HARFORD COUNTY
PUBLIC SCHOOLS

Benefits Enrollment & Reference Guide

OPEN ENROLLMENT PERIOD

May 1, 2017–May 19, 2017

EFFECTIVE

July 1, 2017–June 30, 2018

Table of Contents

Important Resources	Member Services Telephone Number	Web or Claims Mailing Address	
CareFirst BlueCross BlueShield Medical Claims	800-628-8549	**www.carefirst.com**	Mailroom Administrator PO Box 14651 Lexington, KY 40512
Magellan (Mental Health)	800-245-7013		
CVS Caremark	800-241-3371		
CVS Mail Order Pharmacy	800-745-6285	carefirst.com/rx	
Delta Dental	800-932-0783	deltadentalins.com	PO Box 2105 Mechanicsburg, PA 17055-2105
Flexible Benefit Administrators, Inc. (FBA)	800-437-3539	www.flex-admin.com www.mywealthcareonline.com/fba	
KEPRO (EAP)	866-795-5701	www.EAPHelplink.com; company code – HCPS	
State Retirement Agency	800-492-5909	www.sra.state.md.us	
Lincoln Financial Tax Deferred Compensation Plan (457b) (403b)	800-234-3500 Press "Ø"	www.hcps.org/departments/humanresources/benefits/retirement.aspx www.lincolnalliance.com	
Harford County Public Schools Benefits Office	410-588-5275		
Benelogic	844-796-4086	https://hcps.benelogic.com	
Employee Incentives		http://share.hcps.org/sites/HumanResources/Staffing/RecruitmentandRetention/default.aspx	

Board approval on 3/20/16

Welcome

As a Harford County Public Schools (HCPS) employee, you have access to a wide variety of benefits. HCPS benefit programs are designed to help keep you and your family healthy and financially secure with coverage options that feature choice, flexibility, and tax-savings opportunities.

Vision

Harford County Public Schools will be a community of learners in which our public schools, families, public officials, businesses, community organizations, and other citizens work collaboratively to prepare all of our students to succeed academically and socially in a diverse, democratic, change-oriented, and global society.

Mission

The mission of the Harford County Public Schools is to promote excellence in instructional leadership and teaching and to provide facilities and instructional materials that support teaching and learning for the 21st century. The Harford County Board of Education will support this mission by fostering a climate for deliberate change and monitoring progress through measurable indicators.

Goals

1. To prepare every student for success in postsecondary education and a career.
2. To encourage and monitor engagement between the school system and the community to support student achievement.
3. To hire and support skilled staff who are committed to increasing student achievement.
4. To provide safe, secure, and healthy learning environments that are conducive to effective teaching and learning.

It is up to you to make the most of these benefits. You have an opportunity now to enroll in or change specific benefit plan selections. To help you choose wisely, HCPS provides this Enrollment and Reference Guide. Please take time to read this Enrollment Guide carefully and share it with other family members to help you make informed benefits decisions.

Every effort has been made to ensure that the information in this Guide is accurate; however, the provisions of the actual contracts for each plan will govern in the event of any discrepancy. Copies of the Employee Benefit Guides plan document are available at our SharePoint (**https://share.hcps.org**) or the Benelogic website (**https://hcps.benelogic.com**).

What's New for this Plan Year

Changes for 2017–2018

Open Enrollment is the time each year when you get to make your benefit choices for the following fiscal year. During this period, it's important that you set aside some time to learn all you can about your Harford County Public Schools benefit options for 2017–18, and decide which ones make the most sense for you and your family.

All current 2016–17 medical, dental and life benefits will automatically roll over for 2017. Flex Spending elections must be made each plan year.

Take this opportunity to:

- Review or change your medical and dental insurance options
- Review and update eligible dependents as appropriate.
- Review new 2017 premium information
- Start or renew participation in Medical and/or Dependent Care FSA(s)
- Enroll, increase or decrease life insurance Benefits (Statement of Health required for all enrollments)

Reminder—any "new" dependent added to your medical or dental coverage will require proof of relationship to the employee before being approved. Please complete the Dependent Verification form and send with supporting documents to the Human Resources Benefits Office within 30 days of enrollment.

Life insurance rate changes

Effective 7/1/2017 employees will see a decrease in their Basic Life & AD&D premium. Employees enrolled in Supplemental Life will see an adjustment as the rates will move from a composite group rate to age banded rating. New rates are outlined on page 57 of this guide.

New insurance premiums

New 2017 insurance premiums are detailed on pages 5–6 of this guide. New premiums are effective July 1, 2017.

Update on Health Insurance Elections at Retirement

Effective July 1, 2017, employees who retire any date other than July 1 will have a one-time opportunity to change their health insurance benefit plan after retirement. In order to take advantage of this one-time opportunity the employee must indicate their desire to participate in the next open enrollment following their retirement date when meeting with the Harford County Public Schools (HCPS) retirement coordinator before they retire. If the employee does not select this option they will not be able to change plans during the next scheduled open enrollment.

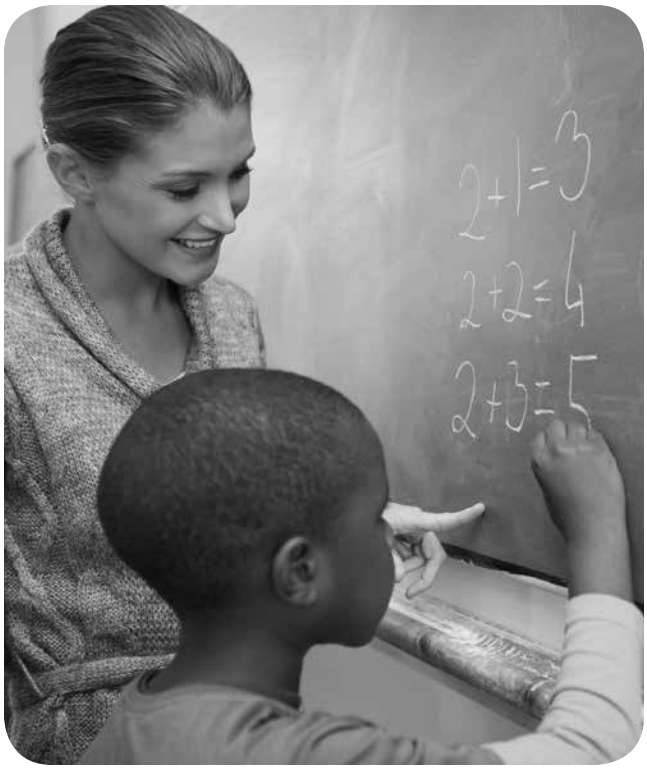
Benefits and Eligibility

Basic benefits

With the exception of the defined benefit pension plans, the costs for the basic benefits for all regular part-time and full-time employees are paid in full by Harford County Public Schools. Basic benefits include:

- Sick Leave
- Family Bereavement Leave
- Personal Business
- Liability Insurance
- Tuition Reimbursement
- Employee Assistance Program
- Pension Plan

Membership in the Maryland State Teachers' and Employees' Pension System is mandatory and requires a 7% contribution based on your annual compensation.



Optional benefits

In general, full and part-time (18+ hours per week) employees may choose to enroll in any combination of the following benefits. HCPS contributes a large portion toward the purchase of health and welfare benefits. This allows you the flexibility to choose the benefit plans that best meet your needs.

The Benefits Program for HCPS is a Section 125 Plan as defined by the Internal Revenue Code. Section 125 allows you to pay for certain employee benefits with pre-tax deductions from your paycheck. You pay for most benefits on a before-tax basis, which lowers the taxes taken out of each paycheck.

Your before-tax benefits include:

- Medical
- Dental
- Group Life insurance
- Flexible Spending Accounts
- 403(b)/457(b) Plans

Your after-tax benefits include:

- U.S. Savings Bonds
- Life Insurance—amounts over $50,000
- Roth 403(b) Plans

Eligibility

Employees

You are eligible to participate in the HCPS Benefits Program if you are a:

- Regular full-time employee
- Part-time employee working .500 FTE or 18 hours per week or more

Dependents*

Eligible family members include your:

- Legal spouse

- Dependent children until the end of the month in which they reach age 26
- Unmarried dependent children over the age limit if:
  - ☐ They are dependent on you for primary financial support and maintenance due to a physical or mental disability,
  - ☐ They are incapable of self-support, and
  - ☐ The disability existed before reaching age 26 or while covered under the plan.

Eligible children include your:

- Natural children
- Stepchildren
- Legally adopted children
- Foster children
- A child for whom you have legal guardianship including grandchildren
- Child for whom the court has issued a QMSCO (Qualified Medical Child Support Order)

Ineligibility

Any ineligible dependents should be removed from your coverage as soon as they become ineligible. As a reminder we have included a few examples of ineligible dependents:

- Anyone who is not your legal spouse (ex-spouse, fiancé, common-law spouse, etc.)
- Dependents no longer covered by a court order
- Live-in partners
- Children of live-in partners
- Stepchildren following divorce from natural parent
- Parents of employees

Note: The Board will not provide two insurance programs, e.g., CareFirst PPO CORE and BlueChoice HMO program for any eligible employees or eligible members of their families. This applies to all employees and eligible members of their families whose spouses are also employees of the school system.

*** You must submit verification of eligibility for all dependents on your account within 30 days of enrollment.**

Dependent Eligibility Documentation Requirements

Relationship to Employee	Eligibility Definition	Documentation for Verification of Relationship
Spouse	A person to whom you are legally married	Copy of Marriage certificate, copy of Social Security card and most recent Federal Tax Form (1040 or 1040A)* that identifies employee-spouse relationship (attach 1st page only & black out financial information) **If marriage occurred in current year, tax form is not needed*
Dependent Child(ren)	Dependent children until the end of the month in which they reach age 26	**Natural Child – Provide a copy of Social Security card and one of the following:** ■ Copy of birth certificate showing employee's name or ■ Hospital verification of birth (must include child's name, date of birth and parents' names) or ■ Certificate of live birth **Step Child – Provide a copy of Social Security card and one of the above** showing employee's spouse name; and a copy of marriage certificate showing the employee and parent's name **Legal Guardian, Adoption, Grandchild(ren), or Foster Child(ren) –**Copy of Final Court Ordered Custody with presiding judge's signature and seal, or Adoption Final Decree with presiding judge's signature and seal and a copy of Social Security card **Child for whom the court has issued a QMSCO** – A copy of the Qualified Medical Child Support Order and a copy of Social Security card
Disabled Dependents	Unmarried dependent children over the age limit if: 1. They are dependent on you for primary financial support and maintenance due to a physical or mental disability, 2. They are incapable of self-support, and 3. The disability existed before reaching age 26 or while covered under the plan.	Copy of Social Security disability award (if a disability ruling by Social Security is pending, include a current copy of the application for disability) **and** Federal Tax Return for year just filed **and** copy of Social Security card **and** Completed Disability Form (Request from Benefits Office)

Medical and Dental Deductions

Active Employees

Plan	Total Annual Premium	Employee Monthly Premium at 100%	BOE % of Annual Cost	Employee % of Annual Cost	Biweekly Payroll Deduction	
					12 Month Employees (24 pays) Your Bi-Weekly Deduction	10 Month Employees (20 pays) Your Bi-Weekly Deduction
Medical Insurance Rates						
HMO			**95%**	**5%**		
Individual	$5,789.88	$482.49	$5,500.39	$289.49	$12.06	$14.47
Parent & Child	$11,435.16	$952.93	$10,863.40	$571.76	$23.82	$28.59
Employee & Spouse	$13,670.76	$1,139.23	$12,987.22	$683.54	$28.48	$34.18
Family	$16,840.44	$1,403.37	$15,998.42	$842.02	$35.08	$42.10
PREFERRED PROVIDER CORE PLAN			**90%**	**10%**		
Individual	$6,493.20	$541.10	$5,843.88	$649.32	$27.06	$32.47
Parent & Child	$14,117.76	$1,176.48	$12,705.98	$1,411.78	$58.82	$70.59
Employee & Spouse	$16,700.64	$1,391.72	$15,030.58	$1,670.06	$69.59	$83.50
Family	$18,111.36	$1,509.28	$16,300.22	$1,811.14	$75.46	$90.56
TRIPLE OPTION			**85%**	**15%**		
Individual	$6,821.40	$568.45	$5,798.19	$1,023.21	$42.63	$51.16
Parent & Child	$14,831.76	$1,235.98	$12,607.00	$2,224.76	$92.70	$111.24
Employee & Spouse	$17,545.08	$1,462.09	$14,913.32	$2,631.76	$109.66	$131.59
Family	$19,025.52	$1,585.46	$16,171.69	$2,853.83	$118.91	$142.69
Dental Insurance Rates						
DELTA PREMIER			**90%**	**10%**		
Individual	$259.92	$21.66	$233.93	$25.99	$1.08	$1.30
Parent & Child	$427.32	$35.61	$384.59	$42.73	$1.78	$2.14
Employee & Spouse	$547.44	$45.62	$492.70	$54.74	$2.28	$2.74
Family	$798.36	$66.53	$718.52	$79.84	$3.33	$3.99
DELTA PPO			**90%**	**10%**		
Individual	$354.48	$29.54	$319.03	$35.45	$1.48	$1.77
Parent & Child	$581.88	$48.49	$523.69	$58.19	$2.42	$2.91
Employee & Spouse	$746.16	$62.18	$671.54	$74.62	$3.11	$3.73
Family	$1,087.80	$90.65	$979.02	$108.78	$4.53	$5.44

Premium deductions will begin in July (September for ten-month employees) and coverage will be effective July 1, 2017. New hires coverage will start on the first pay of the month following the date of hire and enrollment in the plan. Deductions will begin with the first pay of the month following the date of hire and enrollment in the plan.

Medical and Dental Deductions

Active Part Time HCEA and HCESC Represented Employees
(hired or transferred to a PT position of less than 25 hours per week on or after 7/1/2013)

Plan	Total Annual Premium	Employee Monthly Premium at 100%	BOE % of Annual Cost	Employee % of Annual Cost	Biweekly Payroll Deduction	
					12 Month Employees (24 pays) Your Bi-Weekly Deduction	10 Month Employees (20 pays) Your Bi-Weekly Deduction
Medical Insurance Rates						
HMO			**47.5%**	**52.5%**		
Individual	$5,789.88	$482.49	$2,750.19	$3,039.69	$126.65	$151.98
Parent & Child	$11,435.16	$952.93	$5,431.70	$6,003.46	$250.14	$300.17
Employee & Spouse	$13,670.76	$1,139.23	$6,493.61	$7,177.15	$299.05	$358.86
Family	$16,840.44	$1,403.37	$7,999.21	$8,841.23	$368.38	$442.06
PREFERRED PROVIDER CORE PLAN			**45.0%**	**55.0%**		
Individual	$6,493.20	$541.10	$2,921.94	$3,571.26	$148.80	$178.56
Parent & Child	$14,117.76	$1,176.48	$6,352.99	$7,764.77	$323.53	$388.24
Employee & Spouse	$16,700.64	$1,391.72	$7,515.29	$9,185.35	$382.72	$459.27
Family	$18,111.36	$1,509.28	$8,150.11	$9,961.25	$415.05	$498.06
TRIPLE OPTION			**42.5%**	**57.5%**		
Individual	$6,821.40	$568.45	$2,899.10	$3,922.31	$163.43	$196.12
Parent & Child	$14,831.76	$1,235.98	$6,303.50	$8,528.26	$355.34	$426.41
Employee & Spouse	$17,545.08	$1,462.09	$7,456.66	$10,088.42	$420.35	$504.42
Family	$19,025.52	$1,585.46	$8,085.85	$10,939.67	$455.82	$546.98
Dental Insurance Rates						
DELTA PREMIER			**45.0%**	**55.0%**		
Individual	$259.92	$21.66	$116.96	$142.96	$5.96	$7.15
Parent & Child	$427.32	$35.61	$192.29	$235.03	$9.79	$11.75
Employee & Spouse	$547.44	$45.62	$246.35	$301.09	$12.55	$15.05
Family	$798.36	$66.53	$359.26	$439.10	$18.30	$21.95
DELTA PPO			**45.0%**	**55.0%**		
Individual	$354.48	$29.54	$159.52	$194.96	$8.12	$9.75
Parent & Child	$581.88	$48.49	$261.85	$320.03	$13.33	$16.00
Employee & Spouse	$746.16	$62.18	$335.77	$410.39	$17.10	$20.52
Family	$1,087.80	$90.65	$489.51	$598.29	$24.93	$29.91

Premium deductions will begin in July (September for ten-month employees) and coverage will be effective July 1, 2017. New hires coverage will start on the first pay of the month following the date of hire and enrollment in the plan. Deductions will begin with the first pay of the month following the date of hire and enrollment in the plan.

Be an Informed Health Care Consumer

Most people are not accustomed to questioning their doctors about the insurance plans they accept, or the cost and medical necessity of a treatment. Knowing what questions to ask and when to ask them makes the process much easier and less stressful! Asking questions of your health care providers helps maintain both the cost and quality of your health care. So it's important for everyone, regardless of the health care option elected, to ask about the medical necessity of any treatment and if there are alternatives to consider.

Here are some tips to help you become a good health care consumer

- Ask your provider or his/her business office if they accept your HCPS health care plan. If they do, evaluate what plan is best for you.
- Make notes in advance of your office visit about the things you want to ask your doctor. Keep a list of any symptoms you have had or are currently experiencing. Keep a list of the medications you take, whether prescriptions or over the counter. Share the list with all health care providers.
- Bring a spouse or friend along with you... chances are if you don't recall something that was said, he or she will!
- Bring a pad and pencil to the doctor's office; don't rely on your memory for everything!
- If your doctor uses a term that you do not understand, ask what it means and ask that it be spelled. Then, write it down and do some more research once you leave the office.
- Get a copy of any test results.
- If your doctor writes a prescription for you, ask your doctor and pharmacist about interactions with other drugs you may be taking or about side effects that you may experience. Remember, if you are taking any maintenance medications, request one prescription for a 30-day supply from a retail pharmacy and another prescription for mail-order. (for up to a 90-day supply, plus up to three refills).
- If you have access to the Internet, use it to learn about your medications or illnesses. The Internet has excellent information on many health-related subjects. One respected resource is **www.webmd.com**. Ask your physician which web-sites they believe are valuable. Be sure to let your physician know your findings.
- Visit **https://share.hcps.org** or **https://hcps.benelogic.com** to link to our health care vendors' websites for more resources.
- Check the vendor websites for details on providers and other useful information.

Help control the cost of health care and promote your well-being

On an almost-daily basis, the rising cost of health care is in the news. Advances in medical technology, expensive prescription drugs, consumer demand, and an aging population are just a few factors that impact health care costs. While some factors are beyond the control of the consumer, there are some things you can do to help keep health care costs down—both for you and for HCPS. Below are a few tips to help you become a wiser consumer of health care.

Maintain a healthy lifestyle

Maintaining your own health can help to minimize your health care costs. The healthier you are, the less likely you are to need costly health care services—which means you spend less on copays, deductibles, and other medical costs. Eat right and get plenty of exercise.

Get regular checkups

Get a regular annual checkup and/or physical exam, which can uncover early warning signs of potential health problems, and can also help you build a good relationship with your doctor.

Save the emergency room for emergencies

Emergency room visits are two to three times more expensive than a visit to the doctor's office or an urgent care center. These ER visits are not only costly, but they can be unnecessarily stressful and time-consuming for you and your family if what you need is routine care. Urgent care facilities are available in the area and may be used for a variety of urgent health problems for a lower copay than the ER.

Get regular screenings

Get regular screenings (e.g., mammograms) as recommended by your carrier and national organizations, such as the American Cancer Society.

Visit a primary care provider before going to see a specialist

Primary care providers are usually family practitioners, general practitioners, internists or pediatricians. A primary care provider can treat many illnesses and injuries at a lower fee – in many cases at half the cost of a specialist's fee. For example, you don't necessarily need to see an orthopedic specialist for back pain. Primary care providers consider your overall health. They can advise you about disease prevention and how to stay healthy. They are also familiar with your personal health history and needs and have your medical records on file.

