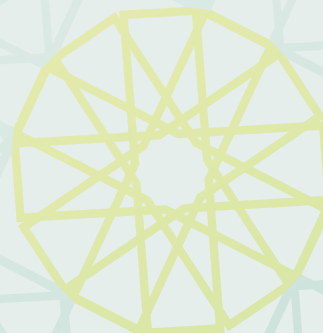


2027

Retiree Benefit Summary

EFFECTIVE JANUARY 1, 2027

- MEDICAL
- PRESCRIPTION DRUGS
- DENTAL
- VISION
- LIFE



Employee and Retiree Service Center

45 W. Gude Drive, Suite 1200, Rockville, MD 20850

240-740-8100 ▪ www.montgomeryschoolsmd.org/departments/ersc





VALUES

*Learning
Respect
Relationships
Excellence
Equity*

VISION

Future Ready

All students will graduate ready to thrive in a changing world—with the knowledge, skills, and confidence necessary to lead, adapt, and make a positive impact in their communities and beyond.

MISSION

To Unleash Potential

All students will receive a solid academic foundation, grounded in strong critical thinking skills, with opportunities to enhance and enrich their learning. All students will develop resilience, be adaptable, and have a lifelong passion for learning. All students will become effective communicators and collaborators predicated on meaningful relationships. All students will make a positive impact in their community and be ready for success in their personal and professional life.

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15 West Gude Drive
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www.montgomeryschoolsmd.org



■ 2027 Retiree Benefit Summary

Montgomery County Public Schools (MCPS) offers eligible retirees and their dependents a comprehensive benefit plan, including medical, dental, vision, and prescription drug coverage, effective January 1, 2027.

The *2027 Retiree Benefit Summary* provides information about eligibility, benefit costs, enrollment forms, and important contact information. Additional plan details, including rate schedules and evidence of coverage documents, are available on the Employee and Retiree Service Center (ERSC) website at www.montgomeryschoolsmd.org/departments/ersc.

■ ERSC Contact Information and Hours

Staff are available in person, by phone, email, or via ERSC connect, an online portal.

- **ADDRESS:** 45 W. Gude Drive, Suite 1200, Rockville, MD 20850
- **TELEPHONE:** 240-740-8100
- **EMAIL:** ersc@mcpsmd.org
- **ERSC CONNECT:** montgomery.service-now.com/csp?id=csp_login

■ Hours of Operation:

- **MONDAYS, TUESDAYS, THURSDAYS, AND FRIDAYS:** 8:00 a.m.–12:45 p.m. and 2:00–4:30 p.m. (Phones close at 4:15 p.m.)
- **WEDNESDAYS:** 10:00 a.m.–12:45 p.m. and 2:00–4:30 p.m. (Phones close at 4:15 p.m.)

IMPORTANT NOTICE

You are not enrolled automatically in MCPS retiree benefits. New retirees must enroll 30 days prior to their effective date of retirement or wait for a future Open Enrollment, held each fall, with coverage effective January 1. In addition, if you or your eligible dependents are eligible for Medicare when you retire, you will need to submit your Medicare Part A and B card to **ERSC 30 days prior to your effective date of retirement**. You must complete MCPS Form 455-22, *Retiree Benefit Plan Enrollment*, to join the Retiree Benefit Plan. This enrollment form also is used to designate and change beneficiaries for retiree life insurance or to make changes during Open Enrollment or due to a qualifying life event.

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ABOUT YOUR BENEFITS

■ Who Can Participate in Open Enrollment?

- Retirees currently enrolled in an MCPS health plan.
- Retirees who retired on or after July 1, 1998, and opted to discontinue their MCPS coverage. (Proof of other coverage during the previous 12 months is required).

■ Who Is Eligible for Benefits?

Your eligibility for retiree benefits depends on your most recent hire or rehire date and your years of MCPS-eligible service at retirement.

- **FIVE OR MORE CUMULATIVE YEARS OF SERVICE:** Must meet **one** of the following:
 - » Hired before July 1, 2006, with no break in employment.
 - » Retired on or before July 1, 2011.
 - » Hired before July 1, 2011, with 30 or more years of state core plan service.
 - » Hired before July 1, 2011, and was 55 years of age by July 1, 2011.
- **TEN OR MORE CUMULATIVE YEARS OF SERVICE:** Retired after July 1, 2011, and hired between July 1, 2006, and June 30, 2019.
- **TEN OR MORE CONTINUOUS YEARS OF SERVICE:** Hired or rehired on or after July 1, 2019.

■ Who Is Ineligible for Benefits?

- Anyone failing to meet the minimum requirements above.
- Anyone ineligible for coverage as an active employee.
- Retirees who lacked coverage when they retired on or before June 30, 1998.
- Dependents who were ineligible at the time of your retirement.

■ Eligible Dependents

AGE LIMITS

Dependents must be enrolled in the same plan as the retiree. Eligible dependents may include a spouse and children up to the following age limits (unless a plan vendor has verified a dependent's disability and approved coverage beyond these age limits):

- **MEDICAL AND PRESCRIPTION:** End of the month the dependent turns **26**.
- **DENTAL AND VISION:** End of the month the dependent turns **24**.
- **LIFE INSURANCE:** September 30 following the dependent's **23rd** birthday.

VERIFICATION DOCUMENTS

Enrollment requires submission of verification documents. All dependents require a Social Security card or Individual Taxpayer Identification Number (ITIN) card, plus—

- **SPOUSE:** Marriage certificate OR a signed/e-filed current joint tax return.
- **BIOLOGICAL CHILDREN:** Birth certificate or verification of birth.
- **STEPCHILDREN:** Birth certificate or verification of birth AND a court-validated joint/shared custody agreement (up to age 18).
- **ADOPTED, FOSTER, OR GUARDED CHILDREN:** Court/government-validated adoption, guardianship, custody, or foster care documents.

■ Disabled Dependents

Coverage for a disabled dependent child may continue beyond standard age limits if they are permanently incapable of self-support due to an intellectual or physical disability that occurred **before age 19**. Coverage may continue as long as the dependent remains incapacitated and dependent, unless coverage otherwise ends under the terms of the plan.

