211	\$420

HCPSS Annual Medical Costs (continued)

Rate Chart for Active Full-Time/Part-Time Employees with a Hire Date on or After 7/01/2011

	Total Cost 1/1/12—12/31/12 (For Information Only)	Your Cost 1/1/12—12/31/12	Benefit Credits
No Medical Coverage Through the School System			
No Coverage		\$-	\$750
With Medical Coverage Through the School System			
	Deductions are based on 20 pay periods		
Aetna Open Choice PPO			
Individual	\$6,071	\$1,005	\$420
Parent/Child(ren)	\$13,053	\$1,958	\$420
Husband/Wife	\$14,690	\$2,204	\$420
Family	\$21,009	\$3,151	\$420
Open Access Aetna Select HMO			
Individual	\$5,326	\$799	\$420
Parent/Child(ren)	\$10,377	\$1,557	\$420
Husband/Wife	\$11,677	\$1,752	\$420
Family	\$16,700	\$2,505	\$420
BlueChoice HMO Open Access			
Individual	\$5,391	\$809	\$420
Parent/Child	\$10,530	\$1,579	\$420
Husband/Wife	\$11,865	\$1,780	\$420
Family	\$17,004	\$2,551	\$420

HCPSS Dental & Vision Rates

HCPSS Annual Dental Rates 2012

Coverage	Rates
Delta Dental – PPO	
Individual	\$373
Parent/Child(ren)	\$602
Husband/Wife	\$859
Family	\$1,158
CIGNA DHMO	
Individual	\$123
Parent/Child	\$275
Husband/Wife	\$209
Family	\$388



HCPSS Annual Vision Rates 2012

Coverage	Rates
VSP Vision	
Individual	\$83
Parent/Child(ren)	\$113
Husband/Wife	\$166
Family	\$210

2012 Benefits Open House For HCPSS Employees



This year's Benefits Open House will give Employees the opportunity to meet individually with the plan representatives. The meetings will also include plan materials, and promotional items as well as healthy lifestyle information. The following plan representatives will be available at the meetings.

- CareFirst BlueCross BlueShield
- Aetna
- Express Scripts
- Delta Dental
- CIGNA Delta DHMO
- Vision Service Plan (VSP)
- Hirsch Financial Services (Flexible Spending Accounts)
- The Standard (Disability plans)
- ReliaStar (Life Insurance Voluntary Benefit Plans)
- AFLAC (Voluntary Benefit)
- AXA Equitable (403(b) vendor)
- Valic (403(b) vendor)
- Horace Mann (403(b) vendor)
- ING (403(b) vendor)
- Met Life (403(b) vendor)
- Nationwide (457(b) vendor)
- Fidelity
- Plan Member Services

Benefits Open House will take place at the following location and times:

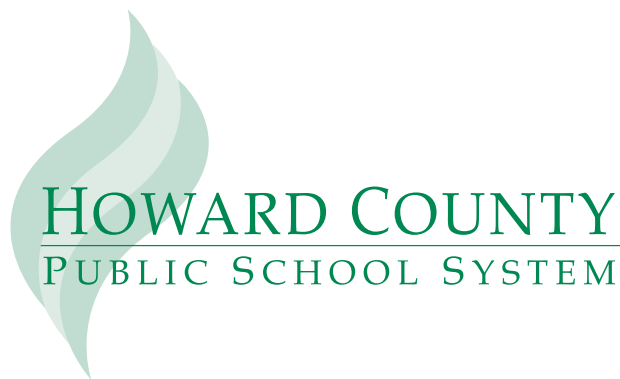
**10910 Route 108, Ellicott City, MD 21042
Central Office Board Room A & B**

Wednesday, October 12, 2011
12:30 p.m. to 6:00 p.m.

Tuesday, October 18, 2011
12:30 p.m. to 6:00 p.m.

Wednesday, October 26, 2011
12:30 p.m. to 6:00 p.m.

Notice of Privacy Practices



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

The privacy of your medical information is important to us.

NOTICE OF PRIVACY PRACTICES

The following entities, affiliated with Howard County Public School System Welfare Benefits Plan, are covered by this notice:

This notice applies to the privacy practices of the health plans listed below. As affiliated (related) entities, we might share your protected health information and the protected health information of others on your insurance policy as needed for payment or health care operations.