Ask for Generic

When you need a prescription, ask your doctor to prescribe a generic, if one is available. Generics have the same chemical equivalency as brand-name drugs, and are held to the same standards by the Food and Drug Administration, but they cost less than brand-name drugs.

Review your bills

Reviewing your health care bills can help you identify and prevent unnecessary health care costs. Here's what to look for to determine if a bill is correct:

- Does the date of service on the bill match the date you went to the doctor or the hospital?
- Did you receive all the services or procedures listed on the bill?
- Are you charged for more x-rays or lab work than you received? Call your provider to report any errors you spot on your bills or Explanation of Benefits forms (EOB's).
- Is your share of the cost correct? If not, call the insurance provider to discuss. If there is a referral involved, was the referral processed prior to the claim?

Enrollment Instructions

Enroll online with web enrollment

The 2017 Harford County Public Schools Benefits Open Enrollment will take place starting May 1, 2017 through May 19, 2017. Web enrollment offers you the convenience to enroll anytime, anywhere through the internet.

New hires must enroll in benefits within 30 days of hire or may be forced to wait for the next open enrollment period.

Before you enroll:

- Familiarize yourself with your options by reading your 2017 benefit guide. This guide is also available at **https://hcps.benelogic.com** or **https://share.hcps.org**.
- Have the following information about you and your dependents:
  - ☐ Social Security Number
  - ☐ Date of birth
  - ☐ Information on other medical coverage that you and your dependents have.

To enroll in your benefits:

- Using a computer with Internet, go to **https://hcps.benelogic.com**. (Enter in address field, not search)
- Enter your User ID (HCPS 5-digit Employee ID#) (New hires should use their Social Security Number with no dashes).
- Enter your password or click on *Forgot User ID/ Password?* (New hires enter the last four digits of your Social Security Number).
- Change your password (if you log into the website again, you will need this new password).
- Follow the instructions on the website and enroll in your 2017 benefits.
- Review your elections to check for errors (highlighted in yellow).
- Confirm that you have linked all dependents to the coverage in which they are to be enrolled.
- YOU MUST click on the *Submit* button to have your elections processed.
- VIEW AND PRINT YOUR ENROLLMENT SUMMARY.
- If dependents have been added to your coverage, submit the dependent verification form and requested documentation to the benefits office (see page 3).

You may make changes to your benefits on the enrollment website during open enrollment from May 1, 2017 until midnight on May 19, 2017. The last elections that you save will be your benefits beginning July 1st, 2017.

** The website may be unavailable periodically during your enrollment period for routine maintenance.*

Remember your selections made during open enrollment will be effective July 1, 2017. Benefits for all new hires will be effective the first of the month following your date of hire.

- If you choose to join CareFirst Health, Delta Dental, Flexible Spending or MetLife Insurance Programs, complete the online enrollment process.
- Remember, if you wish to add or change coverage, you must complete the online enrollment process.
- New hires must submit verification of eligibility for all dependents on your account.
- Current employees must submit verification of eligibility for all new dependents added to coverage.

Any employee needing assistance with enrollment should call the Benefits Office at 410-588-5275 Monday – Friday, 7:30 a.m. – 4:30 p.m.

Social security number required

Due to new reporting requirement under the Affordable Care Act we are required to provide reports to the IRS. The IRS requires that the reports include each covered person's, including dependents, social security number (SSN), which is the primary identifier used by the IRS. Therefore we must have the SSN for all enrollees in an HCPS health plan.

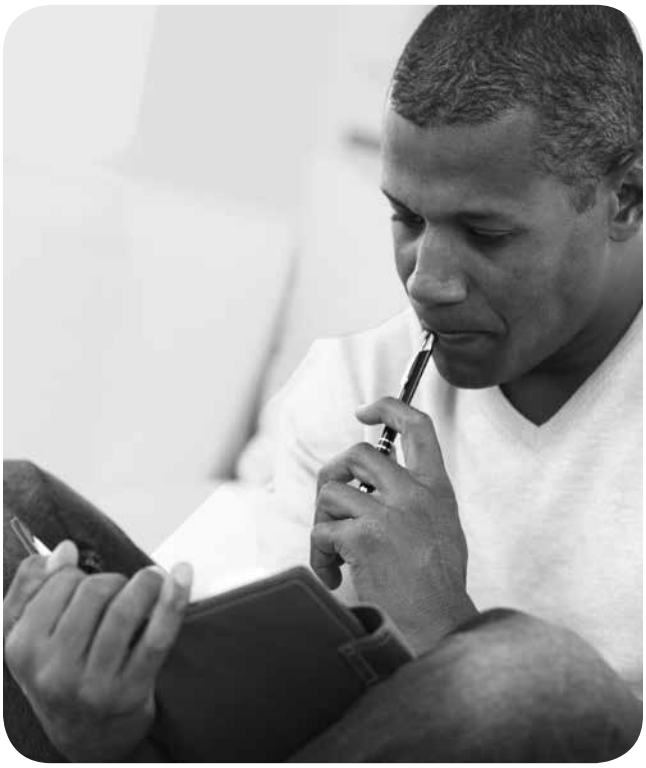
BlueChoice HMO *Open Access*

An HMO plan with no referrals required

With a BlueChoice HMO *Open Access* plan, your primary care provider (PCP) provides preventive care and works with you to find specialty care using a large network of CareFirst BlueChoice specialists. However, unique to this plan is its Open Access feature which allows you to visit specialists directly without needing a referral from your PCP.

Benefits of BlueChoice HMO *Open Access*

- Choose from more than 37,000 providers, specialists and hospitals in Maryland, Washington, D.C. and Northern Virginia.
- HMO plans encourage you to establish a relationship with your PCP for consistent, quality care.
- No PCP referral required to see a specialist.
- Receive comprehensive coverage for preventive health care visits at no cost.
- Avoid the unwelcome surprise of high medical costs with predictable copays and deductibles (if applicable).
- Save time—you don't have to file a claim when you receive care from a CareFirst BlueChoice provider.
- Avoid balance billing when you receive care from a CareFirst BlueChoice provider.
- Access the Away from Home Care® program to enjoy plan benefits if you're out of the area for at least 90 days.



The BlueChoice HMO plan achieved a "Commendable" rating from the National Committee for Quality Assuarcnce (NCQA).

How your plan works

Establishing a relationship with one provider is the best way for you to receive consistent, quality health care. When you enroll in a BlueChoice HMO *Open Access* plan, you will select a PCP to manage your primary medical care. Make sure you select a PCP for not only yourself but each of your family members as well. Your PCP must participate in the CareFirst BlueChoice provider network and must specialize in either family practice, general practice, pediatrics or internal medicine.

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To ensure you receive the highest level of benefits (and pay the lowest out-of-pocket cost), you should first call your PCP when you need care.

Your PCP will:

- Provide basic medical care.
- Prescribe any medications you need.
- Maintain your medical history.
- Work with you to determine when you should see a specialist.
- Assist you in the selection of a specialist, if needed.

While traditional HMO plans require you to obtain a written referral from your PCP before seeing a specialist, this plan has an Open Access feature, so you have direct access to CareFirst BlueChoice specialists without needing a written referral from your PCP. Make sure you only receive care from a CareFirst BlueChoice provider or you will not be covered, with the exception of emergency services and follow-up care after emergency surgery.

Your benefits

Step 1: Meet your deductible (if applicable)

If your plan requires you to meet a deductible, you will be responsible for the entire cost of services up to the amount of your deductible. Once your deductible is satisfied, your BlueChoice HMO *Open Access* coverage will become available to you. Some services do not require you to meet a deductible first.

If more than one person is covered under your plan, once the total deductible amount is satisfied, the plan will start to make payments for everyone covered. Deductible requirements can vary based on your coverage level (e.g. individual, family) as well as the specific plan selected. Members should refer to their Evidence of Coverage for detailed deductible information.

Step 2: Your plan will start to pay for services

After you satisfy your deductible (if applicable), your plan will start to pay for covered services, as long as you visit participating CareFirst BlueChoice providers and facilities. Please remember, depending on your particular plan, you may have to pay a copay or coinsurance when you receive care.

Step 3: Your out-of-pocket maximum

Your out-of-pocket maximum is the maximum amount you pay during your benefit period. Should you ever reach your out-of-pocket maximum, CareFirst BlueChoice, Inc. will then pay 100% of the allowed benefit for most covered services for the remainder of the benefit period. Any amount you pay toward your deductible (if applicable) and most copays and/or coinsurance will count toward your out-of-pocket maximum.

If more than one person is covered under your BlueChoice HMO *Open Access* plan, once the total out-of-pocket maximum is satisfied, no copays or coinsurance amounts will be required for anyone covered under your plan. Out-of-pocket maximum requirements vary based on your coverage level (e.g. individual, family). Members should refer to their Certificate or Evidence of Coverage for detailed out-of-pocket maximum information.

Laboratory services

To receive the maximum laboratory benefit from your BlueChoice HMO *Open Access* plan, you must use a LabCorp® facility for any laboratory services. Services performed at a facility that is not part of the LabCorp network may not be covered under your plan. Also, any lab work performed in an outpatient hospital setting will require a prior authorization from your PCP.

LabCorp has approximately 100 locations throughout Maryland, Washington, D.C. and Northern Virginia. To locate the LabCorp patient service center near you, call (888) LAB-CORP or visit **www.labcorp.com**.

Out-of-area coverage

Out-of-area coverage is limited to emergency or urgent care only. However, members and their covered dependents planning to be out of the CareFirst BlueChoice, Inc. service area for at least 90 consecutive days may be able to take advantage of a special program, Away from Home Care®.

This program allows temporary benefits through another Blue Cross and Blue Shield affiliated HMO. It 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 the phone number listed on your identification card.

Away From Home Care®

Your HMO coverage goes with you

We've got you covered when you're away from home for 90 consecutive days or more. Whether you're out-of-town on extended business, traveling, or going to school out-of-state, you have access to routine and urgent care with our Away From Home Care program.

Coverage while you're away

You're covered when you see a provider of an affiliated Blue Cross Blue Shield HMO (Host HMO) outside of the CareFirst BlueChoice, Inc. service area (Maryland, DC and Northern Virginia). If you receive care, then you're considered a member of that Host HMO receiving the benefits under that plan. So your copays may be different than when you're in the CareFirst BlueChoice service area. You'll be responsible for any copays under that plan.

Enrolling in Away From Home Care

To make sure you and your covered dependents have ongoing access to care:

- Call the Member Service phone number on your ID card and ask for the Away From Home Care Coordinator.
- The coordinator will let you know the name of the Host HMO in the area. **If there are no participating affiliated HMOs in the area, the program will not be available to you.**
- The coordinator will help you choose a primary care physician (PCP) and complete the application. Once completed, the coordinator will send you the application to sign and date.
- Once the application is returned, we will send it to your Host HMO.
- The Host HMO will send you a new, temporary ID card which will identify your PCP and information on how to access your benefits while using Away From Home Care.

Always remember to carry your ID card to access Away From Home Care.

- Simply call your Host HMO primary care physician for an appointment when you need care.

No paperwork or upfront costs

Once you are enrolled in the program and receive care, you don't have to complete claim forms, so there is no paperwork. And you're only responsible for out-of-pocket expenses such as copays, deductibles, coinsurance and the cost of non-covered services.

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Triple Option
Open Access

Triple Option Open Access offers you the freedom to visit any provider you wish. You have the flexibility to choose from both in- and out-of-network providers with your out-of-pocket costs determined by your choice. There is no need to choose a primary care provider (PCP) or to obtain a referral before visiting a specialist.

Benefits of the Triple Option Open Access Plan

- The ability to visit providers from either our BlueChoice Network, CareFirst PPO Network, National PPO Network or out-of-area providers
- No PCP referral required to see a specialist
- Receive coverage for preventive health care services at no cost
- Take your health care benefits with you—across the country and around the world

How your plan works

With the Triple Option Open Access plan, you can visit any provider of your choosing. Your out-of-pocket costs are determined by who you decide to see.

In-network benefits provide a higher level of coverage, meaning you have lower out-of-pocket costs. **Out-of-network benefits** provide a lower level of coverage in exchange for the freedom to seek care from any provider you choose.

Your in- and out-of-network benefits are organized into three levels of coverage.

Level 1: For your lowest and most predictable in-network out-of-pocket costs, choose a BlueChoice provider. You can visit any of the 37,000 BlueChoice providers within Maryland, Washington, D.C. and Northern Virginia. Visit our online provider directory at **www.carefirst.com/doctor** to locate in-network providers.

Remember, you have direct access to CareFirst BlueChoice specialists without needing to obtain a referral from your PCP.

Level 2: To receive level 2 in-network benefits, visit a provider who participates in either:

- The CareFirst PPO Network (MD, DC and Northern Virginia)

  or

- The national BlueCard® PPO network of over 600,000 doctors and 61,000 hospitals.

To locate a PPO provider, visit **www.carefirst.com/doctor**.

Level 3: This level of coverage is out-of-network and offers you the most flexibility. In exchange for a lower level of coverage, you have the freedom to seek care from any provider you choose.

If you receive services from a provider who does not participate in any of the networks listed above, you may have to:

- Pay the provider's actual charge at the time you receive care
- File a claim for reimbursement
- Satisfy a higher deductible and/or coinsurance amount

In general, out-of-network providers do not have an agreement with CareFirst to accept the allowed benefit as payment in full for their services. Therefore, if you receive services from a non-participating provider, you may be balance billed based on the provider's actual charge.

Certain services under this level of coverage require you to meet a deductible. Check your benefits enrollment guide for details. When applicable, you are responsible for the entire cost of your medical care up to the amount of your deductible. Once your deductible is satisfied, your coverage will become available. Depending on the service,

you may have to pay a copay or coinsurance when you receive care.

Laboratory services

To receive the maximum laboratory benefit from your Triple Option plan, you must use a LabCorp® facility for any laboratory services. Lab services at any other independent lab will be processed at Level 2 or Level 3 based on the laboratory's network status. Also, any lab work performed in an outpatient hospital setting will require a prior authorization.

LabCorp has approximately 100 locations throughout Maryland, Washington, D.C. and Northern Virginia. To locate the LabCorp patient service center near you, call 888-LAB-CORP (522-2677) or visit **www.labcorp.com**.

Hospital authorization

In-network providers will obtain any necessary admission authorizations for in-area (Maryland, Washington, D.C. and Northern VA). You will be responsible for obtaining authorization for services provided by out-of-network and out-of-area admissions. Call toll-free 888-PRE-AUTH (773-2884).

Examples:

Inpatient Hospital Stay Claim					
PROVIDER STATUS/BENEFIT LEVEL	AMOUNT CHARGED	ALLOWED BENEFIT	CAREFIRST BLUECROSS BLUESHIELD PAYS	MEMBER PAYS	
BlueChoice/Level 1	$14,800	$8,160	$8,160	$0	
PPO/Level 2	$14,800	$9,180	$9,180	$0	
Participating*/Level 3	$14,800	$10,200	$8,000	$2,200	$200 deductible then 20% AB ($2,000)
Non-participating*/Level 3	$14,800	$10,200	$8,000	$6,800	$200 deductible then 20% AB ($2,000 + balance to charge $4,600)
Primary Care Provider Office Visit					
PROVIDER STATUS/BENEFIT LEVEL	AMOUNT CHARGED	ALLOWED BENEFIT	CAREFIRST BLUECROSS BLUESHIELD PAYS	MEMBER PAYS	
BlueChoice/Level 1	$150	$64	$54	$10	Office Visit copay
PPO/Level 2	$150	$72	$57	$15	Office Visit copay
Participating*/Level 3	$150	$80	$0	$80	Deductible applied
Non-participating*/Level 3	$150	$80	$0	$150	$80 deductible plus balance to charge $70
Maternity Provider Delivery Charge					
PROVIDER STATUS/BENEFIT LEVEL	AMOUNT CHARGED	ALLOWED BENEFIT	CAREFIRST BLUECROSS BLUESHIELD PAYS	MEMBER PAYS	
BlueChoice/Level 1	$5,864	$3,616	$3,616 (100% AB)	$0	
PPO/Level 2	$5,864	$4,068	$4,068 (100% AB)	$0	
Participating*/Level 3	$5,864	$4,520	$3,616	$904	Deductible was already met 20% AB
Non-participating*/Level 3	$5,864	$4,520	$3,616	$2,248	Deductible was met 20% AB $904 + difference to charge $1344

** Participating Provider—A physician or other provider who has signed an agreement with CareFirst BlueCross BlueShield to accept the Allowed Benefit as payment in full.*

Preferred Provider Organization

A referral-free go anywhere health plan

Designed for today's health conscious and busy families, the Preferred Provider Organization (PPO) plan offers one less thing to worry about during your busy day. Your PPO plan gives you the freedom to visit any provider you wish—any time you wish. This means you can receive care from the provider of your choice without ever needing to select a primary care provider (PCP) or obtaining a PCP referral for specialist care.

Benefits of PPO

- Access to our network of more than 43,000 doctors, specialists and hospitals in Maryland, Washington, D.C. and Northern Virginia.
- No primary care provider required, and no referrals to see a specialist.
- Take your health care benefits with you—across the country and around the world.
- Receive coverage for preventive health care visits at no cost.
- Avoid balance billing when you receive care from a preferred provider.
- Enjoy the freedom to visit providers outside of the PPO network and still be covered but with a higher out-of-pocket cost.

No referrals.
No PCPs.
Coverage everywhere.

How your plan works

In-network vs. out-of-network coverage

The amount of coverage your PPO plan offers depends on whether you see a provider in the PPO network (preferred provider). You will always receive a higher level of benefits when you visit a preferred provider. However, the choice is entirely yours. That's the advantage of a PPO plan.

In-network benefits provide a higher level of coverage. This means you have lower out-of-pocket costs when you choose a preferred provider. If you are out of the CareFirst BlueCross BlueShield (CareFirst) service area, you have the freedom to select any provider that participates with a Blue Cross and Blue Shield PPO plan across the country and receive benefits at the in-network level.

Out-of-network benefits provide a lower level of coverage in exchange for the freedom to seek care from any provider you choose. If you receive services from a provider outside of the PPO network (non-preferred provider), you may have to:

- Pay the provider's actual charge at the time you receive care.
- File a claim for reimbursement.
- Satisfy a higher deductible and/or coinsurance amount.

Hospital authorization/ Utilization management

Preferred providers will obtain any necessary admission authorizations for in-area covered services. You will be responsible for obtaining authorization for services provided by non-preferred providers and out-of-area admissions. Call toll-free at (866)—PREAUTH.

Your benefits

Step 1: Meet your deductible

You will be responsible for the entire cost of your medical care up to the amount of your deductible for services where the deductible applies. Once your deductible is satisfied, your PPO coverage will become available to you.

Following is a list of services for which the deductible does NOT apply in-network:

- Preventive care, including well child care, routine physical exam, routine gynecological exam and routine mammography
- Office Visits for Illness
- Physical, Speech and Occupational Therapy
- Chiropractic Care
- Office Visits for Mental Health and Substance Abuse

PPO CORE members will have a different deductible amount for in-network vs. out-of-network benefits. However, any amount applied to your in-network deductible will also count towards your out-of-network deductible and vice versa.

If more than one person is covered under your PPO plan, once the family deductible amount is satisfied, the plan will start to make payments for everyone covered. Deductible requirements vary based on your coverage level (e.g. individual, family). Members should refer to their Evidence of Coverage for detailed deductible information.

Step 2: Your PPO plan will start to pay for services

After you satisfy your deductible, your PPO plan will start to pay for covered services. The level of those benefits will depend on whether you see preferred or non-preferred providers.

