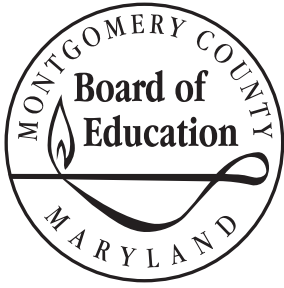


2011
Retiree Benefit Summary
Effective July 1, 2011



EMPLOYEE & RETIREE SERVICE CENTER
www.montgomeryschoolsmd.org/departments/ersc



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A high-quality education is the fundamental right of every child. All children will receive the respect, encouragement, and opportunities they need to build the knowledge, skills, and attitudes to be successful, contributing members of a global society.

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Employee and Retiree Service Center
MONTGOMERY COUNTY PUBLIC SCHOOLS
Rockville, Maryland

April 25, 2011

MEMORANDUM

To: Montgomery County Public Schools' Retirees

From: Richard C. Johnstone, Director 
Benefits Strategy and Vendor Relations

Subject: Retiree Benefits Open Enrollment

Montgomery County Public Schools (MCPS) will conduct the annual Retiree Benefit Open Enrollment on Monday, May 2, 2011, through Friday, June 3, 2011. During benefit Open Enrollment, MCPS retirees will have an opportunity to make changes to their medical, dental, vision, and prescription plans; drop coverage; or, under certain circumstances, add coverage that was previously dropped. All changes made during this period become effective July 1, 2011.

The *Affordable Care Act*, signed into law in March 2010, will result in several changes to your retiree benefits effective in 2011. During this year's Open Enrollment, it is more important than ever to review the changes to your retiree benefits, understand your choices, and make sure you take any necessary action to take advantage of the options available to you. Please read this memorandum carefully. You also should acquaint yourself with the benefit offerings by reading the attached *Retiree Benefit Summary*.

New for the 2011—2012 Plan Year

- No Co-pays for Preventive Care Services—Certain preventive care services will no longer have co-pays when they are provided by in-network providers, regardless of your medical plan choice. Out-of-network coverage for preventive care services remains unchanged under each medical plan.
- Mental Health Coverage—Mental health and substance abuse outpatient visits will now have the same co-pays and/or co-insurance as other office visits.
- Emergency Room Co-pay—Emergency room co-pays on all medical plans will increase from \$50 to \$100 (waived if admitted).
- Young Adult Dependent Eligibility Extended—As a result of the *Affordable Care Act*, young adult dependents now can be covered until the end of the month in which they turn age 26 on all medical and prescription plans. (Please note that you must take action to enroll young adults who were previously ineligible for dependent coverage due to age. You must submit MCPS Form 455-22: *Retiree Benefit Plan Enrollment* with the required birth certificate or other documentation.)
- Lifetime Maximum Limits Eliminated—There no longer will be lifetime maximum limits for medical coverage.

Benefit Highlights for 2011

CVS/Caremark—The prescription drug program is designed to provide the plan and participants with the most cost-effective way to obtain maintenance medications. Retirees and/or covered dependents enrolled in the CVS/Caremark prescription plan can purchase a 90-day supply of maintenance medication at a local CVS pharmacy for the same co-pay as the mail service. MCPS is offering this program as a cost-effective alternative to traditional mail service.

Medicare Eligibility and UnitedHealthcare Point-of-Service—Retirees and/or covered dependents in a UnitedHealthcare Point-of-Service (POS) plan may not remain on the POS plan once Medicare eligible. When a retiree has a UnitedHealthcare POS plan with two-party or family coverage and one individual becomes Medicare-eligible, the remaining individual(s) on the plan may not remain on the POS plan. Retirees have two health plan options in this situation:

- Option 1—The retiree and covered dependent(s) automatically will be transferred to the UnitedHealthcare Indemnity/Medicare Supplemental Indemnity plan. For non-Medicare eligible individual(s), UnitedHealthcare Indemnity will be the primary medical plan. For the Medicare-eligible individual, Medicare will be the primary medical plan, and the UnitedHealthcare Medicare Supplemental Indemnity plan will be the secondary coverage. If the retiree does not elect Option 2, the retiree and covered dependent(s) automatically will be transferred to this plan.
- Option 2—The retiree may choose to enroll in any of the HMO plans offered. The retiree must submit a completed MCPS Form 455-22: *Retiree Benefit Plan Enrollment* to ERSC. For the non-Medicare-eligible individual(s), the selected HMO plan will be the primary (sole) coverage. For the Medicare-eligible individual, Medicare will be the primary medical plan, and the selected HMO plan will be the secondary coverage. Details regarding enrollment procedures and deadlines are in the Medicare section of this booklet.

Diabetic Supplies— Medicare-eligible retirees and/or their covered dependents who are enrolled in the CVS/Caremark prescription drug plan and diagnosed with diabetes have the choice of purchasing diabetic supplies through CVS/Caremark or through their health plan. This does not apply to retirees enrolled in the Kaiser Permanente Medicare Plus health plan.

- Health plan members enrolled in Medicare using either UnitedHealthcare (UHC) or the BlueChoice health plan to fill diabetic supplies must use the supplier offered by their specific health plan. Details on suppliers can be found by calling UHC Select HMO at 800-638-1103, UHC Indemnity/Medicare Supplemental Indemnity at 866-844-4863, or BlueChoice at 800-545-6199.
- For all other retirees and dependents, diabetic supplies can be purchased only through CVS/Caremark. For additional information, please contact ERSC at 301-517-8100 or via e-mail at ERSC@mcpsmd.org.

Retiree Benefit Plan Open Enrollment

If you wish to make changes to any component of your benefit plan(s) during the annual retiree Open Enrollment (May 2–June 3, 2011), ERSC must receive your changes by the close of business on Friday, June 3, 2011.

All changes will be effective July 1, 2011. If you make a change, you will receive a written confirmation of the change. Please review the confirmation upon receipt so any errors may be corrected promptly. Confirmations will be mailed twice weekly.

Please read the *2011 Retiree Benefit Summary* carefully to ensure you understand plan offerings and premium costs for the 2011–2012 plan year.

No action is required if you *do not* wish to make a change, and your current level of coverage will continue.

Unbundling Your Benefit Plan

Retirees are given the option to enroll in the full benefit package that includes medical, dental, vision, and prescription drug coverage or choose only those specific components that meet individual needs. For example, a retiree who has medical insurance through another source and only requires prescription coverage may choose prescription coverage only. Retirees who cancel any component of coverage may reenroll during a future retiree Open Enrollment with documented proof that they had other coverage for the previous 12 months prior to re-enrolling in the MCPS benefit plan. Eligible dependents must be enrolled in the same benefit plan components as the benefit-eligible retiree.

Please note that if a retiree previously canceled coverage, reenrollment will be permitted only if that coverage was canceled on or after July 1, 1998, and with documentation of coverage for the 12 months immediately preceding reenrollment with MCPS.

Retirees enrolled in the Kaiser Permanente HMO must select the Kaiser prescription coverage. Kaiser does not permit enrollment for prescription coverage without medical coverage for this benefit group, and the CVS/Caremark prescription plan is not available to Kaiser members.

Health Fairs

Representatives from the health plans and ERSC will be available to answer questions during the following scheduled health fairs:

Dates	Locations	Times
Tuesday, May 3	Julius West MS 651 Great Falls Road Rockville, MD 20850	3:00–5:30 p.m.
Tuesday, May 10	Julius West MS 651 Great Falls Road Rockville, MD 20850	3:00–5:30 p.m.
Tuesday, May 31	Julius West MS 651 Great Falls Road Rockville, MD 20850	3:00–5:30 p.m.

The attached *2011 Retiree Benefit Summary* includes health plan comparison charts, premium rate charts, and MCPS Form 455-22: *Retiree Benefit Plan Enrollment*. Retirees may make plan changes between Monday, May 2, 2011, and Friday, June 3, 2011.

The *2011 Retiree Benefit Summary*, MCPS Form 455-22: *Retiree Benefit Plan Enrollment*, and the schedule of health fairs also are available on the ERSC website.

ERSC staff is available to assist you from 8:00 a.m. to 4:30 p.m., Monday through Friday, at 301-517-8100, or via e-mail at ERSC@mcpsmd.org.

RCJ: jaa

Attachments

Approved:



 Larry A. Bowers, Chief Operating Officer

2011

Montgomery County Public Schools

2011 BENEFITS SUMMARY FOR RETIREES

Montgomery County Public Schools (MCPS) provides a comprehensive retiree benefit plan for retirees and their eligible dependents. As an eligible MCPS retiree, you have a variety of benefit options from which to choose, including medical, dental, vision, and prescription drug coverage.

The *Retiree Benefit Summary* provides an overview of the benefits available to eligible retirees, effective July 1, 2011. This summary includes information about eligibility for MCPS benefits, a list of benefit costs, important contact information, and enrollment forms.

Keep in mind that this is a summary of the MCPS retiree benefits and is intended to help you understand and properly enroll in the plan. Full benefit plan details are available on the Employee and Retiree Service Center (ERSC) website at www.montgomeryschoolsmd.org/departments/ersc. Information available on the website includes summary plan and evidence of coverage documents. Staff members are available to assist you Monday through Friday from 8:00 a.m.–4:30 p.m. You may contact ERSC directly at:

Montgomery County Public Schools
Employee and Retiree Service Center
7361 Calhoun Place, Suite 190
Rockville, Maryland 20855
ERSC@mcpsmd.org
301-517-8100

Important Notice

You are not automatically enrolled in the MCPS retiree benefit plan. New retirees must enroll 30 days prior to their effective date of retirement or wait for a future Open Enrollment, typically held in May, with coverage effective July 1 of the current year. You must complete MCPS Form 455-22: *Retiree Benefit Plan Enrollment* to join the Retiree Benefit Plan. This enrollment form also is used to make changes during the annual Open Enrollment for retirees and changes due to a qualifying event. This form also is used to designate and change beneficiaries for retiree life insurance.

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About Your Benefits

WHO IS ELIGIBLE

Retirees currently enrolled in a health plan are eligible to enroll in any of the options offered during the retiree benefit plan Open Enrollment. Under certain circumstances, retirees who opted to discontinue their MCPS coverage may re-enroll during a future retiree Open Enrollment. Anyone retired on or after July 1, 1998, is eligible to enroll during a future retiree Open Enrollment with proof of coverage for the 12 months prior to the time period you want to enroll. If you retired on or before June 30, 1998, and did not have coverage at that time, you and your dependents are not eligible to enroll in the MCPS plan at any time.

Please Note: Any retiree who was not eligible for coverage as an active employee is not eligible for coverage as a retiree.

Eligible Dependents

You may choose to cover your eligible dependents under the MCPS retiree benefit plan. Any eligible covered dependents must be enrolled in the same coverage in which you are enrolled.

Eligible dependents include your—

- Spouse
- Qualified same sex domestic partner
- Eligible children meeting the following age requirements:
 - Until the end of the month in which they turn 26 for medical and prescription coverage
 - Until September 30 following their 23rd birthday for dental and vision coverage

The documentation you submit to show eligibility of a spouse, qualified same sex domestic partner, or child(ren) must include but is not limited to the following:

Spouse:

- Social Security number and
- Marriage certificate or current joint tax return

Qualified Same Sex Domestic Partner:

- Social Security number and
- Signed and notarized MCPS affidavit (available on ERSC website) plus additional documentation as required by the affidavit

Newborn or Biological Children:

- Social Security number and
- Birth certificate or birth registration

Children of same sex domestic partner:

- Social Security number and
- Birth certificate or birth registration and one of the following—
 - Adoption documents
 - Shared or joint custody agreement

Stepchildren:

- Social Security number and
- Birth certificate or birth registration and shared/joint custody agreement

Adopted Children, Foster Children, Children in Guardianship/Custodial Relationships:

- Social Security number and one of the following:
 - Adoption documents
 - Guardianship/custody documents
 - Foster child documents

Continuation of Coverage for Disabled Dependents

Your disabled dependent child(ren)'s benefits coverage may be continued beyond the standard eligibility if—

- he or she is permanently incapable of self-support because of mental retardation or physical handicap or became disabled, and
- the disability occurred before he or she reached age 19.