Traditional Medical Plan, Alternate Medical Plan, Aetna Select Open Access HMO, Aetna PPO, CareFirst BlueChoice HMO Open Access, Kaiser Permanente Select HMO, UnitedHealthcare Choice HMO, Current Dental Plan, Alternate Dental Plan, Delta Dental PPO, Vision Care Plan, Vision Service Plan, Health Care Spending Account, and Dependent Care Account.

Our Legal Duty

This Notice describes our privacy practices, which include how we might use, disclose (share or give out), collect, handle, and protect our members' protected health information. We are required by certain federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice took effect April 14, 2003, and is not intended to amend any prior notice of Howard County Public School System Welfare Benefits Plan privacy practices.

We reserve the right to change our privacy practices and the terms of this notice at any time, as long as law permits the changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including protected health information we created or received before we made the changes. If we make a significant change in our privacy practices, we will change this notice and send the new notice to our health plan subscribers within 60 days of the effective date of the change.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Medical Information

Primary Uses and Disclosures of Protected Health Information

We use and disclose protected health information about you for payment and health care operations. The federal health care Privacy Regulations generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under

Notice of Privacy Practices (*continued*)

which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of the protected health information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, and reproductive rights. In addition to these state law requirements, we also may use or disclose protected health information in the following situations:

Payment

We might use and disclose your protected health information for all activities that are included within the definition of “payment” as written in the Federal Privacy Regulations. For example, we might use and disclose your protected health information to pay claims for services provided to you by doctors, hospitals, pharmacies and others for services delivered to you that are covered by your health plan. We might also use your information to determine your eligibility for benefits, to coordinate benefits, to examine medical necessity, to obtain premiums, and to issue explanations of benefits to the person who subscribes to the health plan in which you participate.

Health Care Operations

We might use and disclose your protected health information for all activities that are included within the definition of “health care operations” as defined in the Federal Privacy Regulations. For example, we might use and disclose your protected health information for stop-loss underwriting to determine our premiums for your health plan, to conduct quality assessment and improvement activities, to engage in care coordination or case management, and to manage our business.

Business Associates

In connection with our payment and health care operations activities, we contract with individuals and entities (called “business associates”) to perform various functions on our behalf or to provide certain types of services (such as member service support, utilization management, subrogation, or pharmacy benefit management). To perform these functions or to provide the services, our business associates will receive, create, maintain, use, or disclose protected health information, but only after we require the business associates to agree in writing to contract terms designed to appropriately safeguard your information.

Other Covered Entities

In addition, we might use or disclose your protected health information to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with certain of their health care operations. For example, we might disclose your protected health information to a health care provider when needed by the provider to render treatment to you, and we might disclose protected health information to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing or credentialing.

Other Possible Uses and Disclosures of Protected Health Information

The following is a description of other possible ways in which we might (and are permitted to) use and/or disclose your protected health information.

To You or with Your Authorization

We must disclose your protected health information to you, as described in the Individual Rights section of this notice. You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose not listed on this notice. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures that we made as permitted by your authorization while it was in effect. Without your written authorization, we might not use or disclose your protected health information for any reason except those described in this notice.

Disclosures to the Secretary of the U.S.

Department of Health and Human Services

We are required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the federal Privacy Regulations.

To Plan Sponsors

Where permitted by law, we may disclose your protected health information to the plan sponsor of your group health plan to permit the plan sponsor to perform plan administration functions. For example, a plan sponsor may

Notice of Privacy Practices *(continued)*

contact us seeking information to evaluate future changes to your benefit plan. We may also disclose summary health information (this type of information is defined in the Federal Privacy Regulations) about the enrollees in your group health plan to the plan sponsor to obtain premium bids for the health insurance coverage offered through your group health plan or to decide whether to modify, amend or terminate your group health plan.

To Family and Friends

If you agree (or if you are unavailable to agree), such as in a medical emergency situation we might disclose your protected health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care.

Underwriting

We might receive your protected health information for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits. We will not use or further disclose this protected health information received under these circumstances for any other purpose, except as required by law, unless and until you enter into a contract of health insurance or health benefits with us.

Health Oversight Activities

We might disclose your protected health information to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.

Abuse or Neglect

We might disclose your protected health information to appropriate authorities if we reasonably believe that you might be a possible victim of abuse, neglect, domestic violence or other crimes.

To Prevent a Serious Threat to Health or Safety.