Step 3: Your out-of-pocket maximum

Your out-of-pocket maximum is the maximum amount you will pay during your benefit period. Should you reach your out-of-pocket maximum, CareFirst will then pay 100% of the allowed benefit for most covered services for the remainder of the benefit period. Any amount you pay toward your deductible and most copays and/ or coinsurance will count toward your out-of-pocket maximum.

You will have a different out-of-pocket maximum for in-network vs. out-of-network benefits. However, deductible amounts applied to your in-network out-of-pocket maximum will also count toward your out-of-network out-of-pocket maximum and vice versa.

If more than one person is covered under your PPO plan, once the total out-of-pocket maximum is satisfied, no copays or coinsurance amounts will be required for anyone covered under your plan. Out-of-pocket maximum requirements vary based on your coverage level (e.g. individual, family) as well as the specific PPO plan selected. Members should refer to their Certificate or Evidence of Coverage for detailed out-of-pocket maximum information.

Out-of-area coverage PPO®

You have the freedom to take your health care benefits with you—across the country and around the world. BlueCard® PPO, a program from the Blue Cross and Blue Shield Association, allows you to receive the same health care benefits when receiving care from a BlueCard® preferred provider while living or traveling outside of the CareFirst service area (Maryland, Washington, D.C. and Northern Virginia). The BlueCard® program includes more than 6,100 hospitals and 600,000 other health care providers nationally.

BlueCard®

Wherever you go, your health care coverage goes with you

With your Blue Cross and Blue Shield member ID card, you have access to doctors and hospitals almost anywhere. BlueCard gives you the peace of mind that you'll always have the care you need when you're away from home.

As always, go directly to the nearest hospital in an emergency.

Your membership gives you a world of choices. More than 85% of all doctors and hospitals throughout the U.S. contract with Blue Cross and Blue Shield plans. Whether you need care here in the United States or abroad, you'll have access to health care in more than 190 countries.

When you're outside of the CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. service area (Maryland, D.C., and Northern VA), you'll have access to the local Blue Cross Blue Shield Plan and their negotiated rates with doctors and hospitals in that area. You shouldn't have to pay any amount above these negotiated rates. Also, you shouldn't have to complete a claim form or pay up front for your health care services, except for those out-of-pocket expenses (like non-covered services, deductibles, copayments, and coinsurance) that you'd pay anyway.

Within the U.S.

1. Always carry your current member ID card for easy reference and access to service.
2. To find names and addresses of nearby doctors and hospitals, visit the National Doctor and Hospital Finder at **www.bcbs.com**, or call BlueCard Access at 800-810-BLUE (2583).
3. Call Member Services for pre-certification or prior authorization, if necessary. Refer to the phone number on your ID card because it's different from the BlueCard Access number listed in Step 2.
4. When you arrive at the participating doctor's office or hospital, simply present your ID card.
5. After you receive care, you shouldn't have to complete any claim forms or have to pay up front for medical services other than the usual out-of-pocket expenses. CareFirst will send you a complete explanation of benefits.

Around the world

Like your passport, you should always carry your ID card when you travel or live outside the U.S. The BlueCard Worldwide program provides medical assistance services and access to doctors, hospitals and other health care professionals around the world. Follow the same process as if you were in the U.S. with the following exceptions:

- At BlueCard Worldwide hospitals, you shouldn't have to pay up front for inpatient care, in most cases. You're responsible for the usual out-of-pocket expenses. And, the hospital should submit your claim.
- At non-BlueCard Worldwide hospitals, you pay the doctor or hospital for inpatient care, outpatient hospital care, and other medical services. Then, complete an international claim form and send it to the BlueCard Worldwide Service Center. The claim form is available online at **www.bcbs.com**.
- To find a BlueCard provider outside of the U.S. visit **www.bcbs.com**, select *Find a Doctor or Hospital*.

Medical assistance when outside the U.S.

Call 800-810-BLUE (2583) toll-free or (804) 673-1177, 24 hours a day, 7 days a week for information on doctors, hospitals, other health care professionals or to receive medical assistance services. A medical assistance coordinator, in conjunction with a medical professional, will make an appointment with a doctor or arrange hospitalization if necessary.

Visit **www.bcbs.com** to find providers within the U.S. and around the world.

CareFirst Prescription Drug Program

For BlueChoice HMO, Triple Option and PPO Plans

Your pharmacy benefit program is now administered by CVS Caremark. This program is based on the CareFirst Preferred Drug List, formerly formulary, that encourages the use of Generic drugs and certain Brand drugs. You pay a different copay depending on whether you choose a Generic drug, a Brand drug on the Preferred Drug List, or a Non-preferred Brand drug. Always remember to talk to your doctor about using Preferred drugs that can save you money. You and your doctor should check your Preferred Drug List before you receive a prescription.

Retail program

The retail program provides a 34-day or less supply of medication when purchased at a participating retail pharmacy. Present your prescription drug identification card at any participating pharmacy and pay the appropriate copayment for your medication. Maintenance medication when purchased at a participating pharmacy is dispensed up to a 90-day supply for one copay for Triple Option members, two copays for PPO CORE Plan members and three copays for HMO Plan members.

Mail order service prescription program

Your mail order prescription drug program is administered by CVS Caremark. The Mail Order Service Prescription Program is a special added feature to your CareFirst Plan. For those who regularly take one or more types of maintenance medication, this service provides a convenient, inexpensive way for you to order these medications and have them delivered at home.

For Triple Option, you can order up to a 90-day supply of maintenance medication for the $20 copayment. For PPO CORE, you can order up to a 90-day supply of maintenance medication for 1 times the required copayment ($10/25/40). For HMO, you can order a 90-day supply of maintenance medication for 2 times the copayment ($5/15/35). The copayment cannot be reimbursed through your Medical Benefits Plan.

Medications are delivered to your home postage paid via UPS or First Class U.S. Mail.

If you have any questions regarding this prescription service, call the CareFirst Pharmacy Services toll-free telephone number Monday through Friday 8:00 a.m. – 8:00 p.m. and Saturday 8:00 a.m. – 12:00 p.m. at (800) 241-3371.

Refill guidelines

Refills will not be authorized on any prescriptions until 25% or less of the original quantity is remaining in your possession (75% has been used).

Vacation supply

Since your program has a nationwide network, in most cases there are several area participating pharmacies available when on vacation. You may obtain a written prescription from the physician prior to leaving and obtain a list of pharmacies in the area in which you will be traveling.

- If you are traveling out of the country for less than one month, call CareFirst Pharmacy Services at (800) 241-3371 to receive authorization for an additional short-term supply.
- For additional quantities greater than one month, please contact CareFirst Member Services using the number on your ID card.

Please call no less than 10 days in advance of your departure date to request the additional supply.

Non-participating pharmacy

If a pharmacy is non-participating you will be required to pay the full cost of the prescription at the time of purchase. Claims for these prescriptions should be submitted on the appropriate claim form.

CVS Caremark claim forms are available on the CareFirst website at **www.carefirst.com** or you can contact CareFirst Pharmacy Services at (800) 241-3371.

Generic drug appeal process when medically necessary

1. When members cannot take the Generic medication due to medical reasons, the member's physician would be required to supply medical justification for prescribing the Brand medication.
2. The member's physician must initiate the request process.
3. Requests will be forwarded directly to the Carefirst Pharmacy Management Department. Requests will be reviewed and turned around within 2 business days when submitted during business hours.
4. Once the appeal is received and approval is given by CareFirst pharmacy department, the prescribing physician and the pharmacy are provided notification of the appeal, and the pharmacy will be requested to reprocess the claim.
5. The approval of a Brand medication will be valid for 12 months from the original fill date of the medication.

CareFirst Drug Program

Summary of Benefits

Plan Feature	BlueChoice HMO *Open Access*	Triple Option	PPO CORE	Description
DEDUCTIBLE	None	None	None	Your benefit does not have a deductible.
FAMILY DEDUCTIBLE MAXIMUM	None	None	None	Your benefit does not have a family deductible maximum.
PREVENTIVE DRUGS (up to a 34-day supply)	$0	$0	$0	A Preventive Drug (not subject to any copay and deductible) is a medication or item on CareFirst's Preventive Drug List that is prescribed under certain medical criteria by a provider under a written prescription for – Aspirin, Folic Acid, Fluoride, Iron Supplements, Smoking Cessation Products, and FDA approved contraceptives for women.
ORAL CHEMOTHERAPY & DIABETIC SUPPLIES (up to a 34-day supply)	$0	$0	$0	Diabetic supplies include needles, lancets, test strips and alcohol swabs.
GENERIC DRUGS (TIER 1) (up to a 34-day supply)	$5	$10	$10	All Generic drugs are covered at this copay level.
PREFERRED BRAND DRUGS (TIER 2) (up to a 34-day supply)	$15	$25	$25	All Preferred Brand drugs are covered at this copay level.
NON-PREFERRED BRAND DRUGS (TIER 3) (up to a 34-day supply)	$35	$40	$40	All Non-preferred Brand drugs are covered at this copay level. If you choose a Non-preferred brand drug (Tier 3) instead of its Generic equivalent, you will pay the highest copay plus, the difference in cost between the Non-preferred Brand drug and the Generic. These drugs are not on the Preferred Drug List. Check the online Preferred Drug List to see if there is an alternative drug available. Discuss using alternatives with your physician or pharmacist.
MAINTENANCE COPAYS (up to a 90-day supply)				Maintenance drugs of up to a 90-day supply are available through Rx Mail Order or retail pharmacy.
Mail Order:				
Generic	$10	$20	$10	
Preferred	$30	$20	$25	
Non-preferred	$70	$20	$40	
Retail:				
Generic	$15	$10	$20	
Preferred	$45	$25	$50	
Non-preferred	$105	$40	$80	
PRIOR AUTHORIZATION	Yes	Yes	Yes	Some prescription drugs require Prior Authorization. Prior Authorization is a tool used to ensure that you will achieve the maximum clinical benefit from the use of specific targeted drugs. Your physician or pharmacist must call (800) 294-5979 to begin the prior authorization process. For the most up-to-date prior authorization list, visit the prescription drug website at **www.carefirst.com/rx**.
MANDATORY GENERIC SUBSTITUTION	Yes	Yes	Yes	If you choose a Non-preferred Brand drug (Tier 3) instead of its Generic equivalent, you will pay the highest copay plus, the difference in cost between the Non-preferred Brand drug and the Generic. If a Generic version is not available, you will only pay the copay.

Rx Drug Program–3 Tiers

A total prescription for health

Prescription drugs are an integral part of high-quality health care. The prescription benefits your employer is offering give you an affordable and convenient way to make the best decisions when it comes to your prescriptions.

Your Rx benefits

As a CareFirst BlueCross BlueShield or CareFirst BlueChoice, Inc. (CareFirst) member, you have access to:

- A nationwide network with more than 60,000 participating pharmacies
- Nearly 5,000 drugs
- Mail Service Pharmacy, our convenient, fast and accurate mail order drug program
- Coordinated medical and pharmacy programs to help improve your overall health and reduce costs
- Personalized notices detailing cost savings opportunities, safety alerts and other important drug information

How your plan works

A formulary is a list of covered prescription drugs. Our drug list is reviewed and approved by an independent national committee comprised of physicians, pharmacists and other health care professionals who make sure the drugs on the formulary are safe and clinically effective.

Talk to your doctor to make sure you are using drugs on CareFirst's Preferred Drug List. Remember, you'll save the most money when using drugs on the Preferred Drug List.

Rx Drug Program–3 Tiers

A total prescription for health

The prescription drugs found on the CareFirst Formulary (drug list) are divided into tiers. These tiers include no cost drugs, generics, preferred brand and non-preferred brand name drugs and the price you pay is determined by the tier the drug falls into.

Drug tier (Cost-share)	Definition	More information
No cost drugs (preventive drugs)	The Affordable Care Act (ACA) classifies certain drug therapies as "preventive" if they reduce the risk of some serious health conditions.	Preventive drugs (aspirin, folic acid, fluoride, iron supplements, smoking cessation products and FDA-approved contraceptives for women) are available at no cost if prescribed under certain medical criteria by your doctor.
Tier 1 You pay: lowest copay ($)	Generic drugs	Generic drugs will be in Tier 1.
Tier 2* You pay: higher copay ($$)	Preferred brand drugs	If a generic version of a Tier 2 drug is released then: The generic drug is added to Tier 1. The brand drug moves to Tier 3 and becomes a non-preferred brand drug.
Tier 3* You pay: highest copay ($$$)	Non-preferred brand drugs	Drugs in this tier will cost the most.

** Self-Injectable drugs are covered under Tier 2 or Tier 3 in three-tier designs.*

Note: If the cost of your medication is less than your copay or coinsurance, you only pay the cost of the medication. Once you meet your deductible (if applicable to your plan), you may pay a different copay or coinsurance amount for drugs depending on if you use generic, preferred brand or non-preferred brand drugs. Check your benefit summary or enrollment materials for specific plan information. Once you are a member, you can view specific cost-share information in *My Account*.

Preferred Drug List

CareFirst has identified a Preferred Drug List that may save you money. The list includes generic and preferred brand drugs selected for their quality, effectiveness, safety and cost by an independent CVS/caremark[1] national Pharmacy and Therapeutics (P&T) committee.

- By using the CareFirst Preferred Drug List, you can work with your doctor or pharmacists to make safe and cost-effective decisions to better manage your health care and costs.
- Even though non-preferred drugs aren't part of the Preferred Drug List, they're still covered, but at the highest cost-share. Go to **www.carefirst.com/rxgroup** to view the entire formulary.

Two ways to fill

Retail pharmacies

With access to more than 60,000 pharmacies across the country, you can visit **www.carefirst.com/rxgroup** and use our *Find a Pharmacy* tool to locate a convenient participating pharmacy. Be sure to take your prescription and member ID card with you when filling prescriptions.

Mail Service Pharmacy

Mail Service Pharmacy is a convenient way to fill your prescriptions, especially for refilling medications taken frequently. You can register three ways—online through *My Account*, by phone or by mail. Once you register for Mail Service Pharmacy you'll be able to:

- Refill prescriptions online, by phone or by email
- Choose your delivery location

[1] *CVS/caremark is an independent company that provides pharmacy benefit management services.*

- Consult with pharmacists by phone 24 hours a day, seven days a week
- Schedule automatic refills
- Receive email notification of order status
- Choose from multiple payment options

Prescription guidelines

In addition, some medications are only intended to be used in limited quantities; others require that your doctor obtain prior authorization through CareFirst before they can be filled. These drug provisions are indicated on the formulary found on **www.carefirst.com/rxgroup**.

- **Quantity limits** have been placed on the use of selected drugs for quality, safety or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.
- **Prior authorization** is required before you fill prescriptions for certain drugs. Your doctor must obtain prior authorization from CareFirst before these drugs are covered.
- **Step therapy** asks that you try lower-cost, equally effective drugs that treat the same medical condition before trying a higher-cost alternative. Your physician can speak to your experience with these alternatives prior to dispensing a more expensive drug.

Care management

Take advantage of the following programs and resources available at no cost to you with your CareFirst prescription drug plan.

Specialty Pharmacy Coordination Program

The specialty pharmacy program provides personalized care for our members with certain chronic conditions requiring specialty medications. Working together, we can help you achieve the best possible results from your specialty medication therapy.

Personal Attention

The more you know about your health condition, the better you can successfully manage it. Our specialty customer care team works together with your doctors and case managers to provide you with in-depth support and service for your particular condition. We offer:

- One-on-one therapy support with a registered nurse for certain chronic conditions like multiple sclerosis, hepatitis C, hemophilia, and selected autoimmune diseases
- Injection training coordination
- Medications mailed to your home or office, or available for pick up at any CVS retail pharmacy
- 24-hour pharmacist assistance
- Educational materials for your specific condition
- Drug interaction monitoring and review
- Refill reminders

To take full advantage of these program benefits, your specialty medications must be filled through the CVS/caremark Specialty Pharmacy[2].

Comprehensive Medication Review (CMR)

Medication complications cause 10% of hospital admissions[3]. The Comprehensive Medication Review program seeks to reduce prescription drug-related complications, and related hospitalizations, and ensure the best possible outcomes for members with high potential for medication-related issues. If you are identified for the program, a dedicated team of pharmacists will collaborate with you and your doctor(s) to review and evaluate:

- Possibilities for drug interactions
- Opportunities to support medication adherence
- Cost effective therapy
- Gaps in care
- Duplications in drug therapy

The program's one-on-one support ensures you are not only taking the most favorable drug therapy to manage your conditions, but you are also able to take your medications as prescribed.

Medication Therapy Management (MTM) program

Taking medications as prescribed not only helps improve your health but can also reduce health care costs. Working together with CVS/caremark, CareFirst's MTM program is designed to help you get the best results from your medication therapy.

We review pharmacy claims for opportunities to:

- Save you money;
- Support compliance with medications;
- Improve your care; and
- Ensure safe use of high risk medications.

When opportunities are identified, "Drug Advisories" are mailed to you and/or your providers outlining potential for savings for any medication-related issues. You may also have the opportunity to speak one-to-one with pharmacist, through the Pharmacy Advisor program, who can answer questions and help you manage your prescription medications.

Online tools and resources

To get the most from your prescription drug plan, you need to stay informed. Our easy-to-use, interactive tools and resources are available 24 hours a day, seven days a week. Visit **www.carefirst.com/rxgroup** to see if a drug is covered, find a pharmacy, learn how drugs interact with each other and get more information about medications. You can access even more tools and resources once you're a member through *My Account*.

Keeping you informed

Our pharmacy benefit manager, CVS/caremark, keeps you informed about your prescription drug coverage and provides you with periodic updates about your plan through targeted mailings. You could get notices about lower cost drug alternatives, alerts about possible safety concerns, drug tier changes and more.

Ways to save

Here are some ways to help you save on your prescription drug costs.

- **Use generic drugs**—generic drugs can cost up to 80 percent less than their brand-name counterparts. Made with the same active ingredients as their brand-name counterparts, generics are also equivalent in dosage, safety, strength, quality, performance and intended use.
- **Use drugs on the Preferred Drug List**—the Preferred Drug List identifies generic and preferred brand drugs that may save you money.
- **Use maintenance medications**—maintenance medications are drugs you take regularly for ongoing conditions such as diabetes, high blood pressure or asthma. You can get up to a three-month supply of your maintenance medications for the cost of two copays through any pharmacy in the network, including through mail order.
- **Use mail order**—by using our Mail Service Pharmacy you get the added convenience of having your prescriptions delivered right to your home. Plus, if you pay a coinsurance for your maintenance drugs, the overall cost of the drug may be less expensive through mail order, reducing your out-of-pocket costs.

Should you have any questions about your prescription benefits, please call CareFirst Pharmacy Services at 800-241-3371.

BlueVision

Discounts included when you elect BlueChoice or Triple Option medical plans

Professional vision services including routine eye examinations, eyeglasses and contact lenses offered by CareFirst BlueChoice, through the Davis Vision, Inc. national network of providers.

How the plan works

How do I find a provider?

To find a provider, go to **www.carefirst.com** and utilize the *Find a Provider* feature or call Davis Vision at **800-783-5602** for a list of network providers closest to you. Be sure to ask your provider if he or she participates with the Davis Vision network before you receive care.

How do I receive care from a network provider?

Simply call your provider and schedule an appointment. Identify yourself as a CareFirst BlueChoice member and provide the doctor with your identification number, as well as your date of birth. Then go to the provider to receive your service. There are no claim forms to file.

Can I get contacts and eyeglasses in the same benefit period?

With BlueVision, you receive one pair of eyeglasses or a supply of contact lenses per benefit period at a discounted price.[1]

Mail order replacement contact lenses

DavisVisionContacts.com offers members the flexibility to shop for replacement contact lenses online after benefits are spent. This website offers a wide array of contact lenses, easy, convenient purchasing online and quick shipping direct to your door.