Coverage will continue as long as the disabled child is incapacitated and dependent unless coverage is otherwise terminated in accordance with the terms of the plan. You will be asked to provide the plan administrator with proof that the child's incapacity and dependency existed prior to age 19. Before the plan administrator agrees to the extension of coverage, the plan administrator may require that a physician chosen by your health plan provider examine the child. The plan administrator may ask for proof that the child continues to meet these conditions of incapacity and dependency. If you do not provide proof that the child's incapacity and dependency existed prior to age 19, as described above, coverage for that child will end September 30 following his/her 23rd birthday for dental and vision benefits. Medical and prescription coverage will end at the end of the month in which he/she turns the age of 26.

If you change your medical plan, you may be required to submit new medical documentation to the new health plan provider.

It is your responsibility to notify MCPS of the child's incapacity and dependency to be considered for continuous benefits coverage beyond the standard eligibility. Forms for incapacitated/disabled dependent children are available from ERSC. Coverage ends if you predecease your disabled dependent, except as provided under federal *Consolidated Omnibus Budget Reconciliation Act* (COBRA) legislation.

ADDING DEPENDENTS

Dependents of anyone retired on or before June 30, 1998, who were not covered at that time are not eligible for coverage. Children may be added to your retiree benefit plan up to age 26. To enroll a child in your retiree benefits, you must complete MCPS Form 455-22: *Retiree Benefit Plan Enrollment*. **New spouses or qualified same sex domestic partners who were not covered as dependents at the time of your retirement are not eligible for coverage under the plan and may not be added after retirement.**

CHANGES IN COVERAGE

In general, you are not permitted to make changes to your coverage during the plan year.

Changes due to qualifying life events may be made during the plan year. Qualifying life events include the following:

- Divorce
- Loss of alternative coverage
- Birth or adoption of a child
- Relocation outside your current plan service area

If you experience a qualifying life event, you have 60 days from the date of the qualifying event to submit the required enrollment forms to ERSC. You must use MCPS Form 455-22: *Retiree Benefit Plan Enrollment* to change your benefit plan enrollment, and you must attach all required documentation to the enrollment form at the time you submit your form. If you fail to submit all required information with MCPS Form 455-22, your form will be rejected and returned to you.

If you do not submit the form and required documentation within the 60-day period, you must wait until a future Open Enrollment to make any changes.

You may drop a dependent or cancel coverage at any time by completing MCPS Form 455-22, *Retiree Benefit Plan Enrollment*. However, you

may not cancel individual components of your benefit plan. If you choose to cancel coverage, you must cancel the entire retiree benefit plan (with the exception of life insurance coverage).

It is your responsibility to notify ERSC of all changes, including death of dependents, changes to name, address, and phone number. During the annual benefit plan enrollment, you may drop one or more components of your benefit plan. However, you may not cancel individual components of the benefit plan (except life insurance) during the plan year.

Changes become effective on the first day of the month following receipt of the form, provided notification is received by the fifth day of the month. If the fifth day of the month falls on a weekend or holiday, the deadline is the last business day prior to the fifth. Enrollment forms received after the fifth day of the month will have coverage commence on the first day of the second month.

It is recommended that you notify ERSC promptly. Removing a dependent could change your coverage level and reduce your monthly premium.

PAYING FOR COVERAGE

Health plan coverage premiums are deducted from your retirement check or directly billed to you when your retirement check is not sufficient to cover your premiums.

Refer to the retiree rate chart in this document for your 2011 health coverage costs.

WHEN BENEFITS COVERAGE ENDS

Retiree coverage is provided to the retiree and surviving spouse for life. Please keep in mind that your medical benefits change when you become eligible for Medicare.

Benefits coverage for a dependent child automatically ends at the end of the month in

which he/she turns 26 for medical and prescription plans. Benefits coverage for a dependent child's dental and vision plans automatically ends on September 30 following the dependent child's 23rd birthday. You should complete MCPS Form 455-22: *Retiree Benefit Plan Enrollment*, to remove your dependent from benefits coverage if your child becomes benefit-eligible on his/her own with MCPS.

CONTINUATION OF BENEFITS

If coverage ends, you and/or your dependents may be eligible to continue coverage as provided under COBRA.

Under COBRA you may continue coverage by paying the full cost of coverage plus a two percent administrative fee for a period legally mandated by COBRA regulations (generally 18–36 months).

MCPS does not share the cost of COBRA coverage. A COBRA rate chart can be found on the ERSC website. You will receive a qualifying event notice from the MCPS third party administrator (SHPS | Carewise Health).

OUT-OF-AREA COVERAGE

Retirees enrolled in the Kaiser Permanente Health Maintenance Organization (HMO) are required to live or work in the Kaiser Permanente service area. If you are covered by the Kaiser Permanente HMO and you live or move outside of the Kaiser Permanente service area, please consult ERSC for additional plan options. Eligible dependents who reside or attend school outside the service area of the HMO will be covered only for urgent care or emergency services. Your dependents must contact the medical plan for authorization before receiving out-of-area medical care and the plan may deny out-of-area care. Refer to the applicable HMO summary plan document for details.

If you are enrolled in the CareFirst BlueChoice HMO, you have access to the Away From Home Care (AFHC) program that provides benefits for

participants residing outside of the local HMO service area for 90 days or more. Some areas of the country do not participate in the AFHC program. To take advantage of the AFHC program, you should contact CareFirst at 1-888-452-6403 for more information and enrollment procedures.

If you are enrolled in the UnitedHealthcare (UHC) Select Plus Point-of-Service plans or the UHC Select HMO, you have access to a national network of doctors and facilities. In the event that you and/or your dependents seek care, the plans provide in-network benefits. Out-of-network benefits are available only to UHC Select Plus Point-of-Service (POS) plan members. Please consult the POS plan chart for further details.

COORDINATION OF BENEFITS

If you or one of your dependents is covered by more than one insurance plan, there is an order of benefits determination established by the National Association of Insurance Commissioners. The primary plan will be the first to consider the medical services rendered for coverage. Any medical care not covered in full by the primary plan will be considered for payment by the secondary plan. Your plan is primary coverage over any other plan that covers you as a dependent spouse.

If you or your eligible dependents are covered by Medicare Parts A and B, Medicare will always be primary. For more detailed information see "Enrollment in Medicare" later in this booklet.

Birthday Rule

If dependent children are enrolled for insurance coverage with both biological parents (one MCPS plan, one non-MCPS plan), the primary insurance plan for the children is determined by the birthday of the parents.

The plan of the parent with the birthday that comes first in the calendar year (month and day

only) is primary for the child(ren). This order of benefits determination for dependent children is known as the birthday rule.

All medical plans offered by MCPS use the birthday rule for primary insurance plan determination. The birthday rule does not apply to stepchildren. Primary care for dependent stepchildren follows the biological parent.

ENROLLMENT IN MEDICARE

MCPS requires all participants in the MCPS retiree benefit plan to enroll in Medicare Parts A and B when first eligible for Medicare in order to maintain medical and prescription benefits through MCPS.

You are eligible for Medicare if you:

- are age 65 (or over if you have been employed and covered by an active group health plan), or
- receive disability benefits from the Social Security Administration and are beginning the twenty-fifth month of entitlement, or
- have End-Stage Renal Disease (ESRD).

You are eligible for Medicare the first day of the month you turn age 65 if you have not qualified for enrollment before age 65. If you will be age 65 on the first day of the month, you will be eligible for Medicare the first day of the previous month. ERSC requires that a copy of the Medicare card be submitted 30 days prior to the effective date of Medicare coverage. For example, if your birthday is December 16, the Medicare effective date is December 1, and ERSC must receive the Medicare card by November 1. As of your Medicare eligibility date, Medicare will be the primary medical plan, and the health insurance plan through MCPS will be the secondary medical coverage.

If you and/or your covered dependent(s) deferred enrollment in Medicare because you were actively employed, you must contact the Social Security Administration at least three

months prior to your retirement date to enroll in Medicare Parts A and B. You must submit a copy of the Medicare card to ERSC with your retirement forms.

If you and/or your covered dependent(s) become eligible for Medicare after you retire, you must contact the Social Security Administration at least three months prior to eligibility to enroll in Medicare Parts A and B. It is the retiree and/or dependent's responsibility to enroll in Medicare Parts A and B and submit a copy of the Medicare card to ERSC 30 days prior to the effective date of Medicare coverage. Sending the Medicare card to ERSC will initiate the process to notify the insurance carriers and update your benefit enrollment plan, thereby reducing your monthly premium.

If you and/or your covered dependent(s) become Medicare eligible through Social Security Disability Benefits or End-Stage Renal Disease, you must contact ERSC at 301-517-8100.

Each insurance carrier has different procedures regarding the coordination of Medicare benefits with the MCPS insurance plans.

Kaiser Permanente HMO plan

Two to three months prior to your or your dependent's 65th birthday, Kaiser will send the Kaiser Permanente Medicare Plus application. Kaiser must have the completed Kaiser Permanente Medicare Plus application 30 days prior to the effective date of Medicare coverage. A copy of the Medicare card must be submitted to ERSC 30 days prior to the effective date of the Medicare coverage. Kaiser Permanente Medicare Plus includes enrollment in Medicare Part D (prescription drug benefit program). If you enroll in another Medicare Part D plan, your Kaiser Permanente Medicare Plus membership (prescription and medical) will be terminated on the start day of your new Medicare Part D plan.

CareFirst BlueChoice HMO plan

A copy of the Medicare card must be submitted to ERSC 30 days prior to the effective date of Medicare coverage. No additional information or special procedures are required. After the Medicare-effective date, CareFirst BlueChoice will send you a form to complete and return to CareFirst.

UnitedHealthcare plans

The following applies to all UnitedHealthcare plans:

- UnitedHealthcare Point-of-Service plans (Open and Closed)
- UnitedHealthcare Select HMO
- UnitedHealthcare Indemnity/Medicare Supplemental Indemnity plan

A copy of the Medicare card must be submitted to ERSC 30 days prior to the effective date of Medicare coverage.

MCPS and UnitedHealthcare (UHC) require retirees and/or dependents to complete the UnitedHealthcare Medicare Crossover form. The crossover form enables automatic processing of insurance claims filed with Medicare to your UHC Medicare Supplemental plan. The UnitedHealthcare Medicare Crossover form is available on the ERSC website. Once completed, return the form to ERSC. Medical claims are submitted by the provider's office first to Medicare. Medicare determines the eligible amount, pays the Medicare portion of the claim (80%), and then submits the claim to UnitedHealthcare for secondary payment (20% of the Medicare-eligible amount).

For specific considerations regarding the Point-of-Service plans, please read below.

UnitedHealthcare Point-of-Service (POS) plans (Open and Closed)

Retirees and/or covered dependents in a UnitedHealthcare POS plan may not remain on the POS plan once Medicare eligible. When a

retiree is enrolled in a UnitedHealthcare POS plan with 2-party or family coverage and one individual becomes Medicare eligible, the remaining individual(s) on the plan may NOT remain on the POS plan. The retiree will then have the following two health plan options:

Option (1): The retiree and covered dependent(s) will be transferred automatically to the UnitedHealthcare Indemnity/Medicare Supplemental Indemnity plan.