VERIFICATION AND PLAN REQUIREMENTS

- **PROOF OF DISABILITY:** You must provide the plan administrator with proof that the incapacity and dependency existed prior to age 19. The administrator may require an examination by a plan-approved physician and periodic proof of ongoing disability.
- **PLAN CHANGES:** If you switch medical plans, you may submit new medical documentation to the new provider.

STRICT NOTIFICATION DEADLINES

You must notify MCPS of the child's disability before specific milestones, or coverage will be canceled:

- **MEDICAL AND PRESCRIPTION:** Must notify before the dependent's **26th birthday**.
- **DENTAL AND VISION:** Must notify before the dependent's **24th birthday**.
- **LIFE INSURANCE:** Must notify before September 30 following the dependent's **23rd birthday**.

IMPORTANT: If coverage for an over-age disabled dependent is canceled for any reason, they **cannot** be re-enrolled later.

■ Adding Dependents

- **ELIGIBLE DEPENDENTS:** Spouses and dependents who were eligible at the time of your retirement may be added or re-enrolled with proof of other coverage during the previous 12 months.
- **HOW TO ENROLL:** Submit MCPS Form 455-22, *Retiree Benefit Plan Enrollment*.

■ When Benefits Coverage Begins

- **10-MONTH EMPLOYEES:** Retiree health benefits begin on your retirement date unless you retire effective July 1, August 1, or September 1. *See Special Rule for Terminating or Retiring 10-month Employees* below. A refund for any overpaid, prepaid summer employee premiums will be processed for those retiring in any other month. For all retirees, life insurance begins immediately on the retirement date.
- **12-MONTH EMPLOYEES:** Retiree benefits begin on your retirement date. A premium refund is not issued since premiums are paid monthly throughout the year without pre-paying for summer months.

■ Special Rule for Terminating or Retiring 10-Month Employees

- **COVERAGE TIMELINE:** 10-month employees who terminate on their last duty day or retire effective July 1, August 1, or September 1 maintain prepaid health benefits through **September 30**. Retiree health benefits begin **October 1**. Retiree life insurance begins on the retirement date.
- **MEDICARE ENROLLMENT:** If a retiring 10-month employee or their dependent becomes Medicare-eligible between July 1 and September 1, they can start the Medicare application process as early as July 1 (three months before the October 1 effective date), provided MCPS is notified and paperwork is complete.
- **CARD SUBMISSION:** Medicare-eligible retirees and spouses must submit a copy of their Medicare Parts A and B card at least **30 days prior** to their retirement date.

■ Changes in Coverage

Generally, changes can only be made during Open Enrollment. However, plan changes can occur mid-year due to a qualifying life event (divorce, loss/gain of other coverage, work status change, relocation out of service area, retirement, or death).

- **30-DAY WINDOW:** You must submit MCPS Form 455-22, *Retiree Benefit Plan Enrollment* with all required documentation within 30 days of the qualifying event. Incomplete forms will be rejected, and late submissions must wait until the next Open Enrollment.
- **CANCELING COVERAGE DURING THE PLAN YEAR:** You can drop a dependent or cancel your entire plan (except life insurance) at any time using Form 455-22. Individual components of the plan cannot be canceled mid-year, but can be dropped during Open Enrollment.

EFFECTIVE DATES FOR CHANGES

- **NON-MEDICARE-ELIGIBLE:** Effective the first of the following month if forms are received by the end of the current month.
- **MEDICARE-ELIGIBLE:** Effective the first of the following month if forms are received by the fifth of the current month.

You must immediately notify ERSC of all changes, including a dependent's death, removal of coverage, or updates to your name, address, and phone number. Removing a dependent may lower your coverage level and reduce your monthly premium.

■ Loss of Non-MCPS Coverage

If you or your eligible dependents lose non-MCPS health coverage, you may enroll in an MCPS plan mid-year. Your new coverage will take effect on the **first of the month** following your enrollment.

■ Paying for Coverage

- **PAYMENT METHOD:** Premiums are deducted from your (or your surviving spouse's) retirement check. If the check cannot cover the cost, you will be billed directly by the Department of the Controller.
- **RATES:** Coverage costs are listed in the *2027 Retiree Benefit Rate Schedules* mailed to your home before Open Enrollment.

■ Cancellation for Nonpayment

- **NO REINSTATEMENT:** If plans are canceled for nonpayment, benefits cannot be reinstated, and the outstanding balance remains due to the Department of Controller.
- **RE-ENROLLMENT RULE:** To become eligible for re-enrollment in MCPS medical and prescription coverage, you must first obtain other coverage for 12 consecutive months.

■ When Benefits Coverage Ends

- **RETIREES AND SURVIVING SPOUSES:** Coverage is provided for life. Note that medical benefits change on becoming Medicare-eligible (see the “Enrollment in Medicare” section).
- **DEPENDENT CHILDREN:** Medical/prescription coverage automatically ends at the end of the month they turn 26. Dental/vision coverage automatically ends at the end of the month they turn 24 unless the dependent became disabled prior to age 19, which has been approved by the vendor.

■ Continuation of Benefits (COBRA)

- **ELIGIBILITY AND COST:** If coverage ends, dependents may continue it via COBRA at their own expense (paying the full cost plus a 2 percent administrative fee) for the legally mandated period (typically 18–36 months). MCPS does not contribute to COBRA costs.
- **NOTIFICATION:** The third-party administrator, Voya, will mail a qualifying event notice directly to dependents. COBRA rate charts are available on the ERSC website.
- **ALTERNATIVES:** Coverage may also be available via a State Health Insurance Exchange or the Affordable Care Act website.

■ Out-of-Area Coverage

KAISER PERMANENTE HMO

- **RESIDENCY REQUIREMENT:** You must live in the mid-Atlantic Kaiser service area. If you move outside this area, contact ERSC for other plan options.
- **MOVING/DISENROLLMENT:** Contact ERSC at least **30 days prior to a move** to complete a Kaiser disenrollment form (required for Medicare enrollees; also applies to other medical/prescription plans).