Need more information? Please visit **www.carefirst.com** or call **800-783-5602.**

[1] *As of 4/1/14, some providers in Maryland and Virginia may no longer provide these discounts.*

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BlueVision

Discounts included when you elect BlueChoice or Triple Option medical plans

Summary of Benefits *(12-month benefit period)*

In-Network	You Pay
EYE EXAMINATIONS[1]	
Routine Eye Examination with dilation (per benefit period)	$10
FRAMES[1,2]	
Priced up to $70 retail	$40
Priced above $70 retail	$40, plus 90% of the amount over $70
SPECTACLE LENSES[2]	
Single Vision	$35
Bifocal	$55
Trifocal	$65
Lenticular	$110
LENS OPTIONS[2,3] *(add to spectacle lens prices above)*	
Standard Progressive Lenses	$75
Premium Progressive Lenses (Varilux®, etc.)	$125
Ultra Progressive Lenses (digital)	$140
Polarized Lenses	$75
High Index Lenses	$55
Glass Lenses	$18
Polycarbonate Lenses	$30
Blended Invisible Bifocals	$20
Intermediate Vision Lenses	$30
Photochromic Lenses	$35
Scratch-Resistant Coating	$20
Standard Anti-Reflective Coating	$45
Ultraviolet (UV) Coating	$15
Solid Tint	$10
Gradient Tint	$12
Plastic Photosensitive Lenses	$65
CONTACT LENSES[1,2]	
Contact Lens Evaluation and Fitting	85% of retail price
Conventional	80% of retail price
Disposable/Planned Replacement	90% of retail price
DavisVisionContacts.com Mail Order Contact Lens Replacement Online	Discounted prices
LASER VISION CORRECTION[2]	Up to 25% off allowed amount or 5% off any advertised special[4]

[1] *At certain retail locations, members receive comparable value through their everyday low price on examination, frame and contact lens purchase.*

[2] *CareFirst BlueChoice does not underwrite lenses, frames and contact lenses in this program. This portion of the Plan is not an insurance product. As of 4/1/14, some providers in Maryland and Virginia may no longer provide these discounts.*

[3] *Special lens designs, materials, powers and frames may require additional cost.*

[4] *Some providers have flat fees that are equivalent to these discounts.*

Exclusions

The following services are excluded from coverage:

1. Diagnostic services, except as listed in *What's Covered* under the Evidence of Coverage.
2. Medical care or surgery. Covered services related to medical conditions of the eye may be covered under the Evidence of Coverage.
3. Prescription drugs obtained and self-administered by the Member for outpatient use unless the prescription drug is specifically covered under the Evidence of Coverage or a rider or endorsement purchased by your Group and attached to the Evidence of Coverage.
4. Services or supplies not specifically approved by the Vision Care Designee where required in *What's Covered* under the Evidence of Coverage.
5. Orthoptics, vision training and low vision aids.
6. Glasses, sunglasses or contact lenses.
7. Vision Care services for cosmetic use.
8. Services obtained from Non-Contracting Providers.

For BlueChoice Opt-Out Plus members, Vision Care benefits are not available under the Out-of-Network Evidence of Coverage.

Exclusions apply to the Routine Eye Examination portion of your vision coverage. Discounts on materials such as glasses and contacts may still apply.

Benefits issued under policy form numbers: MD/BC-OOP/VISION (R. 6/04) • DC/BC-OOP/VISION (R. 6/04) • VA/BC-OOP/VISION (R. 6/04)

Patient-Centered Medical Home

Focusing on you and your health

Whether you're trying to get healthy or stay healthy, you need the best care available. That's why the CareFirst BlueCross BlueShield[1] family of health plans has created a program to improve health care quality and help slow rising health care costs over time.

Our Patient-Centered Medical Home (PCMH) program focuses on the relationship between you and your primary care provider (PCP)—whether a physician or nurse practitioner (NP). It's designed to provide your PCP[2] with a more complete view of your health needs, as well as the care you're receiving from other providers. As the leader of your health care team, your PCP will be able to use this information to better manage and coordinate your care, a key to better health.

Treating your overall health

Whether you see your PCP for preventive care, or you need more care, your PCP is expected to:

- Coordinate your care with all your health care providers, including specialists, labs, pharmacies, and mental health facilities to help you get access to, and receive, the most appropriate care available in the most affordable settings.
- Identify and address any impact the care you receive for one health issue may have on another.
- Review all of your medications and possible drug interactions with you.
- Review your health records for duplicate tests or services already ordered or performed by another provider.

Why a PCP is important to your health

By visiting your PCP for routine visits as recommended, you can build a relationship, and your PCP will get to know you and your medical history.

A PCP is concerned with your overall health. If you have an urgent health issue, having a PCP who knows your health history often makes it easier and faster to get the care you need. Your PCP can sometimes provide advice over the phone or fit you in for a visit. That helps you avoid long lines and expensive charges at the emergency room.

When you visit your PCP for screenings and preventive services, he or she can detect health concerns in the early stages, when they are easier and less costly to treat.

1 All references to CareFirst refer to CareFirst BlueCross BlueShield and CareFirst, BlueChoice, Inc., collectively.

2 The doctors and other medical providers, who provide your care, are independent providers making their own medical determinations and are not employed by either CareFirst BlueCross BlueShield or CareFirst BlueChoice, Inc.

If you have a chronic condition, or are at risk for one, your PCP may:

- Create a Care Plan based on your health needs with specific follow-up activities to help you manage your health.
- Provide access to a care coordinator, who is a registered nurse (RN), so you have the support you need, answers to your questions and information about your care.

Extra care for certain health issues

When you participate in PCMH, your PCP will take specific steps to coordinate and manage your care. If you have certain health issues, your PCP will create an online record of your health needs with specific follow-up activities.

Your care coordinator is expected to:

- Assist your PCP by coordinating your care and answering your questions.
- Follow up with you to make sure you're not having problems following your treatment plan. For example, if you have diabetes, the care coordinator can help you take steps to better understand and control your diabetes.
- Assist you in obtaining services and equipment necessary to manage your health condition.

It's your choice

PCMH is a voluntary program. When you participate:

- You pay no additional premium.
- There is no change in your benefits.
- There is no change to your health plan requirements.
- You can opt-out at any time without penalty and without changing your PCP and/or NP.

Please note that if you have a high deductible health plan, certain charges may apply until you meet your deductible.

How do I get started?

Simply sign the Election to Participate form and return it to your PCP.

You can get the form from your PCP, or you can download it from the Forms section at **www.carefirst.com/memberpcmh**. By signing the election form, you agree to give your PCP access to your health information on file with CareFirst. This includes data from claims and notes from any CareFirst programs in which you have participated.

Medical Benefits Options

Effective for plan year July 1, 2017–June 30, 2018

The Benefits	BlueChoice HMO OpenAccess BlueChoice Providers	Level 1 BlueChoice Providers
DEDUCTIBLE – CONTRACT YEAR JULY 1 – JUNE 30	$100 Individual / $200 Family aggregate (does not apply to Rx benefits)	None
MEDICAL OUT-OF-POCKET MAXIMUM	None	$1,200 Individual /
LIFETIME MAXIMUM	Unlimited	
HOSPITAL		
Hospital Room/Semi-Private*	100% AB	365 days at 100% AB
Skilled Nursing Facility*	100% AB (limited to 60 days/contract year)	100% AB
Inpatient Rehabilitation*	100% AB (limited to 60 days/contract year)	100% AB
Outpatient Surgery	100% AB	100% AB
Emergency Care**	Emergency Room—$50 copay, (waived if admitted) Urgent Care Center—$30 copay	Emergency Room—$50 copay, (waived if admitted) Urgent Care Center—$15 copay
PHYSICIAN SERVICES		
Surgeon	100% AB	100% AB
Assistant Surgeon	100% AB	100% AB
Anesthesiologist	100% AB	100% AB
In-Hospital Medical	100% AB	100% AB
MEDICAL SERVICES		
Office Visits	$10 PCP/$15 Specialist copay	$10 PCP/$15 Specialist copay
Outpatient Facility	100% AB	100% AB
Outpatient Physician	$10 PCP/$15 Specialist copay	$10 PCP/$15 Specialist copay
Diagnostic X-rays	100% AB	100% AB
Radiation Therapy	$15 Specialist copay	100% AB
Chemotherapy	$15 Specialist copay	100% AB
Laboratory Tests	100% AB (LabCorp only)	100% AB (LabCorp only)
Allergy Testing	$10 PCP/$15 Specialist copay	100% AB
Allergy Treatment/Injections	$10 PCP/$15 Specialist copay	100% AB
Physical, Speech and Occupational Therapy (combined visits)	$15 Specialist copay; 60 visit maximum per condition per contract year combined with speech and occupational therapy	$15 Specialist copay; 100 visit maximum per contract year combined with speech and occupational therapy
Chiropractic Care (Spinal Manipulation)	$15 Specialist copay	$15 Specialist copay
Acupuncture	Not covered	$15 Specialist copay

AB = Allowed Benefit

This chart contains highlights only and is subject to change. The specific terms of coverage, exclusions and limitations are contained in the Summary Plan Description, the Group Benefit Guide or the Group Service Agreement. AB—Allowed Benefit. AWP—Average Wholesale Price.

** Precertification required or penalties may apply.*

*** Overnight stays for observation are not considered an inpatient admission.*

Triple Option		CareFirst BlueCross BlueShield Preferred Provider Organization CORE	
Level 2 BlueCross BlueShield PPO Providers	**Level 3 Participating and Non-participating Providers**	**In-Network BlueCross BlueShield PPO Providers**	**Out-of-Network Participating and Non-participating Providers**
None	$200 Individual $400 Family aggregate (Deductible applies to all services unless otherwise noted.)	$100 Individual / $200 Family aggregate (Deductible applies to all services unless otherwise noted.)	$300 Individual / $600 Family aggregate (Deductible applies to all services unless otherwise noted.)
$2,400 Family (combined in- and out-of-network)		$2,400 Individual / $4,800 Family (combined in- and out-of-network)	
Unlimited		Unlimited	
365 days at 100% AB	365 days at 80% AB	365 days at 90% AB	365 days at 70% AB
100% AB	80% AB	90% AB	70% AB
100% AB	80% AB	90% AB	70% AB
100% AB	80% AB	90% AB	70% AB
Emergency Room—$50 copay, (waived if admitted) Urgent Care Center—$20 copay	Emergency Room—$50 copay, (waived if admitted) Urgent Care Center—80% AB	Emergency Room—$75 copay (waived if admitted) Urgent Care Center—$20 copay	Emergency Room—$75 copay (waived if admitted) Urgent Care Center—70% AB
100% AB	80% AB	90% AB	70% AB
100% AB	100% AB (no deductible)	90% AB	90% AB
100% AB	100% AB (no deductible)	90% AB	90% AB
100% AB	80% AB	90% AB	70% AB
$15 PCP/$20 Specialist copay	80% AB	$15 PCP / $20 Specialist copay (no deductible)	70% AB
100% AB	80% AB	100% AB	70% AB
$25 copay	80% AB	$25 copay	70% AB
100% AB	100% AB inpatient, waive deductible 80% AB outpatient	90% AB	90% AB inpatient / 70% AB office
100% AB	80% AB	90% AB	70% AB
100% AB	80% AB	90% AB	70% AB
100% AB	100% AB inpatient (no deductible) 80% AB outpatient	90% AB	90% AB inpatient / 70% AB office
100% AB	80% AB	90% AB	70% AB
100% AB	80% AB	90% AB	70% AB
$20 Specialist office; $25 OP Facility; $25 OP Professional; 100 visit maximum per contract year (occupational/speech combined in- and out-of-network)	80% AB; 100 visit maximum per contract year (occupational/speech combined in- and out-of-network)	$20 Specialist copay; $25 OP Facility, $25 OP Professional (no deductible); 100 visit maximum per contract year (occupational/speech combined in- and out-of-network)	70% AB; 100 visit maximum per contract year (occupational/speech combined in- and out-of-network)
$20 Specialist copay	80% AB	$20 Specialist copay	70% AB
$20 Specialist copay	80% AB	$20 Specialist copay	70% AB

Medical Benefits Options

Effective for plan year July 1, 2017 – June 30, 2018

The Benefits	BlueChoice HMO OpenAccess BlueChoice Providers	Level 1 BlueChoice Providers
PREVENTIVE CARE		
Well Child Care/Immunization	100% AB (no deductible)	100% AB
Routine Physical Exam	100% AB (no deductible)	100% AB
Breast Cancer Screening/ Routine Mammography	100% AB (no deductible)	100% AB
Prostate Cancer Screening	100% AB (no deductible)	100% AB
Routine Gynecological Exam (one per contract year)	100% AB (no deductible)	100% AB
Eye Exams	$10 copay per annual visit no-referral (Davis Vision provider)	
Eye Glasses/Lenses/Contact Lenses	Discounts available; See pages 26–27	Discou
SPECIAL SERVICES		
Durable Medical Equipment	100% AB	100% AB
Home Health Care Visits*	100% AB	100% AB
Hospice*	100% AB	100% AB
Maternity Care (Pre/Post/Delivery)	100% AB	100% AB
Nursery Care (Must be enrolled within 30 days)	100% AB	100% AB
Infertility Services	Pre-approval required Artificial Insemination—50% copayment of charges; In Vitro Fertilization—50% copayment of charges (limited to 3 attempts per live birth not to exceed a maximum lifetime limit of $100,000)	Pre-approval required Artificial Insemination—100% copayment of charges; In Vitro Fertilization—100% copayment of charges (limited to 3 attempts per live birth not to exceed a maximum lifetime limit of $100,000)
Lapband Benefits	100% AB	100% AB
Surgical Treatment for Morbid Obesity (Gastric Bypass)	Not Covered	Not Covered
Ambulance When Medically Necessary (surface, air, private, and public)	100% AB	100% AB
Hearing Exam	$15 copay	$15 copay
Hearing Aids (one per hearing impaired ear every 36 months)	100% AB	100% AB
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES	(administered by Magellan Behavioral Health)	(administered by Magellan Behavioral Health)
Inpatient Care*	100% AB	100% AB
Outpatient Facility	100% AB	100% AB
Office Visits	$10 copay	$10 copay
PRESCRIPTION DRUGS		

Triple Option		CareFirst BlueCross BlueShield Preferred Provider Organization CORE	
Level 2 BlueCross BlueShield PPO Providers	**Level 3 Participating and Non-participating Providers**	**In-Network BlueCross BlueShield PPO Providers**	**Out-of-Network Participating and Non-participating Providers**
100% AB	80% AB	100% AB (no deductible)	70% AB
100% AB	80% AB	100% AB (no deductible)	70% AB
100% AB	100% AB (no deductible)	100% AB (no deductible)	100% AB (no deductible)
100% AB	100% AB (no deductible)	100% AB (no deductible)	100% AB (no deductible)
100% AB	80% AB	100% AB (no deductible)	70% AB
$10 copay per annual visit no-referral (Davis Vision provider)		No Benefit	No Benefit
nts available; See pages 26–27		No Benefit	No Benefit
100% AB	80% AB	90% AB	70% AB
100% AB	80% AB	90% AB	70% AB
100% AB	100% AB (no deductible)	90% AB	70% AB
100% AB	80% AB	100% AB (no deductible)	70% AB
100% AB	80% AB	90% AB	70% AB
Artificial Insemination—100% AB, pre-approval required; In Vitro Fertilization—100% AB, pre-approval required; (limited to 3 attempts per live birth not to exceed a maximum lifetime limit of $100,000)	Artificial Insemination—80% AB, pre-approval required; In Vitro Fertilization—80% AB, pre-approval required; (limited to 3 attempts per live birth not to exceed a maximum lifetime limit of $100,000)	Artificial Insemination – 90% AB, pre-approval required; In Vitro Fertilization – 90% AB, pre-approval required; (limited to 3 attempts per live birth not to exceed a maximum lifetime limit of $100,000)	Artificial Insemination – 70% AB, pre-approval required; In Vitro Fertilization – 70% AB, pre-approval required; (limited to 3 attempts per live birth not to exceed a maximum lifetime limit of $100,000)
100% AB	80% AB	90% AB	70% AB
Not Covered	Not Covered	Not Covered	Not Covered
100% AB	100% AB (no deductible)	90% AB	90% AB
$20 copay	80% AB	$20 copay (no deductible)	70% AB
100% AB	80% AB	90% AB	70% AB
(administered by Magellan Behavioral Health)		(administered by Magellan Behavioral Health)	
100% AB	80% AB	90% AB	70% AB
100% AB	80% AB	90% AB	70% AB
$15 copay	80% AB	$15 copay (no deductible)	70% AB

AB = Allowed Benefit
This chart contains highlights only and is subject to change. The specific terms of coverage, exclusions and limitations are contained in the Summary Plan Description, the Group Benefit Guide or the Group Service Agreement. AB—Allowed Benefit. AWP—Average Wholesale Price.
** Precertification required or penalties may apply.*
*** Mandatory generic substitution—see the CareFirst Drug Program section on page 21.*

Medical Benefits Options

Effective for plan year July 1, 2017 – June 30, 2018

The Benefits	BlueChoice HMO OpenAccess BlueChoice Providers	Level 1 BlueChoice Providers
Prescription Drug Out-of-Pocket Max.	$6,600 Individual / $13,200 Family	$5,400 Individual / $10,800 Family
Retail Prescription Drug**	$5 copay – Generic drug (Tier 1) $15 copay – Preferred Brand (Tier 2) $35 copay – Non-preferred Brand (Tier 3) Maintenance drugs: 90 day supply, 3 times retail copay: $15 copay – Generic drug (Tier 1) $45 copay – Preferred Brand (Tier 2) $105 copay – Non-preferred Brand (Tier 3)	$10 copay Generic drug (Tier 1) $25 copay Preferred Brand (Tier 2) $40 copay Non-preferred Brand (Tier 3) (Maintenance medication up to 90 day supply 1X copay)
Mail Order Drug**	CVS Caremark Mail Order – 2X retail copay – up to 90 day supply $10 copay – Generic drug (Tier 1) $30 copay – Preferred Brand (Tier 2) $70 copay – Non-preferred Brand (Tier 3)	CVS Caremark Mail Order Prescription Program for maintenance medication $20 copay — Up to 90 day supply
Oral Contraceptives**	100% AB	100% AB
Diabetic supplies	100% AB	100% AB

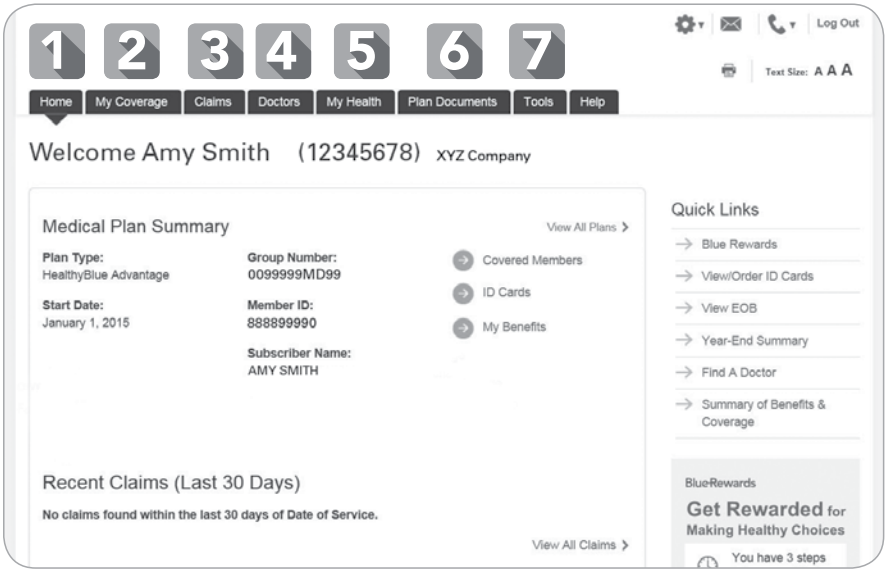
Triple Option		CareFirst BlueCross BlueShield Preferred Provider Organization CORE	
Level 2 BlueCross BlueShield PPO Providers	**Level 3 Participating and Non-participating Providers**	**In-Network BlueCross BlueShield PPO Providers**	**Out-of-Network Participating and Non-participating Providers**
$5,400 Individual / $10,800 Family		$4,200 Individual / $8,400 Family	
$10 copay Generic drug (Tier 1) $25 copay Preferred Brand (Tier 2) $40 copay Non-preferred Brand (Tier 3) (Maintenance medication up to 90 day supply 1X copay)		$10 copay Generic drug (Tier 1) $25 copay Preferred Brand (Tier 2) $40 copay Non-preferred Brand (Tier 3) Maintenance medication up to 90 day supply 2X copay: $20 copay – Generic drug (Tier 1) $50 copay – Preferred Brand (Tier 2) $80 copay – Non-preferred Brand (Tier 3)	
CVS Caremark Mail Order Prescription Program for maintenance medication $20 copay — Up to 90 day supply		CVS Caremark Mail Order Prescription Program for maintenance medication 1X copay – Up to 90 day supply $10 copay – Generic drug (Tier 1) $25 copay – Preferred Brand (Tier 2) $40 copay – Non-preferred Brand (Tier 3)	
100% AB		100% AB	
100% AB		100% AB	

AB = Allowed Benefit
This chart contains highlights only and is subject to change. The specific terms of coverage, exclusions and limitations are contained in the Summary Plan Description, the Group Benefit Guide or the Group Service Agreement. AB—Allowed Benefit. AWP—Average Wholesale Price.
** Precertification required or penalties may apply.*
*** Mandatory generic substitution—see the CareFirst Drug Program section on page* 21.