For the non-Medicare individual(s), the UnitedHealthcare Indemnity/Medicare Supplemental UnitedHealthcare Supplemental Indemnity plan will be the sole medical coverage. For the Medicare-eligible individual, Medicare will be the primary medical plan and the UnitedHealthcare Indemnity/Medicare Supplemental Indemnity plan will be the secondary coverage. If the retiree does not elect Option 2, the retiree and covered dependent(s) will be transferred automatically to this option.

Option (2): The retiree may choose to enroll in any of the HMO medical plans offered by MCPS as long as he/she resides within the service area of the plan. The retiree must submit a completed MCPS Form 455-22: *Retiree Benefit Plan Enrollment* to ERSC by the fifth of the month PRIOR to the Medicare effective date. If the fifth day of the month falls on a weekend or holiday, the deadline is the last business day prior to the fifth. The retiree and covered dependent(s) will be transferred to the new plan with a start date of the Medicare effective date.

If the retiree does not meet the deadline for Option 2, the retiree and covered dependent(s) will be enrolled automatically in the UnitedHealthcare Indemnity/Medicare Supplemental Indemnity plan and may not make changes until the next Open Enrollment.

MEDICARE PART D

A Medicare prescription drug benefit program, Medicare Part D, is available to Medicare-eligible individuals. Medicare Part D provides the option to purchase prescription drug coverage as a separate Medicare benefit. You may continue your CVS/Caremark prescription drug coverage through MCPS in lieu of Medicare Part D, but you cannot participate in both plans. The MCPS plan has been actuarially certified to provide equal or greater benefits than the Medicare Part D plan. The Notice of Creditable Coverage attesting to this fact is available on the ERSC website. Most MCPS retirees elect to continue their MCPS prescription coverage and do not enroll in Medicare Part D.

If you or your covered dependent(s) enroll with a Medicare Part D provider, neither you nor your dependent(s) are eligible to enroll in the MCPS-sponsored CVS/Caremark prescription drug plan. If you and/or your covered dependent(s) enroll in a Medicare Part D plan while enrolled in the CVS/Caremark prescription drug plan, the CVS/Caremark prescription drug plan will be terminated on the start date of your Medicare Part D plan. Please contact ERSC at 301-517-8100 for exception information if an individual is in a nursing home or on medical assistance.

Kaiser Permanente Medicare Plus includes enrollment in Medicare Part D. If you enroll in another Medicare Part D plan, your Kaiser Permanente Medicare Plus membership (including medical) will be terminated on the start date of your new Medicare Part D plan.

Important Notice

Your medical and prescription coverage with MCPS will be cancelled if you fail to enroll in Medicare Parts A and B and provide ERSC with a copy of the Medicare card.

Your Benefits at a Glance

The chart below is a brief overview of your benefit options for 2011. For more information, refer to the appropriate section in this benefits summary.

Benefit	Your Options
Protecting Your Health	
Medical Point-of-Service (POS) Health Plans	<ul style="list-style-type: none"> • UnitedHealthcare Select Plus—Open POS Plan • UnitedHealthcare Select Plus—Closed POS Plan (open only to retirees who were retired on or after December 31, 1999, and who were eligible to participate as active employees hired before January 1, 1994)
Health Maintenance Organizations (HMO) Health Plans	<ul style="list-style-type: none"> • CareFirst BlueChoice HMO • Kaiser Permanente HMO • UnitedHealthcare Select HMO
Indemnity (PPO) Plan	<ul style="list-style-type: none"> • UnitedHealthcare Indemnity/Medicare Supplemental Indemnity—fee-for-service plan
Prescription Drug	<ul style="list-style-type: none"> • CVS/Caremark Prescription Drug Option A or B (not available to Kaiser Permanente plan participants) • Kaiser Permanente Prescription Drug (only available to Kaiser Permanente medical plan participants)
Dental	<ul style="list-style-type: none"> • Aetna Dental Preferred Provider Organization (PPO) • Aetna Dental Maintenance Organization (DMO)
Vision	<ul style="list-style-type: none"> • National Vision Administrators, LLC
Protecting Your Income	
Basic Term Life Insurance	<ul style="list-style-type: none"> • Retiree (64% paid by MCPS, 36% paid by retiree)
Defined Contribution Plans	
403(b) Tax Shelter Savings Plan	Participants in the MCPS 403(b) Plan become eligible for distributions, without penalty, upon attaining age 59 ½ (regardless of employment status) or separation from service after attaining age 55. For directions to obtain distributions, please visit http://mcps.yourplan.info/index.html .
457(b) Deferred Compensation Plan	Participants in the MCPS 457(b) Plan become eligible for distributions upon separation from service or attaining age 70 ½. For directions to obtain distributions, please visit http://mcps.yourplan.info/index.html . Please note: If you are employed by MCPS in any capacity after retirement, including as a temporary employee or substitute teacher, you are ineligible to take a distribution from the 457(b) plan based on retirement or separation from service.

Medical Coverage

Six medical plan options are offered to eligible MCPS retirees.

- Two Point-of-Service (POS) options:
 - UnitedHealthcare Select Plus Open POS Plan
 - UnitedHealthcare Select Plus Closed POS Plan (**only open to retirees and dependents not yet eligible for Medicare who were retired on or after December 31, 1999, and who were eligible to participate in the Closed POS plan as an active employee hired before January 1, 1994**)
- Three Health Maintenance Organization (HMO) options:
 - CareFirst BlueChoice HMO
 - Kaiser Permanente HMO
 - UnitedHealthcare Select HMO
- One Indemnity Plan (traditional fee-for-service):
 - UnitedHealthcare Indemnity/Medicare Supplemental Indemnity Plan

POINT-OF-SERVICE (POS) PLANS

A POS plan combines features of an HMO and an indemnity plan. You receive care in one of two ways. There is an in-network HMO-like component offering a full range of services provided or authorized by your primary care physician or by an in-network specialist. In addition, there is an out-of-network component similar to traditional indemnity insurance. The out-of-network benefit provides payment for treatments received from non-network physicians or specialists after the co-insurance and a yearly deductible are met. You also will be responsible for any charge above the usual, customary, and reasonable (UCR) charges determined by the plan.

The POS plans do not require you to obtain a referral to visit a participating in-network

physician or specialist for medically necessary care.

Please Note

Once Medicare eligible, participants may not remain in the POS plans.

UnitedHealthcare Select Plus—Open POS

The Open POS plan is offered to retirees and their eligible dependents through UnitedHealthcare (UHC) Select Plus.

When you enroll in the UHC Select Plus plan, you should select a primary care physician (PCP) who will direct your care. You can contact UHC directly to select a PCP or use the PCP UHC automatically assigns when you enroll in the plan. You may change your PCP once you are enrolled in the plan by registering through the UHC website at www.myuhc.com or by calling 1-888-607-5214.

The Open POS is an open-access plan that allows you to see any in-network physician or specialist without a referral. If you receive care from any in-network specialist, benefits will be paid according to the in-network schedule of benefits outlined later in this document. If you choose to go out-of-network for medical care, you will receive benefits under the out-of-network schedule of benefits.

As a participant in this plan, you have access to UnitedHealthcare's national network of doctors and facilities. The availability of a national network allows access to in-network care for members wherever you are in the country, when traveling, and for dependent children when they are away at college.

A percentage of out-of-network benefits are paid after you meet an annual deductible of \$300 for individual coverage or \$600 for family coverage. Benefits generally are paid at 80 percent of the

UCR charges determined by the insurance carrier, depending on the type of service provided. The plan pays 100 percent of the UCR after you reach a \$1,000 out-of-pocket maximum. The out-of-pocket maximum excludes the deductible and the cost of services above the UCR. Some services, such as preventive care, are not covered out-of-network and are covered only when performed by an in-network physician.

You decide whether to stay in-network or use an out-of-network physician each time you receive medical care. Out-of-pocket expenses will vary depending on the types of services rendered.

Refer to the benefits comparison chart later in this document for more details.

UnitedHealthcare Select Plus— Closed POS

This option is open only to retirees and dependents not yet eligible for Medicare who were retired on or after December 31, 1999, and who were eligible to participate in the Closed POS plan as an active employee hired before January 1, 1994.

For more details about this plan, contact ERSC at 301-517-8100 or visit the ERSC website.

HEALTH MAINTENANCE ORGANIZATIONS

A health maintenance organization (HMO) offers a full range of services provided or authorized by your PCP or by an in-network specialist. You may only receive benefits for medical services and supplies received from a network provider, except in a true emergency. However, you do not have to meet a deductible before the plan pays applicable benefit costs.

Refer to the HMO comparison chart outlined later in this document for further details.

CareFirst BlueChoice HMO

BlueChoice is an individual practice HMO where you select a PCP from a list of participating doctors in the BlueChoice provider directory or online at www.carefirst.com. Your PCP will provide medical care and may refer you to an in-network specialist, as necessary. However, the plan is an open access plan, and referrals are not necessary to see an in-network specialist. Referrals are necessary for certain coverage, such as laboratory and X-ray services. Each covered family member may select a different PCP. You must select your PCP prior to your first appointment by contacting BlueChoice directly online or by phone at 1-800-545-6199.

Specialty care benefits are covered as follows:

- Chiropractic Manipulation: 20 visits/year, \$10 co-pay/visit
- Diabetic Education/Training: \$10 co-pay (benefits are paid at 100 percent of the allowed amount)
- Physical, Speech, and Occupational Therapy: 30 visits/year, \$10 co-pay/visit, 100 percent of allowed amount
- Away From Home Care*

**Away From Home Care (AFHC) is an out-of-area program that provides benefits for CareFirst BlueChoice plan participants residing outside of their local HMO service area for 90 days or more. Some areas of the country do not participate in the AFHC program. To take advantage of the AFHC program, members should contact CareFirst at 1-888-452-6403 for more information and enrollment procedures.*

Kaiser Permanente HMO

Kaiser Permanente is a center-based HMO with approximately 30 medical centers in the MCPS service area. You may receive information about locations at www.kp.org or from the provider directory. Medical centers are staffed by doctors, nurses, and specialists and offer a wide range of services such as pharmacy, laboratory, X-ray services, ambulatory surgery, and health education. We encourage you to select a center

and PCP that best meet your needs when you enroll in the plan. If you do not choose a center, Kaiser automatically will assign a center nearest to your residence of record.

When scheduling an appointment, be sure to ask for your PCP. You may call and change your PCP or medical center location at any time. Each of your covered family members may select a separate center and PCP. Your PCP is responsible for coordinating all health needs, including hospital and specialty care if needed. If you enroll in the Kaiser Permanente HMO, your prescription drug benefits and diabetic supplies are provided under this plan.

As a participant in the Kaiser Permanente HMO, you also may receive complementary medicine discounts via the ASHN (American Specialty Health Network). You can get discounts and preferred rates through ASHN on the following services:

- Chiropractic care, acupuncture, and massage therapy
- Fitness club memberships
- Health tools and health products

To select a provider, join a fitness club, or learn more about the services offered, go to www.kp.org/healthyroads or call the ASHN toll-free customer service line at 1-877-335-2746.

UnitedHealthcare Select HMO

UnitedHealthcare Select HMO is an individual practice HMO where you select a PCP from a list of participating doctors. If you do not select a PCP, one will be assigned to you. Participating doctors are listed in the UHC provider directory or online at www.myuhc.com. Your PCP will provide medical care and may refer you to network specialists, as necessary. However, referrals are not necessary to see an in-network specialist. Referrals are necessary for certain coverage, such as laboratory and X-ray services. Each family member may select a different PCP.