- **OUT-OF-AREA DEPENDENTS:** Dependents living or attending school outside the service area are covered **only for urgent or emergency room care** (no prior authorization required for ER visits). Non-emergency out-of-area care requires prior plan authorization and may be denied.

CIGNA OPEN ACCESS PLUS (OAP) AND CIGNA OPEN ACCESS PLUS IN-NETWORK (OAPIN) (HMO) PLANS

- **NATIONAL NETWORK:** Both plans offer a national network, providing in-network benefits while traveling or living outside the local service area.
- **CIGNA OAP OUT-OF-NETWORK OPTION:** You may see nonparticipating providers, but out-of-pocket costs will be higher. You must pay the provider's actual charge upfront, satisfy a deductible and coinsurance, and file a claim for reimbursement.

CIGNA INDEMNITY/MEDICARE SUPPLEMENTAL PLAN

- Although these plans do not have a network, they do offer nationwide coverage.

■ Coordination of Benefits

- **ORDER OF BENEFITS:** For retirees who are not eligible for Medicare and are covered by multiple plans, a primary plan pays first, and the secondary plan considers the remaining balance. Your MCPS plan is primary over any plan covering you as a dependent spouse.
- **MEDICARE:** Medicare Parts A and B are always primary for eligible retirees and dependents.
- **THE BIRTHDAY RULE (DEPENDENT CHILDREN):** If children are covered by both biological parents (one MCPS, one non-MCPS), the plan of the parent whose birthday falls earlier in the calendar year (month and day only) is primary.

IMPORTANT: This rule applies to all MCPS medical plans but **does not apply to step-children**, whose primary coverage is determined by the courts.

■ Enrollment in Medicare

Medicare becomes your primary medical coverage when you become eligible, and your MCPS medical coverage becomes secondary.

To maintain MCPS medical and prescription benefits, all retirees and dependents **must enroll in Medicare Parts A and B** as soon as they become eligible.

MEDICARE ELIGIBILITY AND TIMELINE

You are eligible for Medicare if you are **65 or older**, have **End-Stage Renal Disease (ESRD)**, or have received Social Security disability benefits for **25 months**.

- **EFFECTIVE DATE:** Coverage begins the first day of the month you turn 65. If your birthday is on the first of the month, it begins the first day of the previous month.
- **SUBMISSION DEADLINES:** ERSC prefers your Medicare card (or SSA entitlement letter) **60 days prior** to your Medicare effective date, but it must be submitted at least **30 days prior**.

ENROLLMENT INSTRUCTIONS

- **IF RETIRING AFTER AGE 65 (DEFERRED ENROLLMENT):** Contact the SSA three months before retiring to enroll in Parts A and B. Obtain a completed CMS-L564 from ERSC before applying.
- Submit your Medicare card to ERSC alongside your retirement forms.
- **IF BECOMING ELIGIBLE AFTER RETIREMENT:** Contact the SSA **three months before becoming eligible for Medicare**. You must enroll and submit your card to ERSC within the 30-to-60-day window noted above to update your plan and reduce your premium.
- **DISABILITY OR ESRD ELIGIBILITY:** If you become eligible via disability or ESRD, you must contact ERSC immediately at **240-740-8100**.
- **TRACKING YOUR APPLICATION:** Create an account at www.medicare.gov to track your application and download a PDF version of your card, which can be emailed to ERSC at ersc@mcpsmd.org. Online enrollment instructions can be found at www.ssa.gov/pubs/EN-05-10531.pdf
- If you are already enrolled in Part A, contact your local SSA office before applying for Part B online.

HIGH-INCOME PREMIUMS (IRMAA)

High-income beneficiaries pay a higher monthly Medicare Part B premium called the **Income-Related Monthly Adjustment Amount (IRMAA)**.

- The SSA determines this annually using your IRS tax returns from the previous two years.
- If assessed an IRMAA, you can contact the SSA to see if you qualify for an adjustment based on one of eight “life-changing events.”
- For details, review the SSA publication “*Medicare Premiums: Rules for Higher-Income Beneficiaries*” at www.ssa.gov/benefits/medicare/medicare-premiums.html.

■ Coordination of Medicare Benefits

To properly coordinate benefits, Cigna and Kaiser Permanente members must submit their Medicare cards to ERSC (**60 days prior** strongly recommended, **30 days prior** required).

All MCPS medical plans sync with Medicare. Medical providers submit claims first to Medicare, which pays its portion (80 percent of the allowed amount). The remaining 20 percent is then submitted to your MCPS medical plan for secondary payment.

KAISER PERMANENTE MEDICARE ADVANTAGE HMO MEMBERS

- **FORM REQUIREMENT:** ERSC will mail you a Medicare application 2–3 months before your (or your dependent’s) 65th birthday. You can also download it here: www.montgomeryschoolsmd.org/siteassets/district/departments/ersc/retirees/benefits/health/medical/medicare_kaiser_application.pdf. You must return the completed form to ERSC.
- **MEDICARE PART D RESTRICTION:** Kaiser’s plan includes Medicare Part D. Enrolling in an outside Part D plan will terminate your entire Kaiser membership (medical and prescription) on the start date of that new plan.

CIGNA MEMBERS

Retirees and dependents enrolled in a Cigna OAP plan cannot remain on it once anyone on the coverage becomes Medicare-eligible. You must choose one of two options:

- **OPTION 1—CIGNA INDEMNITY/MEDICARE SUPPLEMENTAL PLAN (DEFAULT):** You and your dependents will transition here automatically if you do not choose Option 2. Medicare becomes primary for the Medicare-eligible individual. Non-Medicare individuals will face a yearly deductible and co-insurance. *(Note: If both parties are already in Cigna OAPIN (HMO) and become Medicare-eligible, they also default to this plan).*
- **OPTION 2—CIGNA OAPIN (HMO) WITH OR WITHOUT PREFERRED CARE MANAGEMENT:** This option is available to members and dependents when at least one of them is ineligible for Medicare. Qualified members enroll by submitting MCPS Form 455-22, *Retiree Benefit Plan Enrollment* to ERSC by the **fifth of the month prior** to the Medicare effective date (or the last business day before the fifth if it falls on a weekend/holiday). Missing this deadline defaults you to Option 1 until the next Open Enrollment.