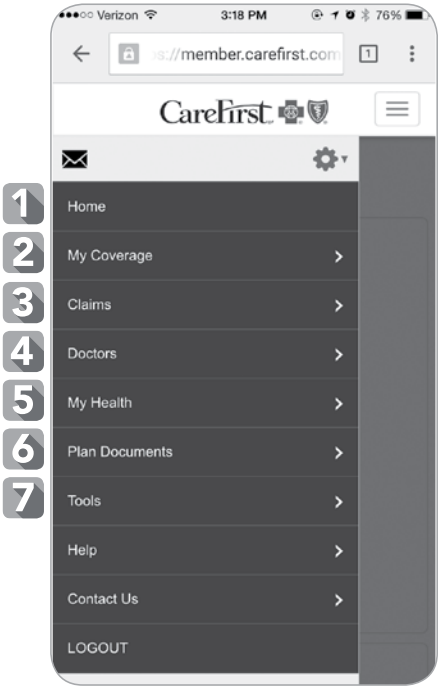
My Account

Online access to your health care information

View your personalized health insurance information online with *My Account*. Simply log on to **www.carefirst.com** from your computer, tablet or smartphone for real-time information about your plan.



As viewed on a computer.



As viewed on a smartphone.

My Account at a glance

1. Home

- Quickly view your coverage, deductible, copays, claims and out-of-pocket costs
- Use *Settings* ⚙ to manage your password and communications preferences
- Access the Message Center ✉

2. My Coverage

- Access your plan information, including who is covered
- Update your other health insurance info
- View/order ID cards
- Order and refill prescriptions[1,2]
- View prescription drug claims[1,2]
- Find a pharmacy[1]
- Oversee your BlueFund account

Signing up is easy

Information included on your member ID card will be needed to set up your account.

- Visit **www.carefirst.com**
- Select *Register Now*
- Create your User ID and Password

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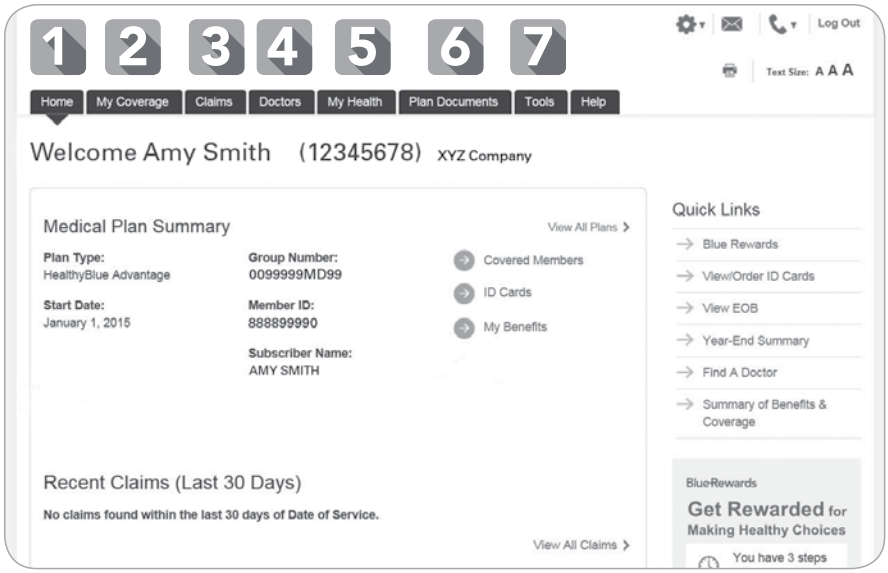
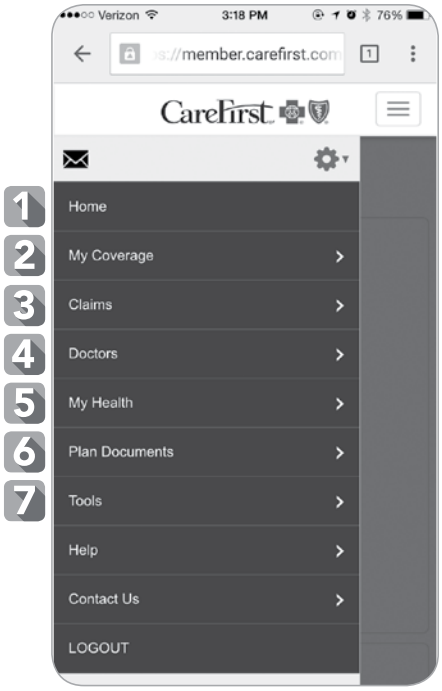
My Account

Online access to your health care information



As viewed on a computer.



As viewed on a smartphone.

3. Claims

- Check your paid claims, deductible and out-of-pocket totals
- Research your Explanation of Benefits (EOBs) history
- Review your year-end claims summary

4. Doctors

- Select or change your primary care provider (PCP)
- Search for a specialist

5. My Health

- Learn about your wellness program options[2]
- Locate an online wellness coach[2]
- Track your Blue Rewards progress

6. Plan Documents

- Look up your forms and other plan documentation[2]
- Review your member handbook[2]

7. Tools

- Treatment Cost Estimator
- Drug pricing tool[1,2]
- Hospital comparison tool[2]

[1] These features are available only if your drug benefits are provided by CareFirst.

[2] These features are available only when using a computer at this time.

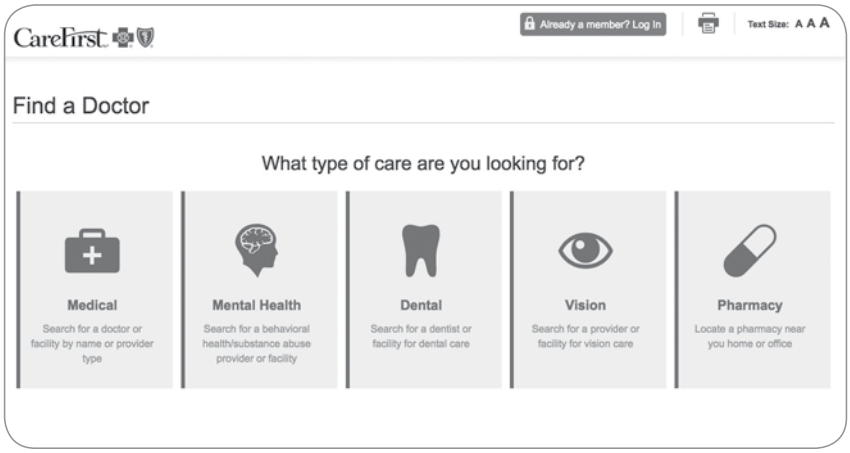
Find a Doctor, Hospital or Urgent Care

www.carefirst.com/doctor

It's easy to find the most up-to-date information on health care providers and facilities who participate with CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (collectively CareFirst).

Whether you need a doctor, nurse practitioner or health care facility, **www.carefirst.com/doctor** can help you find what you're looking for based on your specific needs.

To view personalized information on which doctors are in your network based on your plan, log in to *My Account* on your computer, tablet or smartphone.



The most up-to-date information

Go to **www.carefirst.com/doctor.** From here you can:

- Find a doctor or provider in your plan.
- Search for a doctor by name.
- Search for a doctor by specialty.

CUT5766

Health & Wellness

Take charge

Whether you're looking for health and wellness tips, discounts on health-related services, or support to manage a health condition, we have the resources to help you get on the path to better well-being.

With our Health & Wellness program you can

- Become aware of unhealthy habits.
- Improve your health with programs that target your specific health or lifestyle issues.
- Access online tools to help you get and stay healthy.
- Manage chronic conditions and deal with unexpected health issues.

15 minutes can help improve your well-being

When it comes to your health, it's important to know where you stand. You can get an accurate picture of your health status with our confidential, online assessment. 24 hours after you complete the survey, you'll receive your personalized well-being score, along with a link to create your own personal well-being plan.

Take your well-being assessment today—these may be the most important questions you'll ever answer! Get started by logging in to *My Account* at **www.carefirst.com/myaccount**. Next, click on *Health Assessment and Online Coaching* under *Quick Links*.

Don't forget to take your well-being assessment to get an immediate picture of your health.

Getting healthy

Based on your results after completing the well-being assessment, a health coach may contact you to discuss your results. The health coach will refer you to the appropriate resources, tools and programs that can guide you toward better health.

Health Coaching

Participate in confidential lifestyle and health coaching programs to help improve your health. Your coach will monitor your progress and provide support with programs like tobacco cessation, weight loss and disease management for conditions like diabetes or chronic obstructive pulmonary disease.

CST2442-1P

Online health and wellness tools

Looking for tools and resources that empower you to take action, stay connected and get inspired? Log in to *My Account* at **www.carefirst.com/myaccount** to take advantage of

Well-Being Connect™, our wellness portal:

- **Well-Being Plan**–A personalized, easy-to-navigate interactive plan including recommendations and focus areas to help keep you on track.
- **Resource Center**–Find a library of articles, videos and other resources specific to your interests and focus areas.
- **Trackers**–Record daily behaviors and check your progress for weight, exercise, medication, tobacco use, healthy eating and more. Share within your community group or on Facebook.
- **Social Networking**–Join chat sessions, update group activities and share information, personal stories, tips and successes even on Facebook.
- **Recipe Center**–Search thousands of healthy meal ideas, including cuisine-specific recipes and menus that map out calories and nutrition.
- **Message Center**–Receive health tips, activity tracker reminders and encouraging emails.

Vitality magazine

Vitality provides information about your health plan and includes articles on health and wellness topics, including nutrition, physical fitness and preventive health.

Wellness discount program

Blue365 delivers great discounts from top national and local retailers on fitness gear, gym memberships, family activities, healthy eating options and more.

Coordinating your care

Whether you're trying to get healthy or stay healthy, you need the best care. CareFirst has programs to help you take an active role in your health, address any health care issues and enjoy a healthier future.

Patient-Centered Medical Home (PCMH)

PCMH was designed to provide your primary care provider (PCP) with a more complete view of your health needs, as well as the care you receive from other providers. When you participate in this program, you are the focus of an entire health care team whose goal is to keep you in better health and manage any current or potential health risks.

If you have a chronic condition, or are at risk for one, your PCP may:

- Create a care plan based on your health needs with specific follow-up activities to help you manage your health.
- Provide access to a care coordinator, who is a registered nurse, so you have the support you need, answers to your questions and information about your care.

Find a participating PCMH provider in our provider directory at **www.carefirst.com/findadoc**.

Case Management

If you have a serious illness or injury, our Case Management program can help you navigate the health care system and provide support along the way. Our case managers are registered nurses who will:

- Work closely with you and your doctors to develop a personalized treatment plan.
- Coordinate necessary services.
- Answer any of your questions.

Our Case Management program is voluntary and confidential. For more information, or to enroll, call 888-264-8648.

Mental Health Benefits

All CareFirst Plans

Participants enrolled in the CareFirst medical plans must use Magellan's Behavioral Health Plan for inpatient mental health services. To receive benefits, all participants must certify their care at 1-800-245-7013 before they may access mental health services. Magellan can help you and your eligible family members with a variety of issues including, but not limited to, depression, stress, and alcohol and drug abuse.

A Magellan representative will help you access care within the Magellan network, certify your care, and/or provide authorization to non-participating providers if necessary. Visit **www.magellanhealth.com** for more information on accessing care and providers, as well as wellness topics and self-assessment tools and resources.

Mental Health Support

Well-being for mind and body

Living your best life involves good physical and mental health. Emotional well-being is important at every stage in life, from adolescence through adulthood.

It's common to face some form of mental health challenge during your life, caused by a variety of reasons, many of which are beyond your control. Some of the contributing factors include:

- Biology, such as genes, brain chemistry, physical illness or injury
- Life experiences, such as trauma, tragedy or abuse
- Family history

When mental health difficulties arise for you or a loved one, remember you are not alone. Help is available and feeling better is possible.

Our partner, Magellan* Healthcare, offers specialized services and programs to help you get well, if and when you need assistance related to:

- Depression
- Drug or alcohol dependence
- Stress
- Work-life balance
- Eating disorders

One in five American adults has experienced a mental health issue.[1]

If you or someone close to you needs support or help making an appointment, call Magellan Healthcare at 800-245-7013.

** Magellan Healthcare is an independent company that provides managed behavioral health services to CareFirst BlueCross BlueShield and CareFirst BlueChoice members. Magellan Healthcare does not provide Blue Cross Blue Shield products or services.*

[1] United States Department of Health and Human Services. Mental Health Myths and Facts. Accessed August 21, 2015 at: http://www.mentalhealth.gov/basics/myths-facts/index.html.

Connecting to support

Magellan Customer Service associates can answer your questions and connect you to the services and programs that best fit your needs, including:

Appointment assistance

The associate can help you find a provider or transfer you to a *My Care Link Up* specialist to help you schedule an appointment.

Telehealth services are also available. Telehealth allows you and your behavioral health provider to communicate via an online appointment. Receive the same services as an in-person visit (including prescribing medication, if appropriate) via a secure, private online connection. **Note:** to access this service, you will need a computer with a webcam and high-speed Internet.

Assistance with outpatient and non-emergency services is available Monday through Friday, 8 a.m. to 6 p.m. ET.

Emergency and inpatient services

Care managers are available 24-hours a day, seven days a week to assist you with a clinical emergency or an inpatient prior authorization.

Case management

Additional support is available through the mental health and substance abuse case management program. A personal care coordinator will discuss your situation with you, determine an appropriate treatment plan and help you work toward individualized goals to improve your health. (**Note:** Parents or guardians can provide the necessary information for minors).

If you are more comfortable discussing your concerns with your primary care provider (PCP) first, he or she may contact Magellan on your behalf. Just remember, help is available by calling Magellan Healthcare at 800-245-7013.

DELTA DENTAL PPO℠:

Your smile is covered

Go PPO

Visit a PPO[1] dentist to maximize your savings.[2] These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill.[3] Find a PPO dentist at **deltadentalins.com**.[4]

Access online services

Get information about your plan anytime, anywhere by signing up for an Online Services account at deltadentalins.com. This free service lets you check benefits and eligibility information, find a network dentist and more.

Check in with ease

You don't need a Delta Dental ID card when you visit the dentist. Just provide your name, birth date and enrollee ID or social security number. If your family members are covered under your plan, they will need your name, birth date and enrollee or social security number. Prefer to take a paper or electronic ID card with you? Simply sign in to Online Services, where you can view or print your card with the click of a button. If you're covered under two plans, ask your dental office to include information about both plans with your claim, and we'll handle the rest.

Understand transition of care

Did you start on a dental treatment plan before your PPO coverage kicked in? Multi-stage procedures are only covered under your current plan if treatment began after your plan's effective date of coverage.[5] You can find this date by logging in to Online Services.

Newly covered? Visit **deltadentalins.com/welcome**.

Save with a PPO dentist

PPO

Non-PPO

Maryland law requires we make the following statement:

Our compensation to physicians who offer health care services to our insured members of enrollees may be based on a variety of payment mechanisms such as fee-for-service payments, salary or capitation. Bounses may be used with these various types of payment methods. If you desire method(s) apply to your physician, please call additional information about our methods of paying physicians, or if you want to know which 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.

Where your dental benefits premium goes

Amount of every $100 in premiums used to pay for claims and administration*

* for the year ending December 31, 2015

FFS #95422A1 (1/16)

Legal notices: Access federal and state legal notices related to your plan at deltadentalins.com/about/legal/index-enrollee.html

[1] In Texas, Delta Dental Insurance Company offers a Dental Provider Organization (DPO) plan.

[2] You can still visit any licensed dentist, but your out-of-pocket costs may be higher if you choose a non-PPO dentist. Network dentists are paid contracted fees.

[3] You are responsible for any applicable deductibles, coinsurance, amounts over plan maximums and charges for non-covered services.

[4] Verify that your dentist is a PPO dentist before each appointment.

[5] Applies only to procedures covered under your plan. If you began treatment prior to your effective date of coverage, you or your prior carrier are responsible for any costs. Group- and state-specific exceptions may apply. Enrollees currently undergoing active orthodontic treatment may be eligible to continue treatment under Delta Dental PPO. Review your Evidence of Coverage, Summary Plan Description or Group Dental Service Contract for specific details about your plan.

We keep you smiling®

DELTA DENTAL®

deltadentalins.com/enrollees

HL_PPO_2col #97131B (rev. 4/16)

Plan Benefit Highlights for: Harford County Public Schools
Group No: 00528 - PPO - Comprehensive

Eligibility	Primary enrollee, spouse and eligible dependent children to the end of the month dependent turns age 26			
Deductibles	Delta Dental PPO dentists: $25 per person / $50 per family each plan year Non-Delta Dental PPO dentists: $50 per person / $150 per family each plan year			
Deductibles waived for Diagnostic & Preventive (D & P) and Orthodontics?	Yes			
Maximums	$1,500 per person each plan year			
D & P counts toward maximum?	No			
Waiting Period(s)	Basic Benefits None	Major Benefits None	Prosthodontics None	Orthodontics None

Benefits and Covered Services*	Delta Dental PPO dentists**	Non-Delta Dental PPO dentists**
Diagnostic & Preventive Services Exams, cleanings, x-rays and sealants	100 %	65 %
Surgical Removal of Impacted Teeth	100 %	65 %
Basic Services Fillings, denture repair/relining, stainless steel crowns, bridges, bridge recementation/repair and posterior composite restorations	80 %	50 %
Endodontics (root canals) Covered Under Basic Services	80 %	50 %
Periodontics (gum treatment) Covered Under Basic Services	80 %	50 %
Oral Surgery Covered Under Basic Services	80 %	50 %
Major Services Crowns, inlays, onlays and cast restorations	50 %	30 %
Prosthodontics Dentures	50 %	30 %
Implants Covered only as an alternative to a fixed bridge	80 %	50 %
Orthodontic Benefits Dependent children to age 19	50 %	50 %
Orthodontic Maximums	$800 Lifetime	$800 Lifetime

* Limitations or waiting periodsmay apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, PPO contracted fees for Premier dentists and PPO contracted fees for non-Delta Dental dentists.