Consistent with certain federal and state laws, we might disclose your protected health information if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Coroners, Medical Examiners, Funeral Directors, and Organ Donation

We might disclose protected health information to a coroner or medical examiner for purposes of identifying you after you die, determining your cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We also might disclose, as authorized by law, information to funeral directors so that they may carry out their duties on your behalf. Further, we might disclose protected health information to organizations that handle organ, eye, or tissue donation and transplantation.

Research

We might disclose your protected health information to researchers when an institutional review board or privacy board has: (1) reviewed the research proposal and established protocols to ensure the privacy of the information; and (2) approved the research.

Inmates

If you are an inmate of a correctional institution, we might disclose your protected health information to the correctional institution or to a law enforcement official for: (1) the institution to provide health care to you; (2) your health and safety and the health and safety of others; or (3) the safety and security of the correctional institution.

Workers' Compensation

We might disclose your protected health information to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

Public Health and Safety

We might disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety or the health or safety of others.

Notice of Privacy Practices (continued)

Required by Law

We might use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon their request for purposes of determining whether we are in compliance with federal privacy laws.

Legal Process and Proceedings

We might disclose your protected health information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we might disclose your protected health information to law enforcement officials.

Law Enforcement

We might disclose to a law enforcement official limited protected health information of a suspect, fugitive, material witness, crime victim, or missing person. We might disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

Military and National Security

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

Other Uses and Disclosures of Your Protected Health Information

Other uses and disclosures of your protected health information that are not described above will be made only with your written authorization. If you provide us with such an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of protected health information. However, the revocation will not be effective for information that we already have used or disclosed in reliance on your authorization.

Individual Rights

Access

You have the right to look at or get copies of the protected health information contained in a designated record set, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot reasonably do so. You must make a request in writing to obtain access to your protected health information. You may obtain a form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the address at the end of this notice. If you request copies, we might charge you a reasonable fee for each page, and postage if you want the copies mailed to you. If you request an alternative format, we might charge a cost-based fee for providing your protected health information in that format. If you prefer, we will prepare a summary or an explanation of your protected health information, but we might charge a fee to do so.

We might deny your request to inspect and copy your protected health information in certain limited circumstances. Under certain conditions, our denial will not be reviewable. If this event occurs, we will inform you in our denial that the decision is not reviewable. If you are denied access to your information and the denial is subject to review, you may request that the denial be reviewed. A licensed health care professional chosen by us will review your request and the denial. The person performing this review will not be the same person who denied your initial request.

Disclosure Accounting

You have the right to receive a list of instances in which we or our business associates disclosed your protected health information for purposes other than treatment, payment, health care operations and certain other activities, after April 14, 2003. We will provide you with the date on which we made the disclosure, the name of the person or entity to which we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we might charge you a reasonable, cost-based fee for responding to these additional requests.

Notice of Privacy Practices *(continued)*

You may request an accounting by submitting your request in writing using the information listed at the end of this notice. Your request may be for disclosures made up to 6 years before the date of your request, but in no event, for disclosures made before April 14, 2003.

Restriction Requests

You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement that we might make to a request for additional restrictions must be in writing and signed by a person authorized to make such an agreement on our behalf. We will not be liable for uses and disclosures made outside of the requested restriction unless our agreement to restrict is in writing. We are permitted to end our agreement to the requested restriction by notifying you in writing.

You may request a restriction by writing to us using the information listed at the end of this notice. In your request tell us: (1) the information of which you want to limit our use and disclosure; and (2) how you want to limit our use and/or disclosure of the information.

Confidential Communication

If you believe that a disclosure of all or part of your protected health information may endanger you, you have the right to request that we communicate with you in confidence about your protected health information. This means that you may request that we send you information by alternative means, or to an alternate location. We must accommodate your request if: it is reasonable, specifies the alternative means or alternate location, and specifies how payment issues (premiums and claims) will be handled. You may request a Confidential Communication by writing to us using the information listed at the end of this notice.

Amendment

You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you with a written explanation.

You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: Even if you agree to receive this notice on our web site, or by electronic mail (email), you are entitled to receive a paper copy as well. Please contact us using the information listed at the end of this notice to obtain this notice in written form. If the email transmission has failed, and Howard County Public School System Welfare Benefits Plan is aware of the failure, then we will provide a paper copy of the notice to you.

Questions and Complaints

Information on Howard County Public School System Welfare Benefits Plan Privacy Practices

If you want more information about our privacy practices or have questions or concerns, please contact the member services number on the back of your card.