■ Medicare Part D (Prescription Coverage)

- **SILVERSCRIPT/CAREMARK:** MCPS offers Medicare Part D through SilverScript. Enrolling in a private, outside Medicare Part D plan will terminate your MCPS SilverScript coverage.
- **KAISER MEMBERS:** Your plan already includes Part D. Joining an outside Part D plan cancels your entire Kaiser medical and prescription coverage. **A Kaiser disenrollment form is also required.**

IMPORTANT NOTICE: Your medical and prescription coverage with MCPS will be canceled if you fail to enroll in Medicare Parts A and B and provide ERSC with a copy of the Medicare card OR if you fail to maintain coverage with Medicare.

BENEFIT FORMS ACCESS

Forms to enroll, make changes, and file claims are available online, mostly in PDF format. You can access them as follows:

- **DIRECT ENROLLMENT FORM LINK:** Access MCPS Form 455-22, *Retiree Benefit Plan Enrollment*, directly at www.montgomeryschoolsmd.org/departments/forms/pdf/455-22.pdf.
 - **MCPS FORMS DIRECTORY:** Search by name, number, or keyword at www.montgomeryschoolsmd.org/departments/forms.
 - **ERSC FORMS WEB PAGE:** Browse forms by benefit type at www.montgomeryschoolsmd.org/departments/ersc/retirees/forms.
- MCPS WEBSITE SEARCH:** Use the search box in the upper right corner of any page.

IMPORTANT: Do not submit MCPS Form 455-22, *Retiree Benefit Plan Enrollment*, if you are not making changes during Open Enrollment.

SUBMITTING BENEFITS FORMS

All completed forms must be submitted to ERSC by—

- **MAIL:** 45 W. Gude Drive, Suite 1200, Rockville, MD 20850,
- **EMAIL:** ersc@mcpsmd.org (must be an electronically signed PDF or a scanned copy with an original signature), or
- **FAX:** 301-279-3651 or 301-279-3642.

YOUR BENEFITS OPTIONS AT A GLANCE

BENEFIT	YOUR OPTIONS
PROTECTING YOUR HEALTH	
Medical Open Access Plus (OAP) Health Plan	• Cigna Open Access Plus (OAP) With Preferred Care Management • Cigna Open Access Plus (OAP) Without Preferred Care Management
Health Maintenance Organizations (HMO) Health Plans	• Cigna Open Access Plus In-Network (OAPIN) With Preferred Care Management • Cigna Open Access Plus In-Network (OAPIN) Without Preferred Care Management • Kaiser Permanente Medicare Advantage HMO
Medicare Supplemental	• Cigna Indemnity/Medicare Supplemental Plan (fee-for-service plan)
Indemnity Plan (Non-Medicare)	• Cigna Indemnity/Medicare Supplemental Plan (fee-for-service plan)
Prescription Drug	• CVS Caremark Prescription Drug Option A or B (only available to Cigna plan participants) • Kaiser Permanente Prescription Drug (only available to Kaiser Permanente medical plan participants) • Medicare Part D (SilverScript/Caremark) Option A or B
Dental	• CareFirst Dental Plan Preferred Provider Organization (PPO) • Aetna Dental Maintenance Organization (DMO)
Vision	• Davis Vision (provided through CareFirst)
PROTECTING YOUR INCOME	
Basic Term Life Insurance	• MetLife
DEFINED CONTRIBUTION PLANS	
403(b) Tax Sheltered Savings Plan	FIDELITY—Participants in the MCPS 403(b) plan become eligible for penalty-free distributions upon attaining age 59½ (regardless of employment status) or separation from service during or after the year the employee reaches age 55. To request a distribution, please telephone Fidelity at 1-800-343-0860 or log in to www.NetBenefits.com/mcps.
457(b) Deferred Compensation Plan	FIDELITY—Participants in the MCPS 457(b) plan become eligible for penalty-free distributions upon separation from service at any age or attaining age 59½ while still employed. To request a distribution, please call Fidelity at 1-800-343-0860 or log in to www.NetBenefits.com/mcps.
IMPORTANT: When 403(b) and/or 457(b) plan participants under the age of 59½ separate from service and then become re-employed by MCPS in any capacity, penalty-free withdrawals are not permitted.	

WELLNESS INITIATIVES

Non-Medicare eligible retirees covered by Cigna or Kaiser Permanente can reduce their health insurance premiums by participating in the Wellness Initiatives program.

To earn incentives, you must complete both a **biometric health screening** and an online **health risk assessment** between the first day of fall Open Enrollment and the Friday before the next Open Enrollment begins a year later.

- **TIMELINE AND TIMING:** Incentives take effect on January 1 of the following calendar year.
- **NEW/RECENT RETIREES:** Even if you completed these steps as an active employee, you must recomplete them as a retiree by the deadline to receive the rate reductions for the next benefit year.

■ Program Requirements

- **BIOMETRIC HEALTH SCREENINGS (1 PERCENT PREMIUM REDUCTION):** Monitors blood pressure, blood sugar, body mass index (BMI), and cholesterol to assess medical risks. You can complete it at a visit with your primary care physician during an annual physical or at a Well Aware-sponsored event.
- **HEALTH RISK ASSESSMENT (1 PERCENT PREMIUM REDUCTION):** An online survey assessing basic health and lifestyle habits. It must be completed through your specific insurance portal. If you haven't already, register for an account at—
 - » **CIGNA:** www.MyCigna.com
 - » **KAISER PERMANENTE:** www.kp.org

■ Privacy Information

Your personal health results are fully protected by HIPAA. MCPS never receives your health data; your insurance carrier only reports whether or not you completed the Wellness Initiatives requirements.