As a participant in this plan, you have access to UnitedHealthcare's national network of doctors and facilities. The availability of a national network allows access to in-network care for members wherever you are in the country, when traveling, and for dependent children when they are away at college.

UnitedHealthcare Select HMO and Medicare

MCPS and UnitedHealthcare (UHC) require retirees to complete the *UnitedHealthcare Medicare Crossover* form. The crossover form enables automatic processing of insurance claims filed with Medicare to your UHC Medicare Supplemental Indemnity plan. The *UnitedHealthcare Medicare Crossover* form is available on the ERSC website. Once completed, return the form to ERSC. Medical claims are submitted by the provider's office first to Medicare. Medicare determines the eligible amount, pays the Medicare portion of the claim, and then submits the claim to UnitedHealthcare for secondary payment. A chart outlining the benefits paid by Medicare and the UnitedHealthcare Select HMO is included in this booklet.

UnitedHealthcare Select HMO and Diabetic Supplies for Medicare Part B Enrollees

The Select HMO plan covers diabetic supplies under UnitedHealthcare's pharmacy program only for retirees enrolled in Medicare Part B. UnitedHealthcare's pharmacy program offers a broad network of pharmacies (more than 60,000 nationwide to provide convenient access to medications). Most pharmacies participate in the network. To confirm network participation for a particular pharmacy, you may check with your pharmacist or visit the online pharmacy service at www.myuhc.com.

Pharmacy benefits for diabetic supplies are covered as follows:

United Healthcare Prescription Plan	Retail Pharmacy	Mail Service Pharmacy
Tier 1	\$5 Co-payment per 31-day consecutive day supply	1 Co-payment for 31-day supply; 3 Co-payments per 90-day supply
Tier 2	\$20 Co-payment per 31-day consecutive day supply	

To fill prescriptions for diabetic supplies at a participating retail pharmacy, present your medical ID card to the pharmacist. Your medical ID card shows the Medco logo which allows for the cost of the diabetic supplies to be administered at the point of sale. The pharmacist will tell you how much you owe for the prescription.

The mail order service is optional. You are not required to use the plan's mail order program after the first refill of diabetic supplies at a retail pharmacy. For information on how to use the mail order benefit or obtain a mail order claim form, call the member services toll-free number on the back of your insurance card.

Insulin is not covered under the Select HMO plan. Refer to the prescription drug plan administered by CVS/Caremark for information about coverage for insulin and other prescription drugs.

Refer to the HMO plan chart in this document for more information about the HMO plans.

UNITEDHEALTHCARE INDEMNITY/ MEDICARE SUPPLEMENTAL INDEMNITY PLAN

MCPS requires all participants in the MCPS retiree benefit plan to enroll in Medicare Parts A and B when first eligible for Medicare in order to maintain medical health benefits through MCPS.

As of your Medicare eligibility date, Medicare will be the primary medical plan and the medical insurance coverage through MCPS will be the secondary medical coverage. Medicare-eligible retirees may elect the UnitedHealthcare Indemnity/Medicare Supplemental Indemnity plan. This plan provides coverage for medicare-eligible individuals that is secondary to Medicare.

MCPS retirees who experience a Medicare split, whereby one member of the family is Medicare eligible and the other plan participants are not, also may choose to enroll in the UnitedHealthcare Indemnity/Medicare Supplemental Indemnity plan. In this case, the plan provides primary coverage for the non-Medicare-eligible individual and secondary coverage to the Medicare-eligible individual. The primary coverage benefits are similar to those provided under the out-of-network feature of the Closed POS plan. Refer to the out-of-network column of the UnitedHealthcare Closed POS chart for more details regarding this benefit.

For Medicare enrollees, Medicare Part A is the hospital insurance and generally will pay all but the deductible on Medicare-approved inpatient services. Medicare Part B is the medical insurance and covers 80 percent of the Medicare-allowed amount for Medicare-approved outpatient services after the Medicare Part B yearly deductible. The "allowed amount" or "approved charge" is the amount the federal government sets for medical services. The UnitedHealthcare Medicare Supplemental Indemnity plan pays the Medicare Part A

hospital deductible, the Medicare Part B yearly deductible, and the Medicare Part B co-insurance of 20 percent. **If your medical service is not eligible for Medicare coverage, the service is not eligible for coverage under the UnitedHealthcare Medicare Supplemental Indemnity plan.**

When you receive care from a participating Medicare provider for Medicare-approved medical services and the medical provider accepts Medicare assignment, you should not have any out-of-pocket expenses. Medicare will pay 80% of the Medicare-allowed amount and your MCPS-sponsored supplemental plan will pay the other 20%. If you receive care from a non-participating Medicare provider for Medicare-approved medical services, this means that the medical provider does not accept the allowable amount. You will receive benefits from Medicare that are limited to the Medicare-allowed amount. The UnitedHealthcare Medicare Supplemental Indemnity plan will not cover any expense that exceeds the Medicare-allowed amount and you will be responsible for the additional charges. It is important that you check with your provider about Medicare assignment and any charges for which you may be responsible prior to receiving services. If you have questions regarding your provider's charges, you should contact Medicare prior to receiving services.

MCPS and UnitedHealthcare (UHC) require retirees to complete the *UnitedHealthcare Medicare Crossover* form. The crossover form enables automatic processing of insurance claims filed with Medicare to your UHC Medicare Supplemental Indemnity plan. The *UnitedHealthcare Medicare Crossover* form is available on the ERSC website. Once completed, return the form to ERSC. Medical claims are submitted by the provider's office first to Medicare. Medicare determines the eligible amount, pays the Medicare portion of the claim, and then submits the claim to UnitedHealthcare for secondary payment. A chart outlining the benefits paid by Medicare

and the Medicare Supplemental Indemnity plan is included in this booklet.

UnitedHealthcare Medicare Supplemental Indemnity Plan and Diabetic Supplies for Medicare Part B Enrollees

Diabetic supplies are covered for Medicare Part B enrollees under UnitedHealthcare's pharmacy program. If you are enrolled in the UnitedHealthcare Medicare Supplemental Indemnity plan and choose to receive your diabetic supplies through this plan, you must contact the member services toll-free number on the back of your insurance card to obtain a list of approved pharmacy providers. You will be responsible for any co-pays for your diabetic supplies.

PREVENTIVE CARE SERVICES

For Non-Medicare Eligible Retirees

As a result of the *Affordable Care Act*, certain preventive care procedures no longer will have co-pays when they are provided by in-network providers, regardless of your medical plan choice. The specific procedures provided for adults and children are listed separately in the following charts. Preventive care procedures not listed specifically will be covered by in-network providers with co-pays outlined in the HMO and POS comparison charts on the following pages. Out-of-network coverage remains unchanged, and co-pays are listed in the POS comparison chart later in this document.

For Medicare-Eligible Retirees

Medicare participants receive coverage for certain preventive care services with zero co-payments. For more information about Medicare coverage of preventive services, please see the booklet "Your Guide to Medicare's Preventive Services," available on the Medicare website at www.medicare.gov/Publications/Pubs/pdf/10110.pdf.

Preventive Services Covered with Zero Co-Pay for Non-Medicare Eligible Retirees

Preventive Service Covered	Who is Eligible, Additional Details
Abdominal Aortic Aneurysm Screening	one-time screening for men of specified ages who have ever smoked
Alcohol Misuse Screening and Counseling	all adults
Aspirin Use	men and women of certain ages
Blood Pressure Screening	all adults
Cholesterol Screening	adults of certain ages or at higher risk
Colorectal Cancer Screening	adults over 50
Depression Screening	all adults
Type 2 Diabetes Screening	adults with high blood pressure
Diet Counseling	adults at higher risk for chronic disease
HIV Screening	all adults at higher risk
Immunizations for: <ul style="list-style-type: none"> • Hepatitis A • Hepatitis B • Herpes Zoster • Human Papillomavirus • Influenza • Measles, Mumps, Rubella • Meningococcal • Pneumococcal • Tetanus, Diphtheria, Pertussis • Varicella 	doses, recommended ages, and recommended populations vary
Obesity Screening and Counseling	all adults
Sexually Transmitted Infection (STI) Prevention Counseling	adults at higher risk
Tobacco Use Screening	all adults and cessation interventions for tobacco users, expanded counseling for pregnant tobacco users
Syphilis Screening	all pregnant women, all adults at higher risk
Anemia Screening	pregnant women, on a routine basis
Bacteriuria Urinary Tract or Other Infection Screening	pregnant women
BRCA Counseling about Genetic Testing	women at higher risk
Breast Cancer Mammography Screenings	women over 40, every 1 to 2 years
Breast Cancer Chemoprevention Counseling	women at higher risk
Breast Feeding Interventions	women, to support and promote breast feeding
Cervical Cancer Screening	sexually active women
Chlamydia Infection Screening	younger women and other women at higher risk
Folic Acid Supplements	women who may become pregnant
Gonorrhea Screening	all women at higher risk
Hepatitis B Screening	pregnant women at their first prenatal visit
Osteoporosis Screening	women over age 60 depending on risk factors
Rh Incompatibility Screening	all pregnant women and follow-up testing for women at higher risk

Preventive Services Covered with Zero Co-Pay for Children of Non-Medicare Eligible Retirees

Service	Who is Eligible, Additional Details
Alcohol and Drug Use Assessments	adolescents
Autism Screening	children at 18 and 24 months
Behavioral Assessments	children of all ages
Cervical Dysplasia Screening	sexually active females
Congenital Hypothyroidism Screening	newborns
Developmental Screening	children under age 3, and surveillance throughout childhood
Dyslipidemia Screening	children at higher risk of lipid disorders
Fluoride Chemoprevention Supplements	children without fluoride in their water source
Gonorrhea Preventive Medication for the Eyes	all newborns
Hearing Screening	all newborns
Height, Weight, and Body Mass Index Measurements	children of all ages
Hematocrit or Hemoglobin Screening	children of all ages
Hemoglobinopathies or Sickle Cell Screening	newborns
HIV Screening	adolescents at higher risk
Immunization Vaccines for: <ul style="list-style-type: none"> • Diphtheria, Tetanus, Pertussis • Haemophilus Influenzae Type B • Hepatitis A • Hepatitis B • Human Papillomavirus • Inactivated Poliovirus • Influenza • Measles, Mumps, Rubella • Meningococcal • Pneumococcal • Rotavirus • Varicella 	children from birth to age 18; doses, recommended ages, and recommended populations vary
Iron Supplements	children ages 6 to 12 months at risk for anemia
Lead Screening	children at risk of exposure
Medical History	all children, available throughout development
Obesity Screening and Counseling	children of all ages
Oral Health Risk Assessment	young children
Phenylketonuria (PKU) Screening for Genetic Disorder	newborns
Sexually Transmitted Infection (STI) Prevention Counseling	adolescents at higher risk
Tuberculin Testing	children at higher risk of tuberculosis
Vision Screening	children of all ages