Filing a Complaint

If you are concerned that we might have violated your privacy rights, or you disagree with a decision we made about your individual rights, you may use the contact information listed at the end of this notice to complain to us. You also may submit a written complaint to the U.S. Department of Health and Human Services (DHHS). We will provide you with the contact information for DHHS upon request.

We support your right to protect the privacy of your protected health and financial information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Information

Howard County Public School System Welfare Benefits Plan

Benefits Office

HIPAA Compliance and Privacy Office

10910 Route 108

Ellicott City, MD 21042-6198

Telephone: **410-313-6713**

Fax: **410-313-1531**

HCPS Important Contacts for Benefits Information

Contact:	Regarding:
<p>Benefits Office</p> <p>Howard County Public Schools 10910 Route 108 Ellicott City, MD 21042 Phone: 410-313-6710; 1564; or 6713 Fax: 410-313-1531 Email: Gina_Doyle@hcpss.org Cynthia_Harrison@hcpss.org Jeeni_Griffin@hcpss.org</p>	<ul style="list-style-type: none"> ■ Who is eligible for School System health plan coverage ■ General benefit questions ■ Changes in family status affecting benefits ■ Changes to life insurance beneficiaries ■ Assistance with benefits election when retiring Continuing benefits under COBRA if you or your dependent(s) lose School System benefits ■ Flexible Spending Account (FSA) enrollment ■ Life status changes – i.e. marriage, divorce, birth, adoption, death of dependents, dependent graduation/loss of full-time student status ■ Questions regarding your 403(b) & 457(b) Plans ■ Questions related to HCPSS Employee Wellness program
<p>Payroll</p> <p>Howard County Public Schools 110910 Route 108 Ellicott City, MD 21042 Phone: 410-313-6720; 6721; or 6719</p>	<ul style="list-style-type: none"> ■ Questions about your paycheck ■ Changes to your tax withholding amounts ■ Changes to your direct deposit designation
<p>Retirement</p> <p>Howard County Public Schools 10910 Route 108 Ellicott City, MD 21042 Phone: 410-313-6612 Email: Ann_Fersht@hcpss.org</p>	<ul style="list-style-type: none"> ■ Questions about your retirement
<p>FMLA/Leave of Absence</p> <p>Howard County Public Schools 10910 Route 108 Ellicott City, MD 21042 Phone: 410-313-6695 Email: Melodee_Phillips@hcpss.org</p>	<ul style="list-style-type: none"> ■ Coordination of leave status ■ Family and Medical Leave Act (FMLA)
<p>Employee Assistance Program Administered by Business Health Services (BHS)</p> <p>Phone: 1-800-327-2251 www.bhsonline.com</p>	<ul style="list-style-type: none"> ■ Provides confidential, professional counseling at no cost to employees and dependents ■ Services are provided for a wide range of personal, financial, and legal matters.

The purpose of this Open Enrollment Guide is to give you basic information about your benefits 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 Certificates of Coverage provided by your health plan carriers for important additional information about the plans. Every effort has been made to make the information accurate; however, in the case of any discrepancy, the provisions of the legal documents will govern.

Benefits Plan Contact Information

Group Name	Group	Website	Customer Service
Hirsch Financial Services (HFS)	HCPSS	www.hfsbenefits.com	1-888-460-8005
Health Care Spending Account			
Dependent Care Account			
CareFirst BlueChoice HMO	1901454	www.carefirst.com	1-800-628-8549
Hospital Precertification			1-866-773-2884
Mental Health & Substance Abuse			1-800-245-7013
Davis Vision		www.davisvision.com	1-800-783-5602
Aetna Open Choice PPO	622787	www.aetna.com	1-888-502-3862
Open Access Aetna Select HMO	622787	www.aetna.com	1-888-502-3862
Vision Service Plan (VSP)	12326138	www.vsp.com	1-800-877-7195
Delta Dental	6951	www.deltadentalins.com	1-800-932-0783
CIGNA Dental	3217684	www.cigna.com	1-800-244-6224
Express Scripts	KHQ	www.express-scripts.com	1-877-866-5859
AFLAC (Voluntary Benefits–Critical)	SE884	pamela_dinterman@us.aflac.com	410-207-5341
Jasper & Company – COBRA Administration	HCPSS	JasperandCompany.com	410-268-1003
The Standard (Short & Long Term Disability)	647263		1-800-378-4667
ReliaStar (Voluntary Benefits)	245755		1-800-537-5024
Benefit Focus	hcpss	https://hcpss.hrntouch.com	1-855-859-0971
Virgin HealthMiles	hcpss	www.virginhealthmiles.com/hcpss	1-866-852-6898

Glossary of Terms

Allowed Benefit

The dollar amount allowed for services covered, regardless of the provider's actual charge. A provider who participates in a network cannot charge the member more than this amount for any covered service.