MEDICAL COVERAGE OPTIONS

The following medical plan options are offered to eligible MCPS retirees:

OPEN ACCESS PLUS (OAP) PLANS:

- Cigna OAP **With** Preferred Care Management
- Cigna OAP **Without** Preferred Care Management

HEALTH MAINTENANCE ORGANIZATION (HMO) OPTIONS:

- Cigna OAP In-Network (OAPIN) **With** Preferred Care Management
- Cigna OAPIN **Without** Preferred Care Management
- Kaiser Permanente HMO
- Kaiser Permanente Medicare Advantage HMO

INDEMNITY PLAN (TRADITIONAL FEE-FOR-SERVICE) OPTION:

- Cigna Indemnity/Medicare Supplemental Plan

■ OAP Plans

An OAP plan combines HMO and indemnity features, allowing you to see any medical provider or facility without a referral for medically necessary care. The plan includes two coverage components:

- **IN-NETWORK:** Functions like an HMO, offering a full range of services from participating providers or specialists at a higher coverage level.
- **OUT-OF-NETWORK:** Functions like traditional indemnity insurance. You may use non-network providers, but you will face lower coverage levels and must meet a yearly deductible and coinsurance. You are also responsible for any costs exceeding the plan's Usual, Customary, and Reasonable (UCR) charges.
- **PROVIDER CHOICE:** Provides access to a national network of physicians for in-network care nationwide (including for traveling members or out-of-state dependents). You can choose a primary care physician (PCP) for routine care and guidance, but referrals are not required. An online directory is available at www.cigna.com.
- **NETWORK AND COST CONTROL:** You can see any provider, but using the OAP network maximizes your coverage. The plan uses preadmission screening and prior authorization for specific services to ensure cost-effective care.
- **DIABETIC SUPPLIES:** Covered under the prescription drug benefit administered by CVS/Caremark.
- **MEDICARE ELIGIBILITY:** Once eligible for Medicare, participants may not remain in the Open Access Plus plan.

(For additional details, refer to the Open Access Plus comparison chart later in the document).

■ HMO Plans

HMOs provide a full range of services through an in-network provider or PCP. Except for true emergencies, care received outside the network is not covered. There is no deductible to meet before the plan pays benefits. (See the *HMO comparison chart for details*).

CIGNA OAPIN

- **NO REFERRALS:** You can visit any Cigna network provider without a referral.
- **COSTS AND CLAIMS:** Features low out-of-pocket expenses (mostly copayments) and requires no claim forms. You have the option to choose a PCP to coordinate your care.
- **NATIONAL NETWORK ACCESS AND MEMBER DISCOUNTS:** Includes access to Cigna's national provider network for nationwide in-network care. It also features member discounts on fitness, nutrition, and weight management programs. Learn more via the "Discounts" tab on the MCPS Well Aware web page at www.montgomeryschoolsmd.org/staff/wellness/.

KAISER PERMANENTE MEDICARE ADVANTAGE

Kaiser Permanente Medicare Advantage is a center-based HMO with more than 35 local medical centers staffed by doctors, nurses, and specialists. Services including pharmacy, lab, X-ray, ambulatory surgery, and health education are available through Kaiser medical centers.

- **PCP AND CENTER SELECTION:** You must choose a center and primary care physician (PCP) upon enrollment, or Kaiser will assign the center closest to your home. Each family member can select a separate PCP and center. PCPs coordinate all health needs, including specialist care and hospitalizations.
- **PRESCRIPTIONS AND SUPPLIES:** Prescription drug benefits and diabetic supplies are built directly into this plan.
- **ADDITIONAL BENEFITS:**
 - » **ONE PASS MEMBERSHIP:** No-cost gym membership at participating fitness centers (www.youronepass.com).
 - » **TRANSPORTATION:** Includes 24 one-way rides per year for non-urgent medical appointments at Kaiser or contracted facilities.
 - » **BRAIN HQ:** No-cost online cognitive and memory exercises. Instructions are provided in the new member welcome kit.

■ Cigna Indemnity/Medicare Supplemental Plan

To retain MCPS benefits, retirees must enroll in Medicare Parts A and B when first eligible. Medicare becomes your primary medical coverage, and the MCPS-sponsored Cigna Supplemental plan becomes secondary.

- **MEDICARE SPLIT FAMILIES:** If only some family members are Medicare-eligible, the family can choose this plan. It acts as secondary coverage for Medicare-eligible individuals and primary coverage (with a deductible and coinsurance) for non-Medicare individuals.
- **HOW CLAIMS ARE PAID:** For Medicare-approved services, Medicare Part A covers inpatient care (minus the deductible), and Part B covers 80 percent of outpatient allowed amounts (after the Part B

deductible). The Cigna Supplemental plan pays the Part A hospital deductible, the Part B yearly deductible, and the remaining 20 percent coinsurance.

- **MEDICARE ASSIGNMENT:** You will have zero out-of-pocket expenses if your doctor accepts Medicare assignment. If you see a nonparticipating Medicare provider, there is no coverage under Medicare or Cigna, and you must pay all charges. Confirm Medicare assignment with your provider before receiving care.
- **CLAIM SUBMISSION:** Providers bill Medicare first. Medicare automatically forwards the remaining 20 percent of the eligible amount to Cigna for secondary payment.
- **DIABETIC SUPPLIES:** Covered under either the Cigna medical plan or the Medicare Part D prescription plan. Call the number on your insurance card for a list of approved providers; standard copays apply.

■ Cigna Preferred Care Management

Cigna's Preferred Care Management is a free, confidential program where nurse advocates, social workers, pharmacists, and behavioral professionals collaborate with your doctors to manage your healthcare needs.