Delta Dental of Pennsylvania One Delta Drive Mechanicsburg, PA 17055	**Customer Service** 800-932-0783	**Claims Address** P.O. Box 2105 Mechanicsburg, PA 17055-6999

deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

Plan Benefit Highlights for: Harford County Public Schools
Group No: 00528 - PPO plus Premier - Standard

Eligibility	Primary enrollee, spouse and eligible dependent children to the end of the month dependent turns age 26		
Deductibles	$25 per person / $50 per family each plan year		
Deductibles waived for Diagnostic & Preventive (D & P)?	Yes		
Maximums	$1,500 per person each plan year		
D & P counts toward maximum?	No		
Waiting Period(s)	Basic Benefits None	Major Benefits None	Prosthodontics None

Benefits and Covered Services*	Delta Dental PPO dentists**	Non-Delta Dental PPO dentists**
Diagnostic & Preventive Services Exams, cleanings, x-rays and sealants	100 %	100 %
Basic Services Fillings, stainless steel crowns and posterior composite restorations	100 %	100 %
Endodontics (root canals)	100 %	100 %
Oral Surgery	100 %	100 %
Periodontics (gum treatment)	0 %	0 %
Major Services Crowns, inlays, onlays and cast restorations	0 %	0 %
Prosthodontics Bridges and dentures	0 %	0 %

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and Premier contracted fees for non-Delta Dental dentists.

Delta Dental of Pennsylvania One Delta Drive Mechanicsburg, PA 17055	**Customer Service** 800-932-0783	**Claims Address** P.O. Box 2105 Mechanicsburg, PA 17055-6999

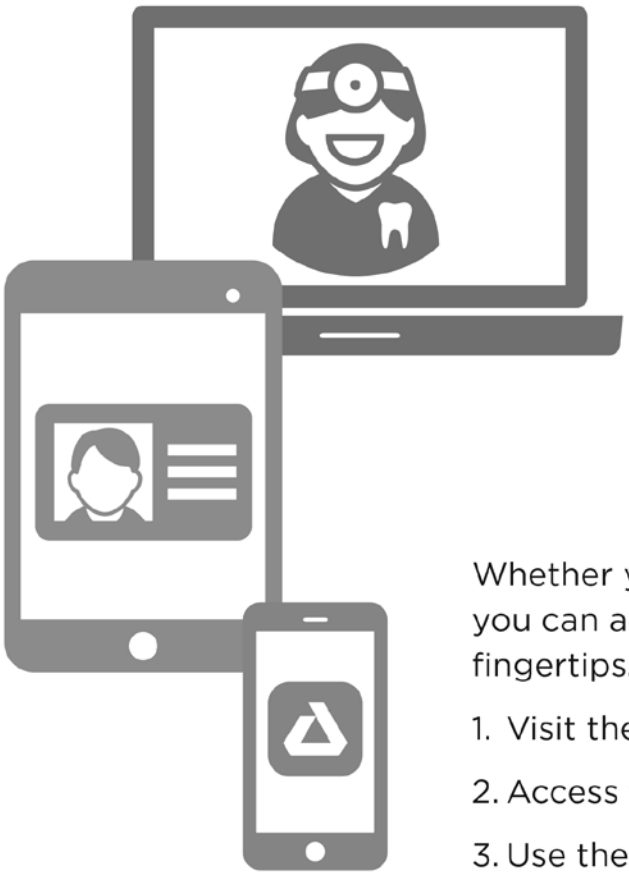
deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

HLT_PPO_2COL_DDP (Rev. 05/02/2016)

DELTA DENTAL

Stay Connected



Want information about your dental plan? Take advantage of our web and mobile resources to:

- **check your eligibility**
- **look up coverage details**
- **check claims**
- **find a network dentist**
- **improve your oral wellness**
- **and more**

Whether you're on a computer, tablet or smartphone, you can access all the information you need at your fingertips.

1. Visit the **website**
2. Access the **mobile-optimized site**
3. Use the **free app**

¿Habla español?

es.deltadentalins.com

We keep you smiling®
deltadentalins.com/enrollees

Check the site

1. Enter **deltadentalins.com/enrollees** on your computer's browser.
2. Browse the features listed below. If you haven't already done so, register for Online Services. Already got an account? Log in!

Features:

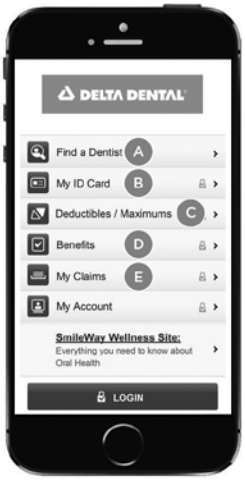
A. **Online Services** (register or log in): See benefits, eligibility, deductibles and maximums; check claims; view or print an ID card

B. **Find a dentist**

C. **Dental Plan Support Guide**

D. **SmileWay® Wellness site**

Go mobile[1]



1. Enter **deltadentalins.com** on your smartphone's browser.
2. Click the **Visit Mobile Site** button.

Features:

A. **Find a dentist**

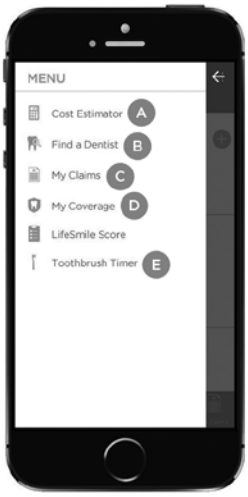
B. **View your electronic ID card**

C. **Check deductibles and maximums**

D. **See your benefits and eligibility**

E. **Check claims**

Get the app[2]



1. Open the **App Store** or **Google Play**.
2. Search for "**Delta Dental**."
3. Download the free app titled **Delta Dental** by Delta Dental Plans Association.

Features:

A. **Get a cost estimate**

B. **Find a dentist**

C. **Check claims**

D. **See your benefits, eligibility, deductibles and maximums**

E. **Use a musical timer to brush for 2 minutes**

[1] Available to Delta Dental PPO℠ and Delta Dental Premier® enrollees only.
[2] Some features available to PPO and Premier enrollees only.

DELTACARE® USA: **800-422-4234**

DELTA DENTAL PPO AND DELTA DENTAL PREMIER

Delta Dental of California: **800-765-6003**

Delta Dental of Delaware, Inc., Delta Dental of the District of Columbia, Delta Dental of New York, Inc., Delta Dental of Pennsylvania (and Maryland), Delta Dental of West Virginia, Inc.: **800-932-0783**

Delta Dental Insurance Company (Alabama, Florida, Georgia, Louisiana, Mississippi, Montana, Nevada, Texas, Utah): **800-521-2651**

Delta Dental Premier and Delta Dental PPO are underwritten by Delta Dental Insurance Company in AL, DC, FL, GA, LA, MS, MT, NV, TX and UT and by not-for-profit dental service companies in these states: CA – Delta Dental of California; PA, MD – Delta Dental of Pennsylvania; NY – Delta Dental of New York; DE – Delta Dental of Delaware; WV – Delta Dental of West Virginia. In Texas, Delta Dental PPO is underwritten as a Dental Provider Organization (DPO) plan.

These enterprise companies are members, or affiliates of members, of the Delta Dental Plans Association, a network of 39 Delta Dental companies that together provide dental coverage to 73 million people in the U.S. The website deltadentalins.com is the home of the Delta Dental companies listed above. For other Delta Dental companies, visit the Delta Dental Plans Association website at deltadental.com.

EF30 #96083 (rev. 6/16)

Elevate Your Smile

8 ways to make the most of your dental plan

1 Save with PPO.
Visit a dentist from the PPO[1] network to maximize your savings.[2] These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill.[3] Find a PPO dentist at **deltadentalins.com**.[4]

2 Seek preventive care.
Regular exams and cleanings are available at low or no cost. These services help catch problems before they require costly and extensive treatment.

3 Set up an online account.
Get information about your plan anytime, anywhere by signing up for an Online Services account. Available once your coverage kicks in, this free service lets you find a network dentist, view or print your ID card and more. The one-time registration process takes only a minute.

4 Go paperless.
Receive an email when a new dental benefits statement is available. Save time, reduce clutter and preserve environmental resources. To enroll, log in to Online Services and update your settings.

Newly covered?

Visit **deltadentalins.com/welcome**

[1] In Texas, Delta Dental Insurance Company offers a Dental Provider Organization (DPO) plan.

[2] You can still visit any licensed dentist, but your out-of-pocket costs may be higher if you choose a non-PPO dentist.

[3] You are responsible for any applicable deductibles, coinsurance, amounts over plan maximums and charges for non-covered services. PPO dentists won't bill you for any amount over their PPO fees.

[4] We recommend confirming that your dentist is a PPO dentist before each appointment.

We keep you smiling®
deltadentalins.com/enrollees

5 **Go mobile.**
Visit **deltadentalins.com** on your smartphone to access mobile-optimized Online Services on the go — including a helpful dentist locator tool. Or, download the Delta Dental app, available through the App Store or Google Play, to access your plan information and try out the handy toothbrush timer.

6 **Coordinate benefits.**
Are you covered under a second dental plan? Ask your dentist to include information about both plans with your claim, and we'll handle the rest.[5]

7 **Talk to your dentist.**
From pregnancy to diabetes, overall health can affect your dental health. Start each visit with a quick chat about any issues.

8 **Stay informed.**
Get tools and tips at our SmileWay® Wellness site (**mysmileway.com**). Don't forget to subscribe to *Grin!*, our free dental wellness e-magazine: **ddins.grinmag.com**.

[5] Group- and state-specific exceptions may apply. Please review your plan booklet for details about coordination of benefits, including rules for determining primary and secondary coverage.

Contact us

Online assistance:

For quick and easy online assistance, go to **deltadentalins.com** > **Contact Us**, select the Delta Dental company and choose the applicable customer service form.

Telephone assistance:

Delta Dental of California: **800-765-6003**

California School District Employees: **866-499-3001**

Delta Dental of Delaware; Delta Dental of the District of Columbia; Delta Dental of New York; Delta Dental of Pennsylvania (and Maryland); Delta Dental of West Virginia: **800-932-0783**

Delta Dental Insurance Company (Alabama, Florida, Georgia, Louisiana, Mississippi, Montana, Nevada, Texas, Utah): **800-521-2651**

Got a simple question? Use our automated phone system, available 24/7. You can check your coverage levels, remaining maximum and more. Just call one of the customer service numbers listed above and follow the prompts.

Delta Dental PPO℠ is underwritten by Delta Dental Insurance Company in AL, DC, FL, GA, LA, MS, MT, NV, TX and UT and by not-for-profit dental service companies in these states: CA – Delta Dental of California; PA, MD – Delta Dental of Pennsylvania; NY – Delta Dental of New York, Inc.; DE – Delta Dental of Delaware, Inc.; WV – Delta Dental of West Virginia, Inc.

Delta Dental of California, Delta Dental of New York, Inc., Delta Dental of Pennsylvania, Delta Dental Insurance Company and our affiliated companies form one of the nation's largest dental benefits delivery systems, covering 34.5 million enrollees. All of our companies are members, or affiliates of members, of the Delta Dental Plans Association, a network of 39 Delta Dental companies that together provide dental coverage to 73 million people in the U.S.

LEGAL NOTICES: Access federal and state legal notices related to your plan: deltadentalins.com/about/legal/index-enrollee.html.

EF17_PPO #96083A (rev. 6/16)

Flexible Spending Account (FSA) Highlights

What is a Flexible Spending Account?

A Flexible Spending Account (FSA) permits you to pay for certain health care and/or dependent care expenses with pre-tax dollars. Because you will not pay any federal, state or social security taxes on income placed into the plan, you can potentially save $30-$40 for every $100 you elect to defer.

Who is eligible?

All active benefit eligible employees working for Harford County Public Schools are eligible to participate in the Flexible Spending Accounts.

Two types of FSAs available to you

Health care spending account

You may set aside up to $2,550 annually in a Health Care Spending Account to pay for qualified medical, prescription drug copayments, certain over-the-counter (OTC) supplies, dental and vision care expenses. The health care expenses may be for you, your spouse, or your dependents (as long as you claim them as dependents on your tax return or through the tax year in which they turn 26.)

Dependent care spending account

The Dependent Care Account helps you pay the cost of day care for your dependents so you and your spouse can work. Eligible dependents for this account must be claimed as dependents on your federal tax return and either be:

- Under age 13, or
- Mentally or physically unable to care for him/herself regardless of age (this may be a spouse or older relative).

If you are single or are married and filing a joint tax return, you may contribute up to $5,000 each contract year. If you are married and filing a separate tax return, you may contribute up to $2,500 per year.

How FSAs work

- During open enrollment (or when you first become eligible) you decide how much you want to contribute from your pay to a FSA. You can establish a FSA for your health care expenses and/or for your dependent care expenses. Note that health care FSAs and dependent care FSAs are two separate accounts, and not interchangeable.
- When you enroll, you authorize your employer to deduct a certain portion of your earnings each pay period, before taxes. Your contributions are set aside in your FSA throughout the year via payroll deduction.
- When you have an eligible expense, you can use your FBA Benefits Card or pay the cost up front and be reimbursed from your account. Remember, you do not pay taxes on the money reimbursed to you from your Flexible Spending Account.

How flexible spending accounts will save you money

When you elect to participate in a FSA, you will have a specific amount of dollars deducted from your gross earnings (before tax) each pay period. By contributing pre-tax dollars, you will lower your taxable income and increase your spendable income! In fact, by participating you are actually using dollars you would have paid in taxes to help pay for your medical and/or dependent care costs. Below are some examples of how much YOU can save on your everyday expenses.

Sample Health Care Expenses	Your cost without a FSA	Your cost with a FSA	Your estimated Out-of-Pocket Savings*
PPO Doctor Copay	$15.00	$10.50	$4.50
HMO Doctor Copay	$10.00	$7.00	$3.00
PPO Generic Retail Rx Copay	$10.00	$7.00	$3.00
HMO Non-preferred Brand Rx Copay	$25.00	$17.50	$7.50
Over-the-Counter Pain Reliever	$10.00	$7.00	$3.00
Monthly Diabetic Supplies	$100.00	$70.00	$30.00
Monthly Orthodontic Payment	$125.00	$87.50	$37.50
Eyeglasses	$300.00	$210.00	$90.00
Laser Eye Surgery	$2,500.00	$1,750.00	$750.00
Sample Dependent Care Expenses			
Daycare for child under age 13	$5,000.00	$3,500.00	$1,500.00
Before/After School Care	$4,000.00	$2,800.00	$1,200.00
Summer Camp	$2,400.00	$1,680.00	$720.00
Disabled/Elder Adult Daycare	$5,000.00	$3,500.00	$1,500.00

**Assuming 15% Federal Tax Bracket*

- You can contribute up to $5,000 a year to the dependent care FSA (or $2,500 a year if you are married but file a separate tax return from your spouse). You can contribute up to $2,550 a year to the health care FSA.
- If you have money left in your account at the end of the plan year, it cannot be returned to you nor carried over to the next plan year. For strategies on using your account balance, see Planning Your Election.

Important Flexible Spending Accounts information

IRS regulations impose a "use it or lose it" rule that requires you to forfeit any money not used by the end of the Plan Year. HCPS can neither refund money to you nor carry it forward from one Plan Year to the next.

You must re-enroll in FSAs each Plan Year, even if you keep the amount of your contributions the same.

You may participate in one or both of the Flexible Spending Accounts, but the Health Care and Dependent Care spending accounts are separate. Money cannot be transferred from one account to the other.

You may choose either the pre-tax advantage of the dependent care spending account, or claim a tax credit on your federal income return, but you may not do both. Consult your tax advisor to determine whether the FSA or the tax credit gives you the greater tax advantage.

New hires (or enrollments due to a qualified life event) joining the plan after the beginning of the Plan Year

should determine how many payroll deductions for benefits remain before deciding upon the amount to set aside in FSAs. Payroll deductions are taken from 24 pays for 12-month employees and 20 pays for 10-month employees. July 1 or September 1 – June 30.

Planning your election

Here are just a few strategies you can use to be sure that you are making every penny count in your FSA!

Plan ahead when enrolling

Base your contribution on your anticipated expenses for the plan year which are not covered by other insurance or benefit plans.

Look back to last year

One way to estimate those expenses is to look back at the health care and dependent care expense you paid out of your own pocket during the past year. This can be the starting point for your annual contribution, adjusted of course for any past or future extraordinary expenses.

Look outside your health plan

Many health care plans offer some, but not full, coverage for certain expenses such as laser eye surgery, orthodontia, over-the-counter (OTC) medicines*, etc.

Evaluate your home pharmacy

Start by throwing away all expired over-the-counter (OTC) medications. Then, the next time your visit your health care provider, ask for a prescription for the OTC medications you use on a regular basis. These may include allergy medications, antacids, cold medications, pain relievers. Bandaids, ace bandages, contact lens solutions, and other OTC items (non-medication) can be reimbursed without a prescription.

Be conservative

Any unused funds cannot carry forward to the next plan year and are forfeited.

** Important: Effective for all purchases made after January 1, 2011, all over-the-counter (OTC) drugs and medicines will require a prescription for reimbursement.*

Enrolling in the plan

Make your election during open enrollment (or when you first become eligible).

- Determine your election amount(s) by using the FSA Worksheet.
- Elect up to the plan maximums.
- Remember you do not have to participate in the health plan to be eligible for the FSA.
- Annual election(s) will be deducted equally pre-tax over the course of your plan year.

FSA debit card

Participating in a FSA with FBA Benefits Card has many advantages! Look at what the card can do for you.

- Eliminates the need of filling out claims forms and waiting for a reimbursement check.
- Most transactions will not require supporting documentation.
- FBA Benefits will notify you by email when substantiation is required and will also provide you with a monthly statement of unsubstantiated claims.
- If you choose not to use the card or if your provider does not accept MasterCard®, you can pay out-of-pocket and submit for reimbursement.

Look how the advantages really add up. It's time for YOU to begin saving money and simplifying your expenses.

FSA grace period

You have an extended 2 1/2 months time frame (until 9/15/18) to incur expenses and have them applied towards your 7/1/17 – 6/30/18 account. Expenses incurred during the Grace Period (July 1 through September 15) and approved for reimbursement will be paid first from available amounts that were remaining at the end of the preceding Plan Year and then from any amounts that are available to reimburse expenses incurred during the current Plan Year. It is important to keep the extension in mind when you determine your new FSA contributions. This added feature will help to virtually eliminate the "use it or lose it" clause associated with Flexible Spending Accounts.

Amounts remaining in your account at the end of the Plan Year that are not applied to pay expenses submitted on or before the October 28th deadline will be forfeited. Claim forms are available at **www.flex-admin.com**

The FBA Benefits Card

The FBA Benefits Card offers the convenience of paying for your eligible expenses directly at the point of sale. It works like any other credit card. Since the card lets you pay for eligible health care expenses directly from your health care FSA, it means no more paying cash for services up front. It also eliminates the waiting period for reimbursement checks and the hassle of filling out claims forms. The FBA Benefits Card can be used at authorized health care providers where MasterCard® is accepted. If you plan to use your FBA Benefits Card to pay for daycare expenses, please check with your daycare provider to see if they are equipped to accept MasterCard®.

Since the FSA plan is a pre-tax benefit, the Internal Revenue Service (IRS) requires that all purchases be substantiated. Therefore, you may be required to submit copies of your receipts to the plan administrator to comply with the guidelines provided by the IRS.

For the health care FSA, the limit on your card is your annual elected contribution amount. For the dependent care FSA, the limit on your card is your YTD payroll deduction less your YTD reimbursed. If a service provider does not accept the card, you can always submit a claim for reimbursement. FBA Benefits will either mail a reimbursement check to your home address or issue a direct deposit into the bank account that you have provided. More information about the FBA Benefits Card is available at **www.flex-admin.com**.

Required record keeping

Save all your receipts in a convenient location since all purchases made with your FBA Benefits Card must be verified. The plan administrator is required to substantiate all transactions that do not match an exact copayment associated with your employer's health plan. This system will also be helpful when preparing your taxes!