Benefit Period

A period of time for which covered services (or benefits) are eligible for payment.

Coinsurance

The percentage or amount patients are required to pay through their insurance plan for reasonable medical expenses after a deductible has been satisfied.

Copayment

The dollar amount a patient pays when services are received.

Deductible

The dollar amount of covered services based on the Allowed Benefit that must be paid by an individual or family per benefit period before the insurance company (CareFirst) begins to pay its portion of claims.

Diagnostic Tests

Medically necessary test(s) and/or non-surgical procedure(s) ordered by a physician/ dentist to determine if the patient has a certain condition or disease. Such diagnostic tools include radiology, laboratory, pathology services or tests.

Durable Medical Equipment (DME)

Goods, implements, prosthetics, etc., that are prescribed for patient care, usually in an outpatient setting. Examples of such equipment include hospital beds, wheelchairs and walkers.

Generic Drug

A drug which is the pharmaceutical equivalent to one or more brand name drugs. The Food and Drug Administration has approved such generic drugs. They meet the same standards of safety, purity, strength and effectiveness as the brand name drug.

Health Maintenance Organization (HMO)

A health benefits program that usually has the lowest out-of-pocket costs. HMOs require that the member select a Primary Care Provider, generally a family practitioner, internist or pediatrician, who is part of the plan's network. There are generally small copayments and no claims to file. In an HMO, a referral is required from the Primary Care Provider to see any specialist in its network except an OB/GYN.

In-Network

Refers to the use of providers who participate in the health plan's provider network. Many benefit plans encourage members to use participating in-network providers to reduce out-of-pocket expenses.

Lifetime Maximum

The maximum amount the plan will pay in benefits for each member during their lifetime.

Out-of-Network

The use of health care providers who have not contracted with the health plan to provide services. HMO members are generally not covered for out-of-network services except in emergency situations. Members enrolled in Preferred Provider Organizations (PPO) and Point-of-Service (POS) coverages can go out-of-network, but will pay higher out-of-pocket costs.

Out-of-Pocket Limit or Out-of-Pocket Maximum

The maximum dollar amount a member will pay out-of-pocket in coinsurance, copays and/or deductibles in a calendar year for covered indemnity expenses. Once the out-of-pocket limit is met, the plan pays 100% of the allowed amount for covered services for the rest of the benefit period.

Pre-Authorization

Approval necessary for designated procedures or hospital admissions. When care is received in-network, the Primary Care Provider or Specialist is usually responsible for obtaining pre-authorization. For out-of-network services, the member is responsible for obtaining pre-authorization.

Glossary of Terms *(continued)*

Primary Care Provider (PCP)

A physician selected by the member, who is part of the plan network, who provides routine care and coordinates other specialized care. The PCP should be selected from the network that corresponds to the plan in which you are a member. The physician you choose as your PCP may be a family or general practitioner, internist or pediatrician.

Preferred Provider Organization (PPO)

An agreement between a medical provider and a health care carrier for the delivery of services to a specific member population using discounted fees for cost savings. This relates to only a fee arrangement, and does not imply that any provider is more or less qualified than another.

Referral

A written recommendation by a physician that a member may receive care from a specialty physician or facility.

Step Therapy

The practice of beginning drug therapy for a medical condition with the most cost-effective and safest drugs and progressing to other more costly or risky therapy, only if necessary. The aims are to control costs and minimize risks.

Well Baby/Well Child Care

Routine care, testing, checkups and immunizations for a generally healthy child from birth through the age of six.

Usual, Customary and Reasonable (UCR)

Limits on reimbursement by an insurance company. Health insurance plans pay a doctor's full charge for service if it does not exceed the usual charge; that is, if it does not exceed the charge for the same service by other physicians in the area or if it is reasonable.





10455 Mill Run Circle
Owings Mills, MD 21117

www.carefirst.com

CareFirst BlueChoice, Inc. is an independent licensee of the Blue Cross and Blue Shield Association.
® Registered trademark of the Blue Cross and Blue Shield Association. ® Registered trademark of CareFirst of Maryland, Inc.