- **PRIOR AUTHORIZATION:** Required for all inpatient hospital admissions and specific outpatient services (e.g., CT/MRI/PET scans, spinal/epidural injections, medical oncology, and private duty nursing).
- **RESPONSIBILITY:** In-network providers handle the approval process automatically. If you use an out-of-network provider, you must manage and secure the prior authorization yourself.
- **LEARN MORE:** View the Cigna Preferred Care Management flyer at www.montgomeryschoolsmd.org/siteassets/district/departments/ersc/retirees/benefits/health/medical/cigna_preferred_care_management_flyer.pdf

■ Preventive Care Services

For non-Medicare-eligible retirees

- **IN-NETWORK:** Under the Affordable Care Act, specific preventive procedures for adults and children have **zero copays** when using in-network providers (see charts in this booklet). Procedures not explicitly listed default to standard plan copays.
- **OUT-OF-NETWORK:** Coinsurance rates remain unchanged and are detailed in the Open Access Plus comparison chart.

For Medicare-eligible retirees

Medicare covers designated preventive services with **zero copayments**. For complete details, review the booklet "Your Guide to Medicare's Preventive Services" at www.medicare.gov/publications/10110-Your-Guide-to-Medicare-Preventive-Services.pdf.

PREVENTIVE SERVICES COVERED WITH ZERO COPAY 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 45
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: • 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

* Using in-network providers only

**Family history of colorectal cancer may qualify for screening before age 45.

PREVENTIVE SERVICES COVERED WITH ZERO COPAY FOR NON-MEDICARE-ELIGIBLE WOMEN*	
Preventive Service Covered	Who is Eligible, Additional Details
Annual well-woman visit	all women
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
Breast Feeding Support, Supplies, and Counseling	Women, to support and promote breast feeding
Cervical Cancer Screening	sexually active women
Chlamydia Infection Screening	younger women and other women at higher risk
Contraceptive Methods and Counseling (FDA-approved**), including: • Female Condom (OTC) • Diaphragm (P) with Spermicide (OTC) • Sponge (OTC) with Spermicide (OTC) • Cervical Cap (P) with Spermicide (OTC) • Spermicide (OTC) • Oral Contraceptive (P) • Combined Pill • Progestin • Extended/Continuous • Patch (P) • Vaginal Contraceptive Ring (P) • Shot/Injection (P) • Morning After Pill (over 17 years of age OTC; under 17 years of age P) • IUD (P) • Implantable Rod (inserted by doctor) • Sterilization Surgery • Sterilization Implant (OTC) Over the Counter (P) Prescription Required	all women
Folic Acid Supplements	women who may become pregnant
Gonorrhea Screening	all women at higher risk
Gestational Diabetes Screening	pregnant women
Hepatitis B Screening	pregnant women at their first prenatal visit
Human Immunodeficiency Virus (HIV) Counseling and Screening	all women, on an annual basis
Human Papilloma Virus (HPV) Testing	all women
Interpersonal & Domestic Violence Screening and Counseling	all women
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
Sexually Transmitted Infections Counseling	all women, on an annual basis

*Using in-network providers only

Includes surgical, prescription, medical, and OTC services/products. Sterilization is considered a contraceptive method. Abortion **is not considered a contraceptive method.

PREVENTIVE SERVICES COVERED WITH ZERO COPAY 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
Immunizations Vaccines for: • 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

* Using in-network providers only

**Family history of colorectal cancer may qualify for screening before age 45.

HEALTH MAINTENANCE ORGANIZATION (HMO) PLANS			
	Cigna Open Access Plus In-Network (OAPIN) HMO Plan		Kaiser Permanente HMO Plan
	WITH Preferred Care Management	WITHOUT Preferred Care Management	
Annual Deductible	None	None	None
PREVENTIVE CARE			
Routine Physical Exam	\$10 copay*	\$10 copay*	Covered in full
Well Baby/Child Care	\$10 copay*	\$10 copay*	Covered in full (under age 5)
Childhood Immunizations	\$10 copay*	\$10 copay*	Covered in full (under age 5)
PHYSICIAN SERVICES			
Physician Office Visit	\$10 copay	\$10 copay	\$10 copay
Specialist Office Visit	\$15 copay	\$15 copay	\$15 copay
Lab Work and X-rays	Covered in full	Covered in full	Covered in full
Allergy Shots	\$10 copay (\$15 copay for specialist)	\$10 copay (\$15 copay for specialist)	\$10 copay
MATERNITY CARE			
Prenatal and Postnatal Care	\$15 copay, no charge once pregnancy is confirmed*	\$15 copay, no charge once pregnancy is confirmed*	\$10 copay, no charge once pregnancy is confirmed*
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	\$15 copay	\$15 copay	\$15 copay
Emergency Room	\$100 copay (waived if admitted)	\$100 copay (waived if admitted)	\$100 copay (waived if admitted)
Emergency Physician Services	Covered in full	Covered in full	Covered in full
Emergency Ambulance	Covered in full	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	Covered in full	Covered in full	\$15 copay
Professional Fees	\$15 copay	\$15 copay	Covered in full
MENTAL HEALTH/SUBSTANCE ABUSE SERVICES			
Inpatient Days	Covered in full	Covered in full	Covered in full
Outpatient Visits	\$10 copay	\$10 copay	\$10 copay
OTHER SERVICES			
Catastrophic Illness	Covered in full	Covered in full	Covered in full
Durable Medical Equipment	You pay 25%**	You pay 25%**	Covered in full
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 up to 100 days	Covered in full up to 100 days per contract year

*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.