Health Maintenance Organization (HMO) Plans	Kaiser Permanente HMO	UnitedHealthcare Select HMO	CareFirst BlueChoice HMO
Annual Deductible	None	None	None
Preventive Care			
Routine Physical Exam	Covered in full	\$5 co-pay*	\$5 co-pay*
Well Baby/Child Care	Covered in full (under age 5)	\$5 co-pay*	\$5 co-pay*
Childhood Immunizations	Covered in full (under age 5)	\$5 co-pay*	\$5 co-pay*
Physician Services			
Physician Office Visit	\$5 co-pay	\$5 co-pay	\$5 co-pay
Specialist Office Visit	\$5 co-pay	\$5 co-pay	\$10 co-pay
Lab Work and X-rays	Covered in full	Covered in full	Covered in full
Allergy Shots	\$5 co-pay	\$5 co-pay	\$5 co-pay (\$10 co-pay for specialist)
Maternity Care			
Prenatal and Postnatal Care	\$5 co-pay, no charge once pregnancy is confirmed	\$5 co-pay first visit; covered in full thereafter per pregnancy	\$10 co-pay per visit; \$100 max co-pay per pregnancy
Physician Services	Covered in full	Covered in full	Covered in full
Hospital Services	Covered in full	Covered in full	Covered in full
Emergency Services (when medically necessary)			
Urgent Care Centers	\$5 co-pay	\$15 co-pay	\$10 co-pay
Emergency Room	\$100 co-pay (waived if admitted)	\$100 co-pay (waived if admitted)	\$100 co-pay (waived if admitted)
Emergency Physician Services	Covered in full	Covered in full	Covered in full
Emergency Ambulance	Covered in full if authorized	Covered in full	Covered in full
Hospital Services—Inpatient			
Semi-Private Room	Covered in full	Covered in full	Covered in full
Professional Services	Covered in full	Covered in full	Covered in full
Surgical Procedures	Covered in full	Covered in full	Covered in full
Specialty Care/Consultation	Covered in full	Covered in full	Covered in full
Anesthesia	Covered in full	Covered in full	Covered in full
Radiology and Drugs	Covered in full	Covered in full	Covered in full
Intensive Care	Covered in full	Covered in full	Covered in full
Coronary Care	Covered in full	Covered in full	Covered in full
Hospital Services—Outpatient			
Surgical Procedures	\$5 co-pay	\$25 co-pay	Covered in full
Professional Fees	Covered in full	Covered in full	Covered in full
Mental Health/Substance Abuse Services			
Inpatient Days	Covered in full	Covered in full, partial hospitalization co-pay \$25/visit up to 60 visits	Covered in full
Outpatient Visits	\$5 co-pay	\$5 co-pay	\$5 co-pay
Other Services			
Catastrophic Illness	Covered in full	Covered in full	Covered in full
Durable Medical Equipment	You pay 20%	You pay 25%** Prior notification is required for items more than \$1000	You pay 25%**
Home Health Care	Covered in full	Covered in full	Covered in full
Hospice Care	Covered in full	Covered in full	Covered in full
Skilled Nursing Care	Covered in full up to 100 days	Covered in full	Covered in full

*Applies to services not specifically listed in the previous preventive care charts.

**Does not include diabetic supplies such as lancets, glucose strips, etc. See CVS/Caremark Prescription for details.

Open Point-of-Service (POS) Plan	UHC Select Plus Open POS	
	In-Network	Out-of-Network
Annual Deductible	None	\$300 individual, \$600 family
Preventive Care		
Routine Physical Exam	\$10 co-pay*	Not covered
Well Baby/Child Care	\$10 co-pay*	80%, no deductible
Childhood Immunizations	Covered in full	80%, no deductible
Physician Services		
Physician Office Visit	\$10 co-pay	80% after deductible Routine: not covered
Specialist Office Visit	\$10 co-pay	80% after deductible Routine: not covered
Lab Work and X-rays	Covered in full	Diagnostic: 80% after deductible Routine: not covered
Allergy Evaluations	\$10 co-pay—each visit	80% after deductible
Allergy Shots	Covered in full	80% after deductible
Maternity Care		
Prenatal and Postnatal Care	\$10 co-pay first visit, covered in full thereafter	80% after deductible
Physician Services	Covered in full	80% after deductible
Hospital Services	Covered in full	80% after deductible
Emergency Service (when medically necessary)		
Urgent Care Centers	\$10 co-pay	80% no deductible
Emergency Room	\$100 co-pay (waived if admitted)	\$100 co-pay (waived if admitted)
Emergency Physician Services	Covered in full	Covered in full
Emergency Ambulance	Covered in full	Covered in full
Hospital Services—Inpatient		
Semi-Private Room	Covered in full	80% after deductible (up to 180 days)
Professional Services	Covered in full	80% after deductible
Surgical Procedures	Covered in full	80% after deductible
Specialty Care/Consultation	Covered in full	80% after deductible
Anesthesia	Covered in full	80% after deductible
Radiology and Drugs	Covered in full	80% after deductible
Intensive Care	Covered in full	80% after deductible
Coronary Care	Covered in full	80% after deductible
Hospital Services—Outpatient		
Surgical Procedures	\$10 co-pay	80% after deductible
Professional Fees	Covered in full	80% after deductible
Mental Health/Substance Abuse Services		
Inpatient Days	Covered in full	80% after deductible (up to 180 days)
Outpatient Visits	\$10 co-pay	80% after deductible
Other Services		
Catastrophic Illness	Covered in full	Covered in full after \$1,000 out-of-pocket expenses (excludes deductible)
Durable Medical Equipment	Covered in full**	80% after deductible**
Home Health Care/ Skilled Nursing Care	Covered in full	80% after deductible (up to 60 visits in- and out-of-network)
Hospice Care	Covered in full	80% after deductible

*Applies to services not specifically listed in the previous preventive care charts.

** Does not include diabetic supplies such as lancets, glucose strips, etc. See CVS/Caremark Prescription for details.

Please Note: All percentages shown for out-of-network service represent percent of Usual, Customary, and Reasonable (UCR) charge as determined by UHC Select Plus. The description of benefits and services is intended to provide a summary. For complete information, please refer to the Evidence of Coverage on the ERSC website.

Closed Point-of-Service (POS) Plan	UHC Select Plus Closed POS	
	In-Network	Out-of-Network
Annual Deductible	None	\$200 individual, \$400 family
Preventive Care		
Routine Physical Exam	\$5 co-pay*	Not covered
Well Baby/Child Care	\$5 co-pay*	80%, no deductible
Childhood Immunizations	Covered in full	80%, no deductible
Physician Services		
Physician Office Visit	\$5 co-pay	80% after deductible Routine: not covered
Specialist Office Visit	\$5 co-pay	80% after deductible Routine: not covered
Lab Work and X-rays	Covered in full	Diagnostic: 90% after deductible Routine: not covered
Allergy Evaluations	\$5 co-pay—each visit	80% after deductible
Allergy Shots	Covered in full	90% after deductible
Maternity Care		
Prenatal and Postnatal Care	\$5 co-pay first visit, covered in full thereafter	90% after deductible
Physician Services	Covered in full	90% after deductible
Hospital Services	Covered in full	90% after deductible
Emergency Service (when medically necessary)		
Urgent Care Centers	\$5 co-pay	80% no deductible
Emergency Room	\$100 co-pay (waived if admitted)	\$100 co-pay (waived if admitted)
Emergency Physician Services	Covered in full	Covered in full
Emergency Ambulance	Covered in full	Covered in full
Hospital Services—Inpatient		
Semi-Private Room	Covered in full	90% after deductible up to 180 days
Professional Services	Covered in full	90% after deductible
Surgical Procedures	Covered in full	90% after deductible
Specialty Care/Consultation	Covered in full	90% after deductible
Anesthesia	Covered in full	90% after deductible
Radiology and Drugs	Covered in full	90% after deductible
Intensive Care	Covered in full	90% after deductible
Coronary Care	Covered in full	90% after deductible
Hospital Services—Outpatient		
Surgical Procedures	Covered in full	90% after deductible
Professional Fees	Covered in full	90% after deductible
Mental Health/Substance Abuse Services		
Inpatient Days	Covered in full	100% up to 180 days (after deductible)
Outpatient Visits	\$5 co-pay	80% after deductible
Other Services		
Catastrophic Illness	Covered in full	Covered in full after \$1,500 out-of-pocket expenses (excludes deductible)
Durable Medical Equipment	Covered in full**	80% after deductible**
Home Health Care/ Skilled Nursing Care	Covered in full (up to 40 visits in- and out-of-network)	90% after deductible
Hospice Care	Covered in full	90% after deductible

*Applies to services not specifically listed in the previous preventive care charts.

** Does not include diabetic supplies such as lancets, glucose strips, etc. See CVS/Caremark Prescription for details.

Please Note: All percentages shown for out-of-network service represent percent of Usual, Customary, and Reasonable (UCR) charge as determined by UHC Select Plus. The description of benefits and services is intended to provide a summary. For complete information, please refer to the Evidence of Coverage on the ERSC website.

Montgomery County Public Schools Medicare Supplemental Chart*

2011 Medicare Supplemental Plan and Standard HMOs	Medicare	UHC Medicare Supplemental Indemnity	BlueChoice**	UnitedHealthCare Select**	Kaiser Medicare Plus**
Durable Medical Equipment	Pays 80% of approved amount (after Medicare Part B deductible)	Pays the Medicare Part B deductible, 20% Medicare coinsurance.	Pays the Medicare Part B deductible, 20% Medicare coinsurance, up to 75% of the allowed charge	Pays the Medicare Part B deductible, 20% Medicare coinsurance, up to 75% of the allowed charge	Pays the Medicare Part B deductible, 20% Medicare coinsurance (covered in full)
Hospice Care (Prescription coverage through Caremark)	Pays all but limited costs (outpatient drugs and 5% of inpatient respite care)	Pays the 5% Medicare coinsurance inpatient respite care	Pays the 5% Medicare coinsurance inpatient respite care	Pays the 5% Medicare coinsurance inpatient respite	Hospice care is provided under Medicare
Medical Expenses: Surgery, X-Ray/Lab, ER treatment within 72 hours of inpatient hospital visit	Pays 80% of approved amount (after Medicare Part B deductible)	Pays the Medicare Part B deductible, 20% Medicare coinsurance	Pays the Medicare Part B deductible and 20% Medicare coinsurance, after \$5 co-pay for routine illness and \$10 co-pay for specialist visits (after \$100 co-pay for emergency room visit waived if admitted)	Pays the Medicare Part B deductible and 20% Medicare coinsurance, after \$5 co-pay for routine illness and specialist visits (after \$100 co-pay for emergency room visit waived if admitted)	Pays the Medicare Part B deductible and 20% Medicare coinsurance, after \$5 co-pay for routine illness and specialist visits (after \$100 co-pay for emergency room visit-waived if admitted)
Outpatient Hospital Treatment	Pays 80% of approved amount (after Medicare Part B deductible)	Pays the Medicare Part B deductible and 20% Medicare coinsurance	Pays the Medicare Part B deductible, 20% Medicare coinsurance after \$25 co-payment	Pays the Medicare Part B deductible and 20% Medicare coinsurance after \$25 co-payment	Pays the Medicare Part B deductible, and 20% Medicare coinsurance; covered in full
Preventive Care	Pays full cost for certain services (see current Medicare handbook or www.medicare.gov)	Covers yearly mammograms, pap smears at 100%, pays 20% Medicare coinsurance for vaccinations approved by Medicare***	Covered in full after \$5 co-pay***	Covered in full after the \$5 co-pay***	Covered in full after \$5 co-pay***

*Benefits provided per calendar year unless otherwise specified.

**HMOs provide standard benefit package. Reimbursement is obtained from Medicare up to the limits shown.

***Some preventive care services are covered by Medicare with zero co-payments. Please see the Medicare website for additional information.