Flexible Spending Account (FSA) Highlights

Type of FSA	Maximum Annual Contribution	Examples of Eligible Expenses*	
Health Care	$2,550 *(NOTE: Deduction amounts must be in whole dollar increments)*	■ orthodontia** ■ copayments ■ deductibles ■ acupuncture ■ chiropractic care ■ hearing aids and batteries	■ eyeglasses ■ smoking cessation expenses ■ LASIK eye surgery ■ Prescription drug copayments ■ certain OTC supplies
Dependent Care	$5,000 *(NOTE: Deduction amounts must be in whole dollar increments)*	■ licensed day care facility, child or adult ■ pre-school or nursery school (not kindergarten) ■ before and after-school programs	■ care in someone else's home ■ housekeeper who performs dependent care duties ■ day care provided by a non-dependent relative over the age of 19

** The Internal Revenue Service (IRS) determines which expenses are eligible and which are ineligible. For a detailed list of examples, please refer to www.hfsbenefits.com.*

*** For orthodontia reimbursement, send a copy of your orthodontia agreement (orthodontic contract) along with your completed claim form when treatment begins. The orthodontic agreement must state:*

1. *The beginning date of service*
2. *The approximate length of service*
3. *Total cost of service*
4. *Record fee*
5. *Initial fee (down payment)*
6. *Subsequent monthly fees*
7. *Total insurance coverage (if applicable)*

*** The fee for orthodontic records is eligible for reimbursement on the date the x-rays, photos, and casts are taken. Proper documentation is a statement of services rendered from orthodontist. The initial fee (down payment) is eligible for reimbursement on the date of the first treatment. Again proper documentation is a statement of services rendered from orthodontist.*

Subsequent monthly fees are eligible for reimbursement as monthly orthodontic adjustments occur. Proper documentation is a statement of services rendered, a receipt from orthodontist showing date of payment ("orthodontic" clearly noted on receipt), or a copy of payment stub from orthodontic payment booklet. Special payment schedules, which do not coincide with dates of service (such as full payment at banding) will be paid in equal installments over the period of service. Orthodontics is an ongoing treatment and the IRS prohibits pre-payment of these services.

Your FSA administrator

Please contact Flexible Benefit Administrators, Inc. with any questions regarding your FSA plan. The flex division is available Monday-Friday 8:30 a.m. - 5:00 p.m. ET.

Flexible Benefit Administrators, Inc.
509 Viking Drive, Suite F
Virginia Beach, VA 23450

Phone: **800-437-3539**
Website Address: **www.flex-admin.com**

All forms are available on HCPS SharePoint at:
http://covs-spa1/sites/HumanResources/benefits
or the FBA website.

Online account access

You also have 24/7 access to your account balance and claim information. If you are a first-time user, you will need to go to the New User link to set up your account. You must have an email address on your account to proceed with the online account creation. Please follow the steps below for account creation:

- Go to **www.mywealthcareonline.com/fba**
- Click on *New User.*
- Employee ID is your SSN (without dashes)
- Enter your **Email**.
- Employer ID is FBAHCPS or benefits card number
- Click on *Submit.*

If you need assistance in setting up your account, please contact FBA Benefits and a representative will assist you.

FSA frequently asked questions

Q. When is the plan year for FSA?.

A. The plan FSA is July 1 to June 30.

Q. Can I participate in the FSA Plans if I am not enrolled in my employer's health plan.

A. Yes. As long as you meet the benefit eligibility requirements you can participate in either FSA.

Q. Can I use the Medical Care FSA to pay for my spouse's deductibles or copayments if they aren't covered by my group medical plan?

A. Yes. However, health care premiums deducted from your spouse's paycheck and premiums for individual health policies are not eligible.

Q. Do I ever pay taxes on the money I put into either account?

A. No. With the exception of New Jersey and Pennsylvania (Dependent Care FSA) state tax, you do not pay tax on money taken out of these accounts.

Q. Can I change the amount of money I set aside in my account(s) during the plan year?

A. As a general rule, no. The IRS, however, does allow you to make changes when a qualifying event occurs, such as marriage, divorce, or gaining or losing a spouse or dependent.

Q. What happens if I terminate employment during the plan year?

A. You will have a period after your termination date (check your SPD) to submit expenses incurred while you were an active employee. Also, you may have the option to continue contributing to your Health Care FSA using after-tax dollars through COBRA.

Q. To what age may I use the Dependent Care FSA for expenses incurred for my child?

A. You may submit expenses incurred for your dependent child on or before his/her 13th birthday.

Q. Are expenses for before/after school programs considered eligible expenses?

A. Yes, but you must separate the cost of such care from the cost of the school.

Q. When I complete my personal tax return, do I have to report anything regarding my FSA?

A. Yes. When you participate in a Dependent Care FSA, you will need to complete and file IRS Form 2441. Instead of completing Part I and Part II, you should complete Part I and III of the form 2441. No action is required for the Medical Care FSA.

Q. What happens if my expenses are lower than I anticipated?

A. The IRS stipulates that you must forfeit any funds remaining in your account at the end of the plan year. However, you are given a grace period of an additional 120 days to submit receipts for services incurred during the plan year or grace period. Please review section titled "Planning Your Election".

Q. How can I obtain my account balance information?

A. You can contact our FBA Benefits Customer Care during normal business hours or you can view your account information online 24 hours a day, 7 days a week at **www.mywealthcareonline.com/fba**. You may view detailed information such as your account balance, claim status and check information. You can also access this information via the free FBA Benefits mobile app or elect to receive this information via text notifications.

Q. How do I receive a reimbursement for my claims?

A. All claims received in the office of Flexible Benefit Administrators, Inc. will be processed within one week. Please allow 2-3 business days for processing of your submitted claims once they have been received. Reimbursement checks will be sent directly to your home address. Reimbursements made through Direct Deposit are available in your bank account within 1-2 business days after processing .. Always verify with your bank that funds are available before making withdrawals.

Q. How do I submit a claim?

A. In order to file a claim for an expense that you did not purchase using your FBA Benefits Card or to respond to a documentation request for a card purchase, you will need to complete and sigri a coordinating form. Please visit our website **www.flex-admin.com** to access the form(s) you nee. Each form contains instruction on how to submit your claim for reimbursement.

Basic Life Insurance and Accidental Death and Dismemberment (AD&D) Insurance

A group life and accidental death and dismemberment insurance program is available to all benefit eligible employees of Harford County Public Schools through MetLife Insurance Company as a financial resource to protect their families.

Basic Life and AD&D insurance allows an employee to purchase a benefit equal to one times their annual earnings (rounded up to the nearest $1,000), minimum of $8,000 up to a maximum of $300,000. AD&D provides financial protection for you and your family against expenses associated with accidental death or injury. A reduced benefit is payable should you become dismembered as a result of an accident.

Supplemental life insurance

Supplemental Life Insurance allows you to purchase an additional amount of life insurance on yourself equal to 1x your salary (for a total of 2x salary) minimum $16,000 up to a maximum of $300,000.

Eligibility

You will be eligible for coverage on the first day of the month following your date of hire.

If you do not enroll within 31 days after becoming eligible the following limitations will apply to a later enrollment:

1. You must submit Statement of Health (SOH); and
2. You may not enroll until an Annual Open Enrollment Period.

If you apply for coverage during an Annual Open Enrollment Period the coverage will start the later of the date MetLife approves your Statement of Health or July 1st following the Annual Enrollment Period.

The completed SOH form must be returned to MetLife no later than June 15, 2017. (SOH form is available at https://hcps.benelogic.com under *Forms 2017*.)

Cost of coverage

The Board pays 90 percent of the cost of Basic Life & AD&D insurance. The employee is responsible for 100% of the cost of Supplemental coverage. The current monthly cost of Basic Life & AD&D is $0.174 cents per thousand dollars of coverage. Supplemental rates are per thousand dollars of coverage based on your age, see chart below for exact rate:

Age	Rate
<25	$0.030
25-29	$0.030
30-34	$0.040
35-39	$0.050
40-44	$0.060
45-49	$0.080
50-54	$0.130
55-59	$0.240
60-64	$0.370
65-69	$0.700
70-74	$1.140
75+	$1.140

Employee Assistance Program

Harford County Public Schools is pleased to offer an Employee Assistance Program (EAP) for all employees, and their family members or significant others that reside in their immediate household. KEPRO will provide these confidential services.

EAP

Sometimes personal and family problems can have a direct impact on personal well being and work performance. Getting timely, professional help can result in a healthier, more productive individual. We recognize the value in assisting employees and their dependents to find the best possible help in a timely manner.

HCPS provides an EAP which is administered by KEPRO. We encourage employees, their covered eligible family members, or other members of their immediate household, to take advantage of this important benefit when needed.

What is an EAP?

An EAP provides the opportunity to talk confidentially with a mental health professional about a wide range of personal matters, such as:

- Family or relationship problems
- Parenting difficulties
- Work-related problems
- Financial issues
- Child and eldercare issues
- Substance abuse and alcohol misuse
- Grief and loss
- Emotional and physical abuse
- Anxiety and stress
- Emotional / mental health concerns
- Convenience Services
- Legal Services*

** Currently this benefit is not available to HCEA or HCESC eligible members.*

What does an EAP offer?

The EAP may provide up to eight (8) visits per issue per year with a local licensed mental health counselor at no cost to you. These sessions are to assist you with problem identification, short-term counseling, or refer you for assistance based on their assessment of your specific situation and treatment needs. Up to eight visits are available to you for each type of situation for which you may want to seek assistance. If additional services outside the EAP are recommended, the EAP professionals provide and help facilitate the referral to the appropriate health care provider or community resource. Keep in mind that the financial responsibility for additional services outside the EAP is yours; however, your medical insurance may cover part of these costs. To determine coverage for

behavioral health services and covered providers, please check with your health care plan.

HCPS employees and their family members also have access to thousands of lawyers, certified public accountants, certified financial planners, and insurance specialists. An EAP counselor will assess your needs and arrange a no-cost 30 minute consultation for you with an attorney or financial consultant. If a member elects to retain the attorney, they will receive a 25% reduction of the professional's customary fee.

A full range of work/life support resources are available to HCPS employees and their family members. Child and Elder Care services include child and elder care referrals, which are researched to your preferences and provider/site availability. Employees and members of their family have consultation, educational materials, and referrals available to address issues involving a dependent or elder care. Dependent care specialists provide case management, educational material, consultations, and referrals on many child/adult/elder care issues. Referrals include, but are not limited to, prenatal care, adoption, summer camps, back-up care, long-term care options, support services, meals, transportation, respite care, day care, and recreational activities.

Convenience services allow you to productively focus your time and attention by letting the EAP research information for you. Convenience services include consultation and referrals for household shopping such as home repairs, pet sitters, cleaning services and other day to day needs. In addition, referrals can be made for dining, entertainment, and travel requests. Please note that the EAP will locate the resources; however the employee or family member is responsible for the cost of the goods/services.

Who may use the EAP?

All employees and their dependents or significant others in their immediate household.

What about confidentiality?

The decision to take advantage of this service is yours. All conversations remain confidential. Except as required by law, KEPRO will not disclose to anyone that you have inquired about benefits, are considering treatment, or are receiving treatment. If you are referred to the EAP due to attendance or disciplinary issues, the referral will be known to HCPS, but the details of your visits will remain confidential between you and your counselor.

What does the EAP cost?

There is no cost to employees and eligible members of their household to access and use the EAP. The initial assessment and short-term counseling are free. For many people, the one to eight visits (per issue per year) may be sufficient. For others, additional services and treatment may be needed. Your EAP counselor will work with you to determine if further treatment is necessary. Additional treatment is subject to the provisions of the health care plan in which you are enrolled. It is the participant's responsibility to verify coverage whenever a referral for treatment is recommended.

How do I make an appointment?

For more information about the EAP, or to arrange an appointment, please call: 1-866-795-5701.

Information and assistance is also available via the internet, at **www.EAPHelpLink.com**, just enter HCPS as your Company Code.

EAP counselors are available 24 hours, 7 days a week.

The EAP is an important resource to help you better manage your personal, work, and family situations. It's easy to use, does not cost you anything, and it can make a difference.

Savings & Retirement Benefits

Harford County Public Schools offers you several ways to begin saving money through payroll deductions. We offer our employees both U.S. Savings Bonds and Tax Sheltered Annuities (403(b) and 457 (b) Plans.)

U.S. Savings Bonds.

Savings Bonds are available to all employees through a payroll distribution to the U.S. Department of the Treasury. The TreasuryDirect program is a convenient and secure web-based system which allows you to purchase, manage, and redeem electronic (paperless) savings bonds at work or from home. TreasuryDirect is not limited to just U.S. Savings Bonds. Employees may purchase the following Treasury marketable securities: bills, notes, bonds and TIPS. For more information go to **www.treasurydirect.gov**. Additionally, for step by step instructions on how to open an account with the U.S. Department of the Treasury, go to the HCPS SharePoint HR Benefits web site (hcpsshare) and click on *"Treasury Direct Directions"*.

Defined Benefit Pension Plan

Did you know that the average person needs to replace 60% to 80% of his final income in order to afford retirement? Did you know that regardless of your years of service the Defined Benefit Pension Plan will not provide 60%–80% of your final income? Therefore, it is important to participate in the 403(b) and 457(b) Tax-Deferred Annuity Plans, described below. When it comes to retirement planning, it's never too soon to start. Your retirement income will come from more than one source. However, the principal sources of income when you retire are personal savings, Social Security, and your pension from one of the systems in which Harford County Public Schools participates. It is important to understand which retirement plan you are eligible for, how to enroll, and the benefits your plan will provide at retirement.

403(b) and 457(b) Retirement Plans

You may save for retirement and reduce your current taxes by participating in 403(b) and 457(b) retirement plans. Sections 403(b) and 457(b) of the Internal Revenue Code authorize a tax-deferred retirement savings program for employees of public schools. The account shelters your money from taxes in two ways:

- Pre-tax investing – Investments are made through the convenience of automatic payroll deductions before federal and state taxes are calculated on your income. FICA tax is also withheld and this lowers your current taxable income.
- Tax-deferred compounding – Your contributions and investment earnings accumulate tax-free while in your 403(b) account. You pay taxes only when you withdraw the money.

Your savings in these accounts are generally not available until age 59 1/2 unless you have a financial hardship, as defined by the IRS. If you meet the hardship requirements, you may be able to borrow or withdraw money from your account before 59 1/2.

Note: An "early withdrawal" penalty from the 403(b) plan will apply to employees separating from service before age 55. Distributions from a 457(b) plan are not subject to the 10% "early withdrawal" penalty.

Roth 403(b) contributions — What are they?

As a part of the 403(b) plan, you can make after-tax Roth 403(b) contributions. A Roth 403(b) contribution allows you to make after-tax contributions on a regular basis. When Roth 403(b) contributions are withdrawn, investment earnings may be tax-free, and your contributions are always tax free, which may result in reduced income taxes during retirement.

If you would like more information, call Lincoln Financial at 800-234-3500, Press "Ø" to speak to a representative or the Finance Office at (410) 588-5200.

Which retirement plan am I eligible for?

Depending on your job classification and the date you were employed, you may be eligible for one of two retirement programs listed below:

	Maryland State Teachers'/Employees Retirement System	Maryland State Teacher's/Employees Pension System
Eligibility provision	Must have enrolled prior to 1980 as a public school educator, administrator, or clerical employee.	Automatic membership after 1980 for eligible employees as defined by Maryland COMAR regulations (State Personnel and Pensions Article).
Vesting Provision	Vested allowance is payable at age 60 after accruing 5 years of creditable service.	A vested allowance is payable at age 65 for members of the Reformed Contributory Pension Benefit after accruing 10 yrs. of eligible service and at age 62 for all other members after accruing 5 years of eligible service.

Key Points: 403(b) and 457(b) Retirement Plans

- All Employees are eligible to participate in the 403(b) and 457(b) plans.
- There is no waiting period to begin saving in a plan. You may enroll or disenroll at anytime.
- Participation is 100% voluntary. Harford County Public Schools does not contribute to your account.
- Deductions are taken from 26 paychecks per contract year for 12-month employees and from 22 paychecks per contract year for 10-month employees. You decide how to invest your contributions and how much of your salary to invest.
- IRS regulations permit you to set aside up to $18,000 for contract year 2017. An additional contribution can be made if you are age 50 or older by the end of the contract year. Contact your approved vendor to assist you in determining your personal annual maximum.
- After you have obtained the age of 50 or older, the IRS permits you to contribute an additional $6,000 per year.
- Harford County Public Schools offers one company, Lincoln Financial, to provide you the 403(b) and 457(b) Plans.

Retiree insurance benefits

Your retiree insurance benefits are provided by Harford County Public Schools regardless of the retirement plan from which you are receiving your pension. Please note that the insurance benefits and the Board's contribution percentages as shown on the following page are subject to change in the future depending upon the Board and its funding authorities.

While you may be vested in your pension plan, your ability to participate in the retirement insurance plans of HCPS may be limited. In order to be eligible to participate in retiree benefits now or in the future, you must be enrolled for the benefit prior to your retirement date, and begin to receive a monthly pension directly following at least 10 years of continuous service to HCPS immediately preceding retirement. An employee who does not qualify to receive a pension or who elects to defer pension benefits or has not completed the last 10 years of continuous service with HCPS is ineligible for future participation in the Board's benefit plans.

Enrolling in your retiree insurance

Prior to retirement, you must submit a letter of retirement to the Superintendent with a copy to your supervisor. Human Resources/Benefits will be notified of your retirement from the Superintendent and will send you a letter and the appropriate retirement forms with instructions to contact a retirement coordinator to schedule your retirement conference.

You must be enrolled in benefits at the time of your retirement to elect retiree benefits. Effective July 1, 2017, employees who retire any date other than July 1 of each year will have a one-time opportunity to change their health insurance benefit plan after retirement. In order to take advantage of this one-time opportunity the employee must indicate their desire to participate in the next open enrollment following their retirement date when meeting with the Harford County Public Schools (HCPS) retirement coordinator before they retire. If the employee does not select this option they will not be able to change plans during the next scheduled open enrollment. Harford County Public Schools' retirees may not enroll in a health, dental or life insurance plan following their retirement date. Employees who elect to discontinue coverage at or after retirement may not elect coverage at a later date.

Health insurance

The cost of your health insurance is paid by you and Harford County Public Schools. For employees hired prior to July 1, 2006, the Board contributes 85–95 percent of the total cost of your health, dental or life insurance. Employees hired after July 1, 2006 receive benefits based on a tiered structure. Service of thirty years or more receive the full Board contribution, retirees with 20–29 years receive two-thirds of Board contribution and 10–19 years of service receive one-third of Board contribution. (Only continuous service time with the Harford County Public Schools applies.)

Health insurance premiums are deducted from a retiree's monthly pension check. Normally, retirements occur at the end of a school year and ten-month employees have already paid premiums for coverage through August 31. Therefore, if a ten-month employee retires on July 1, the first health insurance premium deduction will be taken from the September retirement check. Special handling is required for retiring individuals and/or their spouses who are Medicare eligible.

The same plans available to active employees are available to retiree's who are ineligible for Medicare. Upon reaching eligibility for Medicare (usually at age 65 or earlier if eligible due to disability) retiree's and/or their spouses **must enroll in Medicare Parts A & B** in order to continue participation in the Board's health insurance plans, and will be enrolled in a Medicare Supplemental health plan which coordinates with Medicare. Please note that each of the medical plans offered by Harford County Public Schools includes coverage for prescription drugs. If you elect a Medicare D plan, you will lose your prescription coverage with Harford County Public Schools and cannot re-elect coverage at a later date.

Dental coverage

Dental coverage may be continued into retirement. The cost of the plan, if elected, will be deducted from your pension check.

Life insurance

Life Insurance may be continued into retirement. Premiums are deducted from your pension check. Upon retirement, a retiree's life insurance coverage starts at $20,000. The amount of insurance reduces by $2,000 July 1 each year until it is at $10,000, which is where it remains.

What is Creditable Coverage?

As of January 1, 2006, Medicare beneficiaries have the opportunity to receive subsidized prescription drug coverage through the new Medicare Part D program. Beneficiaries who choose not to sign up at the first opportunity may have to pay more if they wait to enter the program later after the open enrollment period.