CIGNA OPEN ACCESS PLUS (OAP) PLAN WITH PREFERRED CARE MANAGEMENT		
	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible	None	\$300 individual; \$600 family
PREVENTIVE CARE		
Routine Physical Exam	\$15 copay*	Not Covered
Well Baby/Child Care	\$15 copay*	80% after deductible
Childhood Immunizations	\$15 copay	80% after deductible
PHYSICIAN SERVICES		
Physician Office Visit	\$15 copay	80% after deductible
Specialist Office Visit	\$20 copay	80% after deductible
Lab Work and X-rays	Covered in full	80% after deductible
Allergy Evaluations	\$15 copay	80% after deductible
Allergy Shots	Covered in full	80% after deductible
MATERNITY CARE		
Prenatal and Postnatal Care	\$15 copay, no charge once pregnancy is confirmed*	80% after deductible
Physician Services	Covered in full	80% after deductible
Hospital Services	Covered in full	80% after deductible
EMERGENCY SERVICES (WHEN MEDICALLY NECESSARY)		
Urgent Care Centers	\$20 copay	Paid as in-network
Emergency Room	\$100 per visit (copay waived if admitted)	Paid as in-network
Emergency Physician Services	Covered in full	Paid as in-network
Emergency Ambulance	Covered in full	Paid as in-network
HOSPITAL SERVICES—INPATIENT		
Semi-private Room	Covered in full	80% after deductible
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	\$20 copay	80% after deductible
Professional Fees	\$20 copay	80% after deductible
MENTAL HEALTH/SUBSTANCE ABUSE SERVICES		
Inpatient Days	Covered in full	80% after deductible (up to 180 days)
Outpatient Visits	\$15 copay	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 (Up to 60 visits for in- and out-of-network)	80% after deductible (Up to 60 visits for 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.

CIGNA OPEN ACCESS PLUS (OAP) PLAN **WITHOUT** PREFERRED CARE MANAGEMENT

	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible	\$200 individual; \$400 family	\$500 individual; \$1,000 family
PREVENTIVE CARE		
Routine Physical Exam	\$15 copay*	Not Covered
Well Baby/Child Care	\$15 copay*	80% after deductible
Childhood Immunizations	\$15 copay	80% after deductible
PHYSICIAN SERVICES		
Physician Office Visit	\$15 copay	80% after deductible
Specialist Office Visit	\$20 copay	80% after deductible
Lab Work and X-rays	Covered in full	80% after deductible
Allergy Evaluations	\$15 copay	80% after deductible
Allergy Shots	Covered in full	80% after deductible
MATERNITY CARE		
Prenatal and Postnatal Care	\$15 copay, no charge once pregnancy is confirmed*	80% after deductible
Physician Services	Covered in full	80% after deductible
Hospital Services	Covered in full	80% after deductible
EMERGENCY SERVICES (WHEN MEDICALLY NECESSARY)		
Urgent Care Centers	\$20 copay	Paid as in-network
Emergency Room	\$100 per visit (copay waived if admitted)	Paid as in-network
Emergency Physician Services	Covered in full	Paid as in-network
Emergency Ambulance	Covered in full	Paid as in-network
HOSPITAL SERVICES—INPATIENT		
Semi-private Room	Covered in full	80% after deductible
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	\$20 copay	80% after deductible
Professional Fees	\$20 copay	80% after deductible
MENTAL HEALTH/SUBSTANCE ABUSE SERVICES		
Inpatient Days	Covered in full	80% after deductible (up to 180 days)
Outpatient Visits	\$15 copay	80% after deductible
OTHER SERVICES		
Catastrophic Illness	Covered in full	Covered in full after \$1,000 out-of-pocket expenses (excluding deductible)
Durable Medical Equipment	Covered in full	80% after deductible
Home Health Care/Skilled Nursing Care	Covered in full (up to 60 visits in- and out-of-network)	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.

CIGNA INDEMNITY	
Annual Deductible	\$200 individual; \$400 family
PREVENTIVE CARE	
Routine Physical Exam	Not covered
Well Baby/Child Care	80%, no deductible
Childhood Immunizations	80%, no deductible
PHYSICIAN SERVICES	
Physician Office Visit	80% after deductible, routine not covered
Specialist Office Visit	80% after deductible, routine not covered
Lab Work and X-rays	Diagnostic: 90% after deductible, routine not covered
Allergy Evaluations	80% after deductible
Allergy Shots	90% after deductible
MATERNITY CARE	
Prenatal and Postnatal Care	90% after deductible
Physician Services	90% after deductible
Hospital Services	90% after deductible
EMERGENCY SERVICES (WHEN MEDICALLY NECESSARY)	
Urgent Care Centers	80% no deductible
Emergency Room	\$100 copay (waived if admitted)
Emergency Physician Services	Covered in full
Emergency Ambulance	Covered in full
HOSPITAL SERVICES—INPATIENT	
Semi-private Room	90% after deductible up to 180 days
Professional Services	90% after deductible
Surgical Procedures	90% after deductible
Specialty Care/Consultation	90% after deductible
Anesthesia	90% after deductible
Radiology and Drugs	90% after deductible
Intensive Care	90% after deductible
Coronary Care	90% after deductible
HOSPITAL SERVICES—OUTPATIENT	
Surgical Procedures	90% after deductible
Professional Fees	90% after deductible
MENTAL HEALTH/SUBSTANCE ABUSE SERVICES	
Inpatient Days	90% up to 180 days (after deductible)
Outpatient Visits	80% after deductible
OTHER SERVICES	
Catastrophic Illness	Covered in full after \$1,500 out-of-pocket expenses (excludes deductible)
Durable Medical Equipment	80% after deductible**
Home Health Care/Skilled Nursing Care	90% after deductible (up to 40 visits) For indemnity, home health care—unlimited days maximum; for skilled nursing facility— 60 days maximum
Hospice Care	90% after deductible in-patient; 80% after deductible out-patient

*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.