Montgomery County Public Schools Medicare Supplemental Chart

2011 Medicare Supplemental Plan and Standard HMOs	Medicare	UHC Medicare Supplemental Indemnity	BlueChoice**	UnitedHealthCare Select**	Kaiser Medicare Plus**
Hospitalization: Days 1–60	Pays all but Part A deductible	Pays Part A Deductible	Pays Part A Deductible	Pays Part A Deductible	Pays Part A Deductible
Days 61–90	Pays all but Part A deductible	Pays Part A Deductible	Pays Part A Deductible	Pays Part A Deductible	Pays Part A Deductible
Days 91–150	Pays all but Part A deductible	Pays Part A Deductible	Pays Part A Deductible	Pays Part A Deductible	Pays Part A Deductible
Days 151+	Pays nothing	Covered in full up to the 180 th day	Covered in full	Covered in full	Covered in Full
Blood (Inpatient)	Pays all but the first 3 pints per calendar year	Pays for the first 3 pints per calendar year	Pays for the first 3 pints per calendar year	Pays for the first 3 pints per calendar year	Pays all but the first 3 pints per calendar year
Blood (Outpatient)	Pays 80% of approved amount (after Medicare deductible and starting with 4th pint)	Pays for the first 3 pints, the Medicare Part B deductible, and 20% Medicare coinsurance	Pays for the first 3 pints, the Medicare Part B deductible, and 20% Medicare coinsurance	Pays for the first 3 pints, the Medicare Part B deductible, and 20% Medicare coinsurance	Pays all but the first 3 pints per calendar year
Post-Hospital Skilled Nursing Facility Care: Days 1–20	Pays 100%	Coverage not provided	Coverage not provided	Pays 100% up to 60 days/calendar year	Pays 100%
Days 21–100	Pays all but Part A Deductible	Pays Part A Deductible	Pays Part A Deductible up to 60 days a year	Pays Part A Deductible up to 60 days a year	Pays Part A Deductible (covered in full up to 100 days per benefit period)
Home Health Care	Pays 100% of approved amount	Coverage not provided	Coverage not provided	Pays 100% up to 60 visits/calendar year	Pays 100%

*Benefits provided per calendar year unless otherwise specified.

**HMOs provide a standard benefits package. Reimbursement is obtained from Medicare up to the limits shown.

Other Benefit Plan Coverage

In addition to medical coverage, you also may choose dental, vision, and prescription drug coverage when you enroll (refer to the appropriate section in this document for additional information). Rates for the 2011 plan year are included in this document.

You are responsible for updating beneficiary designations for your life insurance plans, your state and county pension plans, as well as the defined contribution plans [403(b) and 457(b)]. Forms to change your beneficiary(ies) are available on the ERSC website. Contact your defined contribution vendor directly to change beneficiaries.

Dental Coverage

If you are eligible for benefits, you may choose from two dental plans:

- Aetna Dental Preferred Provider Organization (PPO) or
- Aetna Dental Maintenance Organization (DMO).

You may change dental plans only during Open Enrollment.

DENTAL PREFERRED PROVIDER ORGANIZATION (PPO)

If you enroll in the Aetna Dental PPO, you have the freedom to select the dentist of your choice. You can access provider information by calling 1-800-282-0555 or visiting Aetna's website at www.aetna.com/docfind. Generally, you receive a higher level of benefits if you receive dental services from a participating (in-network) PPO dentist. If you receive dental services from a non-participating (out-of-network) dentist, you receive a less generous level of benefits. Out-of-network reimbursement is based on the schedule of dental benefits and is subject to deductibles, coinsurance, and reasonable and customary charges.

Prophylaxis, including scaling and polishing, is covered up to two times per calendar year. Orthodontic benefits under the PPO dental plan are not available to retirees or their dependents.

You must submit an Aetna dental claim form for reimbursement for out-of-network PPO expenses. The claim form is available on the ERSC website. The annual maximum benefit per covered participant is \$2,000.

Refer to the dental benefits chart for more information.

DENTAL MAINTENANCE ORGANIZATION (DMO)

If you wish to enroll in the Aetna DMO plan, you must enroll with a primary dentist from a list of participating DMO dentists prior to your first appointment. To obtain information and select a participating DMO provider, visit Aetna's website at www.aetna.com/docfind or call 1-800-843-3661.

The Aetna DMO does not require you to meet an annual deductible before benefits are paid, and there is not a maximum annual benefit limitation. However, benefits are paid only if you receive care from a dentist who is part of the DMO network. Benefits are paid at a certain percentage (100 percent for preventive or basic services and 75 percent for major services).

Refer to the following chart for more information about your dental options.

Dental Benefits	Aetna PPO		Aetna DMO
	In-Network Plan pays:	Out-of-Network Plan pays:	In-Network Only Plan pays:
Maximum Annual Benefit	\$2,000	\$2,000	None
Annual Deductible			
Class I	None	None	None
Class II	\$50	\$100	None
Class III	\$50	\$100	None
Diagnostic (Class I) Routine exams X-rays (bitewings, full series, panoramic) Prophylaxis (includes scaling and polishing) Fluoride (one treatment per year up to age 18) Sealants (one treatment every three years on permanent molars only under age 16) Oral Hygiene Instruction	100% Oral Hygiene Instruction not covered	80% Oral Hygiene Instruction not covered	100%
Basic (Class II) Amalgam Composite Filling (anterior tooth only) Pulp Capping Root Canal Therapy with X-rays and Cultures (other than molar root canal) Scaling and Root Planing	100%	80%	100%
Basic (Class II) Space Maintainers Molar Root Canal Therapy Osseous Surgery (periodontal surgery) General Anesthesia Surgical Removal of Impacted Teeth (partial bony/full bony)	100%	80%	75%
Major (Class III) Inlays, Onlays, and Crowns Full and Partial Dentures Bridge Pontics and Abutments	50%	40% Maximum eligible charge per service: \$400	75%

Vision Coverage

If you are eligible for benefits, you may choose to enroll for vision coverage offered through the National Vision Administrators, L.L.C. (NVA).

As a participant in the plan, you may use any licensed doctor, optometrist, or ophthalmologist for vision services and file a claim for a partial reimbursement with NVA. You will be reimbursed as follows:

Service	Maximum Benefit	Limits
Exams: Optometrist Ophthalmologist	\$25 \$33	One exam during any consecutive 18-month period
Frames: Frames only	\$20	One set of frames during any consecutive 18-month period (in lieu of contact lenses)
Lenses only, per pair: Single vision Bifocal Trifocal Lenticular	\$20 \$35 \$45 \$120	Two lenses during any consecutive 18-month period (in lieu of contact lenses)
Contact Lenses: Medically Necessary** Standard or Disposable	\$230 \$40	In lieu of lenses & frames

**Contact lenses are covered up to \$230 only if they are prescribed after cataract surgery or when needed to restore the visual acuity of the person's healthier eye to 20/70 or better, and if this cannot be accomplished with regular glasses. Otherwise, they are covered at \$40, in lieu of glasses.

This coverage does not provide benefits for the following:

- More than one eye examination, including refraction, and two lenses per person during any consecutive 18-month period.
- More than one set of frames per person during any consecutive 18-month period.
- Services and materials in connection with special procedures, such as orthoptics and vision training, or in connection with medical or surgical treatment of the eye.
- Sunglasses, plain or prescription.
- Replacement of lost, stolen, or broken lenses or frames furnished under this benefit.
- Eye examinations required by an employer as a condition of employment, where the employer is required to provide by virtue of a labor agreement or a government body.
- Any eye care to the extent that benefits are payable for the service or supply under any other coverage of the plan, such as infections of the eye and eye surgery that are covered under your medical plan.

OPTI-VISION PROGRAM

MCPS also has selected NVA to offer a discount vision care program that includes eye examinations, eyeglasses, and supplies at discount prices under the Opti-Vision program.

The discount vision plan enables participants to purchase glasses, standard or disposable contact lenses, frames, and related services at discount prices. The plan also provides discount LASIK surgery at more than 100 locations across the United States. Vision plan participants can schedule a complimentary evaluation.

For additional information on LASIK surgery, please call 1-877-295-8599 or visit www.e-nva.com. Your out-of-pocket expenses are reduced when using an NVA network provider. In addition, there is a mail order program available to plan participants where you can obtain contact lenses, including disposable lenses, at a discounted rate. A list of participating providers is available at www.e-nva.com.

When you enroll in the plan, you will receive a vision plan ID card, a plan description, a provider directory, and claim forms. Please review the specific information included in this document for details of the NVA Opti-Vision discount program.

Prescription Drug Coverage

Two prescription drug plans are offered to MCPS retirees. Eligibility for a plan depends on which medical plan you choose. If you enroll in a UnitedHealthcare or CareFirst BlueChoice medical plan or if you decline medical coverage, then you are eligible to enroll in the CVS/Caremark prescription drug program.

If you enroll in the Kaiser Permanente HMO, then you must enroll in the Kaiser Permanente prescription drug plan to receive a prescription drug benefit.

CVS/CAREMARK PRESCRIPTION PLAN

The CVS/Caremark prescription plan provides benefits for short-term medications to be filled at participating retail pharmacies, using the CVS/Caremark prescription drug card. Short-term medications are medicines prescribed for short-term illnesses, such as a cold, flu, or infection, generally requiring no more than a 30-day supply.

CVS/Caremark provides two options for filling long-term maintenance medications. You may fill your 90-day supply of long-term maintenance medication at any CVS pharmacy, or you may receive your 90-day supply of maintenance medication through the CVS/Caremark Mail Service pharmacy. After an initial fill and one refill at a participating retail pharmacy, you must fill your long-term maintenance medications either at any CVS pharmacy or through CVS/Caremark's Mail Service pharmacy to avoid additional costs.

Long-term maintenance medications generally are used to treat long-term chronic conditions, such as high blood pressure, arthritis, coronary artery disease, and diabetes.

MCPS offers retirees the opportunity to choose between two prescription plan options administered by CVS/Caremark. Plan Option A

has lower co-pays but higher monthly premiums. Plan Option B has higher co-pays, but lower monthly premiums. Both options have a three-tier co-pay structure and provide financial incentives for using generic drugs, using preferred brand name drugs, and purchasing maintenance medications through CVS/Caremark's mail order pharmacy. Refer to the charts below for more information:

Prescription Option A	Retail (up to 30-day supply)	CVS/Caremark Mail Service Pharmacy or CVS retail pharmacy (up to 90-day supply)
CVS/Caremark Generic	\$5 co-pay 1 refill allowed for maintenance medications	\$10 co-pay
CVS/Caremark Preferred Brand Name (no generic equivalent)*	\$15 co-pay 1 refill allowed for maintenance medications	\$30 co-pay
CVS/Caremark Non-Preferred Brand Name**	\$25 co-pay 1 refill allowed for maintenance medications	\$50 co-pay***

Prescription Option B	Retail (up to 30-day supply)	CVS/Caremark Mail Service Pharmacy or CVS retail pharmacy (up to 90-day supply)
CVS/Caremark Generic	\$10 co-pay 1 refill allowed for maintenance medications	\$20 co-pay
CVS/Caremark Preferred Brand Name (no generic equivalent)*	\$25 co-pay 1 refill allowed for maintenance medications	\$50 co-pay
CVS/Caremark Non-Preferred Brand Name**	\$35 co-pay 1 refill allowed for maintenance medications	\$70 co-pay***

*Detailed information provided on CVS/Caremark's website.

**If you purchase a brand name drug when a generic equivalent exists, you pay the generic drug co-pay plus the difference between the non-preferred brand name drug and generic drug cost. Example using RX Option B: Generic drug cost is \$100, Non-Preferred Brand Name drug cost is \$200, and your co-pay is \$110.

***There is no penalty for purchasing a brand name drug that has a generic equivalent if a letter of medical necessity is filed and approved. See details below.

Please Note

You can purchase your 90-day supply of maintenance medication at a CVS pharmacy for the same co-pay as the CVS/Caremark Mail Service pharmacy.