Beneficiaries who have other sources of drug coverage- through a current or former employer or union, for example- may stay in that plan and choose not to enroll in the Medicare drug plan. If their other coverage is at least as good as the new Medicare drug benefit and therefore considered "creditable coverage", then the beneficiary can continue to get the high quality care they have now as well as avoid higher payments if they sign up for the Medicare drug benefit.

Under Section 423.56(a) of the final regulation, coverage is creditable if the actuarial value of the coverage equals or exceeds the actuarial value of standard prescription drug coverage under Medicare Part D, as demonstrated through the use of generally accepted actuarial principles and in accordance with CMS actuarial guidelines. In general, the actuarial equivalence test measures whether the expected amount of paid claims under the entity's prescription drug coverage is at least as much as the expected amount of paid claims under the standard Part D benefit.

Required disclosures to Medicare beneficiaries

Harford County Public Schools must provide a notice of creditable prescription drug coverage to Medicare beneficiaries who are covered by, or who apply for, prescription drug coverage under any of the Harford County Public Schools plans.

<table>
<tr><th>Plans</th><th>Retiree Benefits</th><th>Additional Details</th></tr>
<tr><td>Non-Medicare (‹ 65)
■ CareFirst BlueCross BlueShield PPO CORE/PLUS
■ BlueChoice HMO
■ Triple Option

Medicare Eligible
■ CareFirst BlueCross BlueShield Medicare Supplemental Plan*
■ BlueChoice HMO</td><td>HCPS contributes toward health care premiums for employees with 10 or more years of service who are approved for retirement from the Maryland State Retirement and Pension Systems. Board contributions are:

<table><tr><th>Years of Consecutive Service to HCPS</th><th>Hired Prior to 7/1/06</th><th>Hired After 7/1/06</th></tr><tr><td>10-19 yrs.</td><td>Full Board contribution*</td><td>⅓ Board contribution*</td></tr><tr><td>20-29 yrs.</td><td>Full Board contribution*</td><td>⅔ Board contribution*</td></tr><tr><td>30 yrs. & up</td><td>Full Board contribution*</td><td>Full Board contribution*</td></tr></table>
Upon eligibility for Medicare (usually at age 65 or if eligible due to disability), retiree's and/or their Medicare-eligible dependents are required to convert to coverage which supplements Medicare.</td><td>Continuation of Insurance After Retirement — Deducted monthly from pension in combination with dental and life.</td></tr>
<tr><td>Delta Dental Insurance</td><td>Retirees may elect to continue to participate in the Delta dental plans offered to active employees. *For contribution, see chart in medical row above.</td><td>Deducted monthly from pension in combination with health insurance.</td></tr>
<tr><td>Life Insurance</td><td>Retirees pay 10% of the cost of life insurance. The $20,000 basic term life insurance will continue with a reduction of $2,000 each July 1 until the coverage is at $10,000. *For contribution, see chart in medical row above.</td><td>Deducted monthly from pension in combination with health insurance.</td></tr>
<tr><td>Surviving Spouse's Benefit</td><td>Upon retiree's death, if the spouse has been covered under a HCPS health care or dental plan, he or she will have the option to continue coverage. If elected coverage will continue without any Board contribution. *For contribution, see chart in medical row above.</td><td>Billed monthly by HCPS or deducted from monthly pension benefit check if applicable.</td></tr>
</table>

** 95% for BlueChoice HMO, 90% for PPO CORE, and 85% for Triple Option plan members. Part-time HCEA and HCESC members receive 50% of board contribution.*

Frequently Asked Questions

What are my Open Enrollment Options?

- Enroll in a medical, dental and/or flexible spending plan
- Change from one medical and/or dental plan to another
- Add or delete a dependent
- Cancel enrollment of your life, medical and/or dental insurance plan
- Apply for life insurance (Basic–1x salary/ Supplemental or Basic and Supplemental–2x salary). You must complete an Evidence of Insurability for Underwriting and be approved by the Life Insurance Company before coverage can become effective.

When can I enroll online?

Beginning May 1st. The site will be open from May 1st through May 19th at 11:59 p.m.

Do I have to go online to enroll for benefits?

YES. If you do not currently participate and wish to elect benefits for the 2017-2018 plan year you must go online to enroll.

Will I get a new FBA Benefits Card?

All participants to the plan will be issued a debit card. Debit cards are for three years. Cards will be mailed to your home address.

If I was enrolled in the Flexible Spending Account (FSA) this year will I need to enroll for the next plan year online?

YES. You must enroll for FSA each plan year. Your benefit election **will not** carry over into the next plan year.

If you are currently participating in a Flexible Spending Account your benefits will end on June 30, 2017. To participate in FSA for the 2017–18 plan year **you must** go online during open enrollment to enroll. **If you do nothing, you will not be able to contribute to the Flexible Spending Accounts for 2017-18**.

If I want to change or enroll in Life insurance, do I have to enroll online?

If you are currently enrolled in Basic + Supplemental and wish to enroll in Basic only, you must waive the Supplemental coverage. If you are currently enrolled in Basic Life 1x and want to add the Supplemental Life or if you have no coverage and wish to apply for life insurance, you must print out an Statement of Health Application, complete and mail. **The completed SOH form must be printed, signed and returned to the address at the top of the form no later than June 15, 2017.** MetLife Insurance will not accept any forms postmarked after June 15, 2017. You will be notified by MetLife if you are approved, declined or if additional information is needed. Once the Benefits Office receives confirmation from MetLife of your approval, the benefit will be changed accordingly.

I realized that I made a mistake when I enrolled. Can I correct my error?

Yes. You may log back on at any time during the Open Enrollment period (through May 19th) and make your changes.

I was interrupted and when I came back to continue enrolling the system timed out and/ or I had to stop part way through the session. What should I do?

You will have to log on again. The system will remember what you saved, so you do not have to re-enter the information.

Will I be able to log back on and check my elections after Open Enrollment?

Yes. Using the same password you created, you may log back on at any time and review your elections or plan information. However, you will not be able to make changes after May 19th.

Who is an eligible dependent?

Refer to the Benefits and Eligibility section of this booklet on page 3 & 4.

NOTE: If you and your spouse are both employees of HCPS you can each enroll as an individual or one of you can elect Employee/Spouse or Family coverage. If you elect coverage separately, you cannot cover each other as dependents and your eligible dependent children may only be covered by one of you.

Can I change my elections during the year?

IRS regulations require you to keep your elections through June 30, 2018 unless you have a Qualified Life Event. Changes must be requested within 30 days of the Qualified Life Event.

What is a Qualified Life Event?

- Birth or adoption of a child
- Death
- Marriage or divorce
- Termination of employment or commencement of employment
- Covered dependent ceasing to be an eligible dependent
- Spouse's loss of benefits
- Court ordered custody

To be considered a qualified life event, the event must result in the employee or dependent gaining or losing eligibility for benefits. Only the coverage category can be changed (not the plan choice).

When can I add a spouse, child or newborn to my insurance coverage? (This is usually not an open enrollment event)

You have 30 days from date of birth/adoption or marriage to add the dependent to your health/dental plans. Coverage will take effect retroactively to the date of birth/date of adoption or marriage. If you miss this 30-day period, the next opportunity to add the child or spouse would be during the open enrollment period held annually. You will need to provide a dependent verification form and documentation (birth certificate, marriage certificate, adoption paperwork).

If I am enrolled in a Medical or Dental plan and my doctor leaves the network, can I change my election?

NO. This is not considered a qualified life change.

When do dependents lose eligibility for coverage?

Refer to the Benefits and Eligibility section of this booklet. You must notify the Benefits Office as soon as you know that your dependent will no longer meet the eligibility requirements for coverage. You should notify the Benefits Office in advance so the dependent can be removed from coverage at the appropriate time. There are no refunds of bi-weekly deductions deducted during the period of ineligibility. Remember, when coverage ends for a dependent, he or she may choose to continue coverage under COBRA for a maximum of 36 months, as long as you have notified the Benefits Office of your request to continue coverage within 60 days of the loss of eligibility.

If I enroll for benefits online, when does my coverage start?

Benefits will become effective July 1, 2017 for anyone who elects coverage during our open enrollment period. For all new hires, the benefits are effective the first of the month following your date of hire. ID cards will be mailed to your home address.

When does my coverage end if I resign?

If your employment ends following the close of the school year and you are a 10 month employee, your benefits terminate as of August 31. If your employment ends during the school year or you are a 12 month employee, benefits terminate on the last day of the month in which you are on active pay status.

COBRA

Continuation Coverage Rights Under COBRA

Once you become covered under a group health plan (the Plan) you have COBRA rights. This summary contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end 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." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. The cost is the monthly premium equivalent to the full cost of coverage plus an administrative charge of 2%.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- You become divorced from your spouse.
- Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:
  - The parent-employee dies;
  - The parent-employee's hours of employment are reduced;
  - The parent-employee's employment ends for any reason other than his or her gross misconduct;
  - The parents become divorced; or
  - The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Benefits Office has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, or the death of the employee, the Benefits Office will be notified of the qualifying event.

How is COBRA coverage provided?

Once the Benefits Office receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, your divorce, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Benefits Office in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must provide written notice to: The Benefits Office, 102 South Hickory Ave., Bel Air, MD 21014.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, or gets divorced, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Benefits Office. For COBRA rates, please visit the benefits website.

Keep your plan informed of address changes

In order to protect your family's rights, you should keep the Benefits Office informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Benefits Office.

Health Insurance Portability Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act (HIPAA) places limitations on a group health plan's ability to impose pre-existing condition exclusions, provides special enrollment rights for certain individuals, and prohibits discrimination in group health plans based on health status.

We are electronically transmitting data to the vendors for eligibility purposes. The vendors and HCPS are in compliance with the HIPAA requirements. No personally identifiable information may be released to a third party.

Special enrollment rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

** If you, your spouse or eligible dependent child loses coverage under Medicaid or a State Children's Health Insurance Program (S-CHIP) or becomes eligible for state-provided premium assistance, the affected individual(s) has 60 days from the date of the event to elect coverage in the HCPS Healthcare plans. Contact HR/Benefits Office for more information.*

For more information about your rights, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa.

Family and Medical Leave Act (FMLA)

The Family Medical Leave Act (FMLA) was passed by Congress to protect eligible employees who cannot attend work for reasons related to birth, adoption, and/or serious health conditions involving the employee or the need to care for a spouse, child or parent with a serious health condition.

Eligibility for FMLA leave is also based upon length of time employed and number of hours worked within the 12 month period immediately before date leave is to begin. An eligible employee can take up to 12 work weeks in a 12 month period.

Eligibility will be determined by the Benefits Office upon notification and/or submission of required documents. School system employees who are in need of FMLA leave for one of the reasons noted above must complete an FMLA electronic leave request and provide medical certification or other documentation based upon the reason for the leave request. The application needs be completed within 30 days for any foreseeable need for leave.

In accordance with the law, FMLA may be granted for the following reasons:

- The birth of a child and in order to care for that child.
- The placement of a child with an employee for adoption or foster care.
- The care of a spouse, parent, or child with a serious health condition as defined by the FMLA regulations.
- The serious health condition of the employee.

Military Family Leave

The FMLA also provides certain military family leave entitlement. You may take FMLA leave for specified reasons related to certain military deployment. Additionally, you may take up to 26 weeks of FMLA leave in a single 12 month period to care for a covered service member with a serious injury or illness.

- Military Caregivers Leave
- Qualifying Exigency Leave

The electronic leave request and required documents can be found on SharePoint*. For additional information, contact the Benefits Office at (410) 588-5275.

Harford County Public Schools will maintain group health insurance coverage on the same terms and conditions as if the employee continued to work. Further information concerning benefits and FMLA leave can be obtained by calling the Benefits Office or visiting the HCPS SharePoint website at: ***https://share.hcps.org/sites/HumanResources/benefits**.

From a non-HCPS computer, the electronic leave request form can be accessed via **my.hcps.org**.

Privacy Notice

Your privacy is a high priority for Harford County Public Schools and it will be treated with the highest degree of confidentiality.

Harford County Public Schools (the Board) is required under the Medical Privacy Rules of the Health Insurance Portability and Accountability Act (HIPAA) to provide all of its employees and retirees participating in its self-funded health care plans with this PRIVACY NOTICE, which concerns personal, protected health information you have provided to the Board as a condition of your employment.

In providing health insurance benefits to you, the Board collects the following types of personal information: (1) information you provide to us on an application or enrollment form in order to obtain insurance including your name, address, telephone number, date of birth, and Social Security number; (2) premium payments the Board pays on your behalf; (3) the fact that you are currently or have been one of our employees; (4) information you have given to us from any of your physicians or other health care providers; (5) information related to your health care status including diagnosis and claims payment information and (6) other information about you that is necessary for us to have in order to provide you with health insurance.

We may disclose this information to our third party vendors (the Vendors) without prior authorization, as permitted by law. We do not disclose any personal information about either our current employees or former employees to anyone, except as permitted by law. We may, from time to time, disclose personal information about you without prior authorization, as permitted by law, to the Vendors to perform services or functions on our behalf. If we make such a disclosure, we will do so only if we have a contract in place that prohibits the Vendors from disclosing or using the information for any purpose other than the purpose of the disclosure, except as permitted by law. We restrict access to your personal information to those employees of the Board who need to know that information in order to provide services to you.

We maintain physical, electronic and procedural safeguards that comply with HIPAA regulations to guard your personal information. Employees, who have access to your personal information, are required to abide by the following standards: (1) to safeguard and secure confidential personal information as required by law; (2) to limit the collection and use of any participants information to the minimum necessary and (3) to permit only trained, authorized employees to have access to your personal information. Employees who violate the policy will be subject to our established disciplinary policy. In addition, the Board will: (1) provide all of our participants, at least annually, with any updates to this policy; (2) provide information about you to the Vendors only in accordance with the law; (3) require the Vendors to enter into a contract that prohibits disclosure or the use of your personal information other than to carry out the purpose of the disclosure, except as permitted by law; (4) not share your personal information for purposes other than allowed by law; (5) allow participants the opportunity to correct personal information that they believe is not accurate.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 1-31-2017)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact _____.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Harford County Public Schools		4. Employer Identification Number (EIN) 526000955
5. Employer address 102 South Hickory Avenue		6. Employer phone number 410-838-7300
7. City Bel Air	8. State MD	9. ZIP code 21014
10. Who can we contact about employee health coverage at this job? Benefits Office		
11. Phone number (if different from above) 410-588-5275	12. Email address Benefits@hcps.org	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☑ Some employees. Eligible employees are:

Regular Full-time employees
Part-time employees working .500 FTE or 18 hours per week or more

- With respect to dependents:

☑ We do offer coverage. Eligible dependents are:

☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

Definitions

These definitions have been developed to help you become familiar with some of the terms in this manual.

Allowed Benefit

The criteria CareFirst BlueCross BlueShield uses to determine payments to your physician. It is based upon the Resource Based Relative Value Unit System. This system takes 3 factors into consideration; work value (amount of skill/time/effort required for service), practice expense (cost of overhead expenses), and the liability/ malpractice expense for covered services.

Card (Identification/Membership)

Identification or membership card for medical/pharmacy coverage. The card identifies the employee, types of elected coverage, type of membership and the effective date of coverage.

Coinsurance

A cost-sharing requirement under your CareFirst BlueCross BlueShield policy which requires you to assume a percentage of the costs of covered services.

Copay

Cost sharing in which you pay a flat amount per service. Unlike coinsurance the amount does not vary as a percentage of the cost of the service.

Deductible

Amount of expense you must incur before CareFirst BlueCross BlueShield or Delta Dental will assume any liability for all or part of the remaining cost of covered services.

Eligibility

State of fulfilling requirements for coverage.

In-network Provider

A preferred provider within a Preferred Provider Organization.

Medical Emergency

The sudden and unexpected onset of a serious illness or condition which requires necessary, immediate medical care.

Member Hospital

A hospital that has signed a contract with CareFirst BlueCross BlueShield to provide services to CareFirst BlueCross BlueShield subscribers.

Non-Participating Provider

A physician or other provider who has not signed an agreement with the CareFirst BlueCross BlueShield plan to accept the Allowed Benefit as payment in full.

Out-of-Network Provider

A provider that is not part of the PPO network

Out-of-pocket

The deductible copayment plus any coinsurance amount that the subscriber pays; once this has been met the policy will normally pay at 100% of the Allowed Benefit for most covered services.

Participating Provider

A physician or other provider who has signed an agreement with CareFirst BlueCross BlueShield to accept the Allowed Benefit as payment in full.

Medical and Dental Plan Year

The Plan Year is twelve months July 1–June 30.

FSA Plan Year

FSA Plan Year is twelve months July 1–June 30.

Professional Component

That portion of a charge for x-ray or laboratory services performed in a hospital which is allocated to a physician as his professional fee.

Provider

An individual or institution that provides medical care.

Fully-Insured vs. Self-Insured

What is the Difference?

Employers that offer health insurance benefits finance those benefits in one of two ways: They purchase health insurance from an insurance company (fully-insured plans), or they provide health benefits directly to employees (self-insured plans). Typically, these plans differ by who assumes the insurance risk, plan characteristics, and employer size.

If an employer-sponsored plan is fully-insured:

The insurance company is ultimately responsible for the health care costs and the employer pays premiums. In a fully-insured plan, the employer pays a per-employee premium to someone else (an insurance company) to take on the risk that they will pay out more in benefits than they collect from you in premiums. The insurer collects the premiums and pays the health care claims based on your policy benefits. The covered persons are responsible to pay any deductible amounts or copayments required for covered services under the policy.

If an employer-sponsored plan is self-insured:

The employer assume the financial risk and acts as its own insurer and is ultimately responsible for the health care costs, and pays for all of those costs plus administration fees. Self-insured plans often contract with an insurance company or other third party to administer the plan, but the employer bears the risk associated with offering health benefits.

Harford County Public Schools (HCPS) self-insures all medical and dental plans offered

This means we assume the risk for every dollar of health care expense our employees and their families incur. We use the dollars collected through your payroll contributions and HCPS's contributions to pay employees' claims and the administration costs of the plans. In addition we also share in costs with employees at the point of care, through the plan's benefit features (e.g., coinsurance and copayments). Our third party administrators are CareFirst and Delta Dental.

Self-insuring our medical and dental plans benefits HCPS and our employees in many ways:

- **Our benefit dollars go toward benefits.** Built into the cost of any insurance policy is the insurer's profit. When we self-insure, we eliminate the middleman—the insurer—and its built-in profit. Though third-party insurers administer our plans, they do so on a fee-for-service basis; they take no financial risk for paying our claims. And since HCPS is not making a profit by providing health insurance coverage to you, every dollar of your and HCPS's contributions are used to pay claims and the administrative expenses for our plans.
- **We have more flexibility.** When we self-insure our plans, HCPS, and not an insurance company, decides how our plans work. This provides us with more flexibility in designing our plans (e.g., deciding on copayment and coinsurance levels) to fit the needs of our employees. The insurance carrier is responsible for negotiating rates with in-network providers and the processing of claims.
- **We have more control.** Self-insured plans are subject to federal regulations, while fully-insured plans are regulated by the state in which the plan operates. This exempts HCPS from providing for state-mandated benefits in our plans (which can be costly) and from paying state-mandated taxes on health care premiums (an additional expense for the plans).

Even though HCPS plans are self-funded, HCPS does not assume 100% of the risk for catastrophic claims. Rather, we purchase what is known as Stop-Loss insurance to protect against large individual claims as well as total claims which exceed the expected level for our group of covered persons.

The total cost of a self-funded plan is the fixed costs plus the claims expense less any stop-loss reimbursements.

CareFirst BlueCross BlueShield
CareFirst BlueChoice, Inc.
10455 Mill Run Circle
Owings Mills, MD 21117-5559

www.carefirst.com

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CareFirst

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