***Covered in full for non-Medicare-eligible retirees.

MEDICARE SUPPLEMENTAL CHART

Applies to Medicare-eligible Retirees/Dependents Only

2027	MEDICARE	CIGNA OPEN ACCESS PLUS IN-NETWORK (OAPIN) HMO**	CIGNA INDEMNITY/ MEDICARE SUPPLEMENTAL	KAISER MEDICARE ADVANTAGE HMO
Primary Care Visit	Pays full cost for certain services (see current Medicare handbook or www.medicare.gov)	Covered in full	Covered in full	\$5 copay
Specialist Visit	Pays full cost for certain services (see current Medicare handbook or www.medicare.gov)	Covered in full	Covered in full	\$5 copay
Durable Medical Equipment	Pays 80% of approved amount (after Medicare Part B deductible)	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	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	Hospice care covered in full
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 and 20% Medicare coinsurance	Pays the Medicare Part B deductible and 20% Medicare coinsurance	Pays the Medicare Part B deductible and 20% Medicare coinsurance, after \$5 copay for routine illness and \$5 copay for specialist visits (after \$50 copay 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 Medicare coinsurance	Pays the Medicare Part B deductible Medicare coinsurance	Covered in full
Preventive Care	Pays full cost for certain services (see current Medicare handbook or www.medicare.gov)	Covered in full	Covered in full	Medicare-covered preventive care covered in full
Hospitalization Days 1–60	Pays all but Part A deductible	Pays Part A Deductible	Pays Part A Deductible	Covered in full
Days 61-90	Pays all but Part A deductible	Pays Part A Deductible	Pays Part A Deductible	Covered in full
Days 91–150	Pays all but Part A deductible	Pays Part A Deductible	Pays Part A Deductible	Covered in full
Days 151+	Pays nothing	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 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 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%
Days 21–100	Pays all but Part A Deductible	Pays Part A Deductible up to 60 days a year	Pays Part A Deductible up to 60 days a year	Covered in full
Home Health Care	Pays 100% of approved amount	Coverage not provided	Coverage not provided	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.*

DENTAL COVERAGE

Eligible retirees can choose from the following dental plans. Plan changes are permitted only during Open Enrollment or if a DMO participant moves out of the service area.

IMPORTANT: Orthodontic coverage is not available for retirees or dependents.

■ CareFirst Dental PPO

- **PROVIDER CHOICE:** You may see any dentist, but in-network (PPO) dentists offer a higher level of coverage. Out-of-network care is reimbursed at a lower rate based on a fee schedule and is subject to deductibles, copays, and customary charges.
- **BENEFITS:** Covers prophylaxis (scaling and polishing) up to two times per calendar year. Refer to chart below for other covered treatments and coverages.
- **DIRECTORY:** Call 1-888-755-2657 or visit www.carefirst.com/mcps (Find a Doctor > Search Now > Log into My Account > Dental).

■ Aetna Dental Maintenance Organization (DMO)

- **REQUIREMENTS:** You must select and enroll with a primary DMO dentist prior to your first appointment. Care from non-network dentists is not covered.
- **COSTS:** There is no annual deductible and no maximum annual benefit limit. Preventive and basic services are covered at 100 percent; major services are covered at 75 percent. Refer to chart below for other covered treatments and coverages.
- **DIRECTORY:** Call 1-800-843-3661 or visit www.aetna.com/docfind.

■ Kaiser Permanente Preventive Dental Plan (Liberty Dental)

- **ENROLLMENT:** Kaiser medical members are automatically enrolled in the Kaiser Permanente Smile ML dental plan (provided through Liberty Dental) at no extra cost. Members may still opt to also enroll in the CareFirst PPO or Aetna DMO.
- **COVERAGE:** Includes preventive, diagnostic, and restorative services at fixed copayment amounts. This coverage is strictly for Kaiser members.
- **SCHEDULES AND PROVIDERS:** View the schedule of benefits on the Dental Plan for Retirees web page at www.montgomeryschoolsmd.org/departments/ersc/retirees/benefits/health/dental/ and find a dentist at www.kp.org/dentalprovider/mas.

DENTAL BENEFITS	CAREFIRST 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	100%	80%	100%
X-rays (bitewings, full series, panoramic)	100%	80%	100%
Prophylaxis (includes scaling and polishing)	100%	80%	100%
Fluoride (one treatment per year up to age 18)	100%	80%	100%
Sealants (one treatment every three years on permanent molars only under age 16)	100%	80%	100%
Oral Hygiene Instruction	Not covered	Not covered	100%
BASIC (CLASS II)			
Amalgam	100%	80%	100%
Composite Filling (anterior tooth only)	100%	80%	100%
Pulp Capping	100%	80%	100%
Root Canal Therapy with X-rays and Cultures (other than molar root canal)	100%	80%	100%
Scaling and Root Planing	100%	80%	100%
BASIC (CLASS II)			
Space Maintainers	100%	80%	75%
Molar Root Canal Therapy	100%	80%	75%
Osseous Surgery (periodontal surgery)	100%	80%	75%
General Anesthesia	100%	80%	75%
Surgical Removal of Impacted Teeth (partial bony/full bony)	100%	80%	75%
MAJOR (CLASS III)			
Inlays, Onlays, and Crowns	50%	40%	75%
Full and Partial Dentures	50%	Maximum eligible charge per service: \$400	75%
Bridge Pontics and Abutments	50%		
DENTAL IMPLANTS			
Dental Implants	50%	N/A	N/A

KAISER PERMANENTE PREVENTIVE DENTAL PLAN	
\$30 copay per preventive-care office visit, which includes: • Oral exams up to 2 per year • Cleanings, up to 2 per year • Bitewing X-rays, up to 2 per year	More extensive care (fillings, crowns, dentures, root canals, periodontal treatment, oral surgery, etc.) is provided at a lower cost than usual for these services.

VISION COVERAGE

If you are eligible for benefits, you may choose to enroll in vision coverage offered by Davis Vision (provided through CareFirst). Kaiser Permanente medical plan members are automatically enrolled in the Kaiser Permanente vision plan, but have the option of also enrolling in the Davis Vision plan.

Davis Vision Plan

Eligible retirees may choose to enroll in the Davis Vision plan (provided by CareFirst). You have access to a network of providers, including optometrists and ophthalmologists, as well as to participating retail providers.

SERVICE	MAXIMUM BENEFIT	LIMITS
EXAMS		
Optometrist	\$25	One exam during any consecutive 12-month period
Ophthalmologist	\$33	
FRAMES		
Frames only	\$20	One set of frames during any consecutive 12-month period (in lieu of contact lenses)
LENSES ONLY, PER PAIR		
Single vision	\$20	Two lenses during any consecutive 12-month period (in lieu of contact lenses)
Bifocal	\$35	
Trifocal	\$45	
Lenticular	\$120	
CONTACT LENSES		
Medically Necessary**	