If you choose *not* to purchase a maintenance medication at a CVS pharmacy or through CVS/Caremark Mail Service after two fills at another retail pharmacy, you will pay the corresponding co-pay, plus the difference between the mail order and retail prescription cost.

Note: Medicare enrollees are allowed to purchase a 90-day supply of diabetic supplies at a CVS pharmacy or CVS/Caremark Mail Service Pharmacy. Medicare Part B-eligible drugs, excluding diabetic supplies, are limited to a 30-day supply.

To take advantage of the lowest co-pay, choose generic drugs when available. Plan participants who choose to purchase a brand name drug when a generic equivalent exists will be required to pay the generic drug co-pay plus the difference between the cost of the brand name drug and its generic equivalent.

When your doctor certifies in a letter (along with your prescription) that it is medically necessary to prescribe a brand name drug and not its generic equivalent, if it meets the FDA-approved diagnosis criteria, you will be charged the brand name co-pay without penalty for mail order only.

The letter of medical necessity must be written on the doctor's office letterhead (not written on the prescription) and must contain details of the medical reason accompanied by the prescription. Simply stating that in his/her medical opinion brand name drugs are better than generic drugs is not sufficient medical documentation. CVS/Caremark will require yearly updates of medical necessity.

The letter of medical necessity and prescription should be sent to:

CVS/Caremark
Department of Appeals, MC109
P.O. Box 52084
Phoenix, AZ 85072-2084
or fax to: 1-866-689-3092.

When using CVS/Caremark Mail Service pharmacy, the plan provides two options for the purchase of brand name drugs that do not have a generic equivalent:

- Option A has a \$30 co-pay and Option B has a \$50 co-pay for any preferred brand name drug that appears on CVS/Caremark's Primary Drug list (updated quarterly) or
- Option A has a \$50 co-pay and Option B has a \$70 co-pay for non-preferred brand name drugs that do not appear on CVS/Caremark's Primary Drug list

The Primary Drug list is a list of preferred, brand-name medications that have been carefully reviewed and selected by the CVS/Caremark National Pharmacy and Therapeutics Committee of practicing doctors and clinical pharmacists for their safety, quality, and effectiveness. You can help control the amount you pay for prescriptions by asking your doctor to prescribe medications on the Primary Drug list. The medicines on the Primary Drug list are not equivalents of non-preferred brand-name medicines, but are medicines in the same therapeutic category used to treat the same condition.

For example, there are several drugs on the market for lowering cholesterol. Familiar names include Lipitor and Vytorin. Lipitor is on CVS/Caremark's Primary/Preferred Drug list and would be available at either the \$15 co-pay at retail and \$30 co-pay at mail order for Option A or \$25 co-pay at retail and \$50 co-pay at mail order for Option B. Vytorin is not on the Primary/Preferred Drug list and would be available at either the \$25 co-pay at retail and \$50 co-pay at mail order for Option A and \$35 co-pay at retail and \$70 co-pay at mail order for Option B. Remember, not every drug listed on the Primary Drug list is covered by MCPS. CVS/Caremark updates the Primary Drug list

quarterly. The complete list is available on the CVS/Caremark website at www.caremark.com.

CVS/Caremark Mail Service Pharmacy

If you are taking a maintenance medication, you are allowed an initial fill and one refill up to a 30-day supply at a retail pharmacy at the applicable co-pay. Thereafter, you must either use the CVS/Caremark Mail Service Pharmacy or fill your maintenance medication prescription at any CVS pharmacy. When utilizing a CVS pharmacy or the CVS/Caremark Mail Service pharmacy, you can obtain up to a 90-day supply of medication for the same co-pay. If you choose to purchase a maintenance medication at a retail pharmacy other than a CVS pharmacy after a second fill, you will be required to pay the retail co-pay plus the difference between the mail order and retail cost of the drug.

To receive a 90-day supply of medication at a CVS pharmacy, ask your doctor for a prescription for up to a 90-day supply of medication, plus refills as appropriate (three refills maximum), and submit directly to the CVS pharmacist.

To participate in the CVS/Caremark Mail Service pharmacy, ask your doctor for a prescription for up to a 90-day supply of medication, plus refills as appropriate (three refills maximum). Complete a Patient Profile/Order Form, available from ERSC and on the ERSC website, and mail the form, along with the original prescription, to CVS/Caremark. Keep a copy of the prescription for your records and allow a minimum of 10 to 14 business days for delivery. If you need to begin taking a maintenance medication immediately, have your doctor write two prescriptions: one to be filled at a retail pharmacy up to 30 days, and the other for up to a 90-day supply to be filled through the mail order pharmacy.

If you wish to change your current long-term prescription from CVS/Caremark Mail Service to a CVS pharmacy, you must call Customer Care at 1-800-378-7558.

Coverage for over-the-counter drugs, cosmetic drugs, experimental drugs, and vitamins is excluded under the MCPS plan. While not all drugs are covered, those that are not may be filled at 100 percent of the discounted cost available through the CVS/Caremark prescription plan.

The following medications have prior authorization requirements, corresponding programs, or quantity limits:

- Anabolic steroids, some treatments for acne, botox, growth hormones, and medication to treat fungal infections all require prior authorization.
- Smoking cessation drugs and weight loss medications require corresponding programs.

Your doctor will need to contact the prior authorization staff with your diagnosis. If it meets the FDA-approved diagnosis criteria, your prescription will be approved. The prior authorization number is 1-800-626-3046. The prior authorization will be valid through the life of the prescription (maximum of one year). CVS/Caremark's website provides information on how to use the mail order benefit, forms you can download (mail order claim, etc.), and a feature to request refills once you are registered. You may obtain forms from ERSC and the ERSC website. You also may refill your prescriptions using CVS/Caremark's automated telephone service at 1-800-378-7558.

If you fill a prescription at a non-participating pharmacy, you must pay the full cost of the prescription and may file a paper claim for partial reimbursement. Reimbursement is limited to the network price (an amount that is normally less than the retail price) of the drug minus the appropriate co-pay. Most major pharmacies participate in the CVS/Caremark network.

Please ask your pharmacist or refer to CVS/Caremark's website to determine if your pharmacy participates with CVS/Caremark.

Diabetic Supplies

CVS/Caremark will cover diabetic supplies, including test strips, lancets, swabs, and meters. The medical plans will cover insulin pumps and supplies associated with the pumps under durable medical equipment provisions. Supplies are limited up to:

- 204 strips every 30 days
- 200 lancets every 30 days
- 200 alcohol swabs every 30 days
- Lancet device limit of 1 per 180 days

You can receive up to 612 strips, swabs, and lancets every 90 days through CVS/Caremark Mail Service Pharmacy.

Retirees and Dependents Covered by Medicare Part B

Medicare Part B eligible prescription drugs, excluding diabetic supplies, will be filled only at a 30-day maximum established by Medicare even if using the mail order program.

Some important facts to consider when receiving diabetic supplies or Medicare Part B eligible drugs:

- Members using the CVS/Caremark Mail Service Pharmacy must submit a doctor's diagnosis along with the prescription to receive the standard mail order supply for 90 days. If a diagnosis is not provided, the prescription will be filled only for the maximum 30-day supply limit established by Medicare.
- Medicare Part B covers certain specialty drugs, including diabetic supplies. Filing claims for diabetic supplies with Medicare saves money for you and MCPS.
- CVS/Caremark members enrolled in Medicare and receiving diabetic supplies or Medicare Part B-eligible drugs will be required to complete a CVS/Caremark Assignment of Benefits form before the prescription can be filled. CVS/Caremark will provide this form when the form is necessary.

- CVS/Caremark members using CVS/Caremark do not have to file a direct claim with Medicare. CVS/Caremark electronically submits the claim for diabetic supplies and Medicare Part B-eligible drugs on your behalf. Please contact CVS/Caremark at 800-378-7558 if you have questions.
- CVS/Caremark members enrolled in Medicare must make the Medicare-required 20 percent co-payment at the time of purchase (payable through CVS/Caremark). Members using the CVS/Caremark Mail Service pharmacy will be reimbursed by CVS/Caremark after Medicare processes each claim. This process may take up to four months for reimbursement. Members using a CVS retail pharmacy must submit a paper claim to their health plan in order to receive the 20 percent reimbursement.

KAISER PERMANENTE PRESCRIPTION PLAN

All non-Medicare eligible retirees enrolled in the Kaiser Permanente medical plan who elect to receive prescription benefits will receive their prescription benefit through Kaiser. Medicare members must elect prescription coverage and have a different co-pay structure. Kaiser Permanente has filed with Medicare to be a Medicare Part D provider. Enrollment in the Kaiser Prescription drug program is automatic for Medicare plan participants. Kaiser Permanente Medicare Plus includes enrollment in Medicare Part D. If you enroll in another Medicare Part D plan, your Kaiser Permanente Medicare Plus membership will be terminated on the start day of your new Medicare Part D plan.

The Kaiser prescription plan covers prescriptions you fill at either Kaiser Medical Center pharmacies, participating network pharmacies, or through Kaiser mail order pharmacy.

Short-term medications are those prescribed for illnesses such as colds, flu, and ear/sinus infections. You can obtain up to a 60-day supply

at a Kaiser Medical Center pharmacy or a Kaiser participating network pharmacy.

Long-term maintenance medications and prescriptions taken for chronic illnesses may be obtained up to a 90-day supply via Kaiser’s mail order program. Long-term maintenance medications are those prescribed for high blood pressure, arthritis, heart conditions, and diabetes.

The Kaiser plan does not pay benefits for over-the-counter cosmetics, experimental drugs, or vitamins. Prescriptions written by a dentist will be covered when written either for antibiotics or pain medications. For prescriptions that do not meet these conditions, you must contact your Kaiser physician; otherwise, you will not receive benefits for these prescriptions.

Retail Pharmacy

You can receive benefits for prescriptions you fill at any participating Kaiser Medical Center pharmacy or any participating network pharmacy. Simply present your Kaiser member ID card when you fill your prescription. When you fill your prescription at a Kaiser Medical Center pharmacy, you pay the \$5 co-pay for up to a 60-day supply for a generic drug or a brand-name drug when there is not a generic available. When you fill your prescription at a participating network pharmacy, you pay a \$10 co-pay for up to a 60-day supply for a generic drug or a brand name drug when there is not a generic available.

Major and independent pharmacies participate with Kaiser. Please visit Kaiser’s website at www.kp.org for a complete list. The quantity limitation for medications obtained on the retail level is up to a 60-day supply for non-Medicare participants and 90-day supply for Medicare-eligible participants.

Mail Order Service

You can use the mail order program to fill up to a 90-day supply of maintenance medications with the \$5 co-pay for non-Medicare participants and a \$3 co-pay for Medicare eligible participants. To participate in the mail order program, ask your doctor for a written

prescription for up to a 90-day supply of medication, plus refills as appropriate. You should fill new maintenance prescriptions at your Kaiser Medical Center pharmacy for the first fill so that you have the opportunity to consult with your pharmacist. Please allow seven business days for delivery.

Refer to the chart below for more information about your costs for prescriptions under the plan:

	Kaiser Medical Center Pharmacy	Mail Order	Kaiser Network Pharmacy
Kaiser Non-Medicare	\$5 co-pay (up to 60-day supply)	\$5 co-pay (up to 90-day supply)	\$10 co-pay (up to 60-day supply)
Kaiser Medicare	\$5 co-pay (up to a 60-day supply)	\$3 co-pay (up to a 90-day supply)	\$10 co-pay (up to a 60-day supply)
	\$7.50 co-pay (up to a 90-day supply)		\$15 co-pay (up to a 90-day supply)

Life Insurance

Life Insurance Continuation at Retirement

At retirement, you may either elect to continue your basic employee term life insurance coverage or to cancel your coverage. If you elect to cancel your coverage, you are not permitted to reenroll.

At retirement, the amount of life insurance in force is 42.5 percent of your active employee basic term life insurance amount. For each of the next four years, on the anniversary of your retirement, the life insurance amount will reduce by 7.5 percent of the active life amount. On the 4th anniversary of your retirement, the life

insurance amount becomes 12.5 percent of the active life amount and will remain at that level for your lifetime as long as the premiums are paid.

The monthly premium for life insurance is \$.3967 per \$1,000 of coverage per month. The premiums will be deducted directly from your retirement check. Rates for retiree life are subject to change. See the following chart for an example of the life insurance reduction.

For Example: Active Life Value = \$154,000

	Value	Monthly Rates
1 st Year	\$65,450	\$25.96
2 nd Year	\$53,900	\$21.38
3 rd Year	\$42,350	\$16.80
4 th Year	\$30,800	\$12.22
5 th Year	\$19,250	\$ 7.64

You and MCPS share the cost of your life insurance coverage. You pay 36 percent of the cost for coverage and MCPS pays 64 percent.

Please remember to update your beneficiary information as your personal situations change. You can make life insurance beneficiary updates by completing MCPS Form 455-22: *Retiree Benefit Plan Enrollment*. (Note: The enrollment form does not update your beneficiaries for retirement/pension plans or 403(b) or 457(b) defined contribution plans.)

If you did not elect to continue coverage at the time of retirement, you are not eligible to re-enroll in life insurance after you retire.

Accelerated Death Benefit

MCPS life insurance plans written through Prudential offer an accelerated death benefit. This benefit provides a payment of up to 75 percent of your life insurance benefit if your life expectancy is 12 months or less, and the payment can be used for any purpose. Any remaining life insurance benefits will be paid to your beneficiary(ies) after your death.

To apply for this benefit, you must submit an Accelerated Benefit Option Claim Form, available on the ERSC website. Please read the instructions carefully; forward the portion for completion by your employer to ERSC.

Long-Term Care

MCPS offers you the opportunity to purchase long-term care insurance at group rates through Prudential Life Insurance Company of America. You enroll directly through Prudential for this coverage.

You should contact the Prudential Customer Service line at 1-800-732-0416 to request an enrollment kit and/or ask questions about the program.

You also can visit Prudential's website at www.prudential.com to review detailed descriptions of plan options and eligibility features, as well as online enrollment at www.prudential.com/gltc/mca.html. When accessing the website, you will be prompted to enter a group name and password. Enter the following:

- Group name: MCPS
- Password: mcpsltc

Please note

You will be required to meet Prudential's underwriting standards. Long-term care coverage also is offered to certain family members (your spouse, parents, grandparents, parents-in-laws, and domestic partners) at the same group rates. Family members who wish to apply for this coverage must meet Prudential's underwriting standards regardless of the enrollment date.

Retiree Contribution for Medical, Prescription, Dental and Vision Coverage

The retiree benefits rate structure has been updated effective July 1, 2011.

Please see the *Retiree Benefit Summary: Rate Update Supplement* for complete details and current rates, available at:

www.montgomeryschoolsmd.org/uploadedFiles/retiree_benefit_summary_supplement.pdf

Frequently Requested Websites and Phone Numbers

Employee and Retiree Service Center <i>www.montgomeryschoolsmd.org/departments/ersc</i>	301-517-8100
Office of Human Resources <i>www.montgomeryschoolsmd.org/departments/personnel</i>	301-279-3204
Aetna Dental Plan <i>www.aetna.com</i>	
DMO	800-843-3661
PPO	800-282-0555
Aetna Large Pension	800-952-2700
Carefirst BlueChoice HMO Plan <i>www.carefirst.com</i>	800-545-6199
Caremark Prescription Plan <i>www.caremark.com</i>	800-378-7558
Kaiser Permanente HMO and Prescription Plans <i>www.kp.org</i>	800-777-7902
Maryland State Retirement Agency <i>www.sra.state.md.us</i>	800-492-5909
Medicare <i>www.medicare.gov</i>	800-633-4227
National Vision Administrators Plan <i>www.e-nva.com</i>	800-672-7723
Prudential Long Term Care <i>www.prudential.com/glrc</i>	800-732-0416
Social Security Administration <i>www.ssa.gov</i>	800-772-1213
UnitedHealthcare Select Plus Point of Service Plans <i>www.myuhc.com</i>	888-607-5214
United Health Care Select HMO <i>www.myuhc.com</i>	800-638-1103



Retiree Benefit Plan Enrollment

Employee and Retiree Service Center (ERSC)
MONTGOMERY COUNTY PUBLIC SCHOOLS
7361 Calhoun Place, Ste. 190 • Rockville, Maryland 20855

MCPS Form 455-22
April 2011

INSTRUCTIONS: All new retirees must make a selection in each category. Complete both sides, sign and return to the Employee and Retiree Service Center (ERSC). This form must be signed at the bottom of pages 1 and 2. **You may fax enrollment forms to 301-279-3642/301-279-3651 or e-mail an electronically signed Adobe PDF file to ERSC@mcpsmd.org. Please do not mail copies to ERSC once you have faxed or e-mailed the enrollment form. A confirmation of your requested change(s) will be sent to you. Unsigned forms will be returned to you and become your responsibility to resubmit to ERSC by the appropriate deadline.**

SECTION I: RETIREE INFORMATION—Please print. If your address has changed, please submit MCPS Form 445-1 with your benefit enrollment form. Benefit enrollment confirmations are sent to the address on file.

Name _____ Employee ID # 0 0 0 0 _____ SSN # _____
Last 4 digits

Address _____
Street City State Zip

Home Phone # _____ E-mail _____ **Retiree Date of Birth** ____/____/____

Retirement Date ____/____/____ (new and existing retirees) **Spouse Date of Birth** ____/____/____

SECTION II: RETIREE ENROLLMENT INFORMATION

- Continuation of Benefits in Retirement (new retirees only)
- Open Enrollment
- Transfer to active spouse or/QSSDP MCPS plan
(must include MCPS Form 455-20, *Employee Benefit Plan Enrollment*)
- Re-enrollment/Qualifying Event (if coverage was canceled after 7-1-98)
- I **cancel/decline** all benefit plan enrollment—
skip to **SECTION VI, LIFE INSURANCE OPTION**
- Drop dependent(s)
- Deceased dependent—date of death ____/____/____
- Change of Beneficiary only—skip to **SECTION VII, LIFE INSURANCE BENEFICIARY DESIGNATION**

SECTION III: RETIREE LEVEL OF HEALTH COVERAGE

- Individual
- Two-Party
- Family

You must make a selection in each section. This form must be signed for selections and designations to be valid.

SECTION IV: RETIREE BENEFIT PLAN ENROLLMENT INFORMATION—You must make a selection in each category A-D. Please consult the Retiree Benefit Summary for Benefit Plan enrollment qualifications. **If you do not make a prescription drug selection, you will be defaulted to Option A. Medicare-eligible retirees (and their eligible dependents) must enroll in Medicare Parts A and B to continue coverage with MCPS. If you enroll in a private Medicare Part D plan, all MCPS prescription coverage will be cancelled.**

CATEGORY A (Medical Plans)—

PLEASE SELECT ONE (1) OF THE FOLLOWING OPTIONS

HEALTH MAINTENANCE ORGANIZATION (HMO) PLANS

- CareFirst BlueChoice HMO
- Kaiser Permanente HMO
- UnitedHealthcare Select HMO

OPEN POINT-OF-SERVICE (POS) PLANS

- UnitedHealthcare Select Plus POS¹

CLOSED POINT-OF-SERVICE (POS) PLAN

- UnitedHealthcare Select Plus POS¹
(Eligibility requirements for the closed POS Plan are available in the Retiree Benefit Summary.)
- UnitedHealthcare Indemnity/Medicare Supplemental Plan
- I **decline** medical coverage
- No change to **medical plan**²

CATEGORY B (Prescription Drug Plans)—Please select one

- Caremark (available to all retirees except Kaiser HMO members)
 - Option A Option B
- Kaiser (**only** available to Kaiser HMO members)
- I **decline** prescription drug coverage
- No change to **prescription drug plan**²

CATEGORY C (Dental Plans)—Please select one

- Aetna Preferred Provider Organization (PPO)
- Aetna Dental Maintenance Organization (DMO)
(Benefit plan participant must reside in a DMO service area.)
- I **decline** dental coverage
- No change to **dental plan**²

CATEGORY D (Vision Plan)—Please select one

- National Vision Administrators (NVA)
- I **decline** vision coverage
- No change to **vision plan**²

¹When a retiree or dependent becomes Medicare-eligible, your health plan will coordinate with Medicare. At that time, plan changes will be required.

²If you are a new retiree, you may not select "No Change to Plan."

SIGNATURE REQUIRED

_____/_____/____ (continue on reverse side)
Signature Date

SECTION V: COVERED PARTICIPANTS—To enroll or drop dependent(s).

First Name	Last Name	MI	Social Security #	Date of Birth	Sex	Enroll/ Drop
Spouse						<input type="checkbox"/> / <input type="checkbox"/>
Child						<input type="checkbox"/> / <input type="checkbox"/>
Qualified Same Sex Domestic Partner (QSSDP)*						
						<input type="checkbox"/> / <input type="checkbox"/>

***Please Note:** To enroll or re-enroll a QSSDP you must provide the Employee and Retiree Service Center with certification, verifying you and your dependent's continuous coverage during the previous twelve months prior to enrollment or re-enrollment. Please refer to the Retiree Benefit Summary on the ERSC website for further explanation of benefit qualifications. The completed QSSDP affidavit should include required supporting documentation. If coverage is cancelled, you may be eligible to re-enroll in the future.

FOR ADDITIONAL COVERED DEPENDENTS, PLEASE ATTACH A SEPARATE SHEET OF PAPER.

SECTION VI: BASIC TERM LIFE INSURANCE

- Continue at retirement
- I **cancel/decline** Basic Term Life Insurance (You may not re-enroll once life insurance is cancelled.)
- No change

SECTION VII: LIFE INSURANCE BENEFICIARY DESIGNATION

- Benefits shall be divided equally among Primary Beneficiaries (or Contingent Beneficiaries), unless otherwise stated.
- The Contingent Beneficiary(ies) shall be entitled to life insurance benefits in the event there is no surviving Primary Beneficiary.
- If designating a Trust as a beneficiary, please provide a copy of the title, trustee, address, and signature pages of the Trust.

Please check **Primary** or **Contingent** for each designated beneficiary. If neither box is checked, the named beneficiary will be deemed as a **Primary** Beneficiary.

No change

Primary

Name _____ Social Security # _____-____-_____

Address _____

Share _____ % Relationship _____

Primary **Contingent**

Name _____ Social Security # _____-____-_____

Address _____

Share _____ % Relationship _____

Primary **Contingent**

Name _____ Social Security # _____-____-_____

Address _____

Share _____ % Relationship _____

Primary **Contingent**

Name _____ Social Security # _____-____-_____

Address _____

Share _____ % Relationship _____

FOR ADDITIONAL BENEFICIARIES, PLEASE ATTACH A SEPARATE SHEET OF PAPER.

This form must be signed for selections and designations to be valid.

SIGNATURE REQUIRED _____ /_____/_____
Signature Date

Printed name _____ Employee ID # 0 0 0 0 _____

Montgomery County Public Schools
Employee and Retiree Service Center (ERSC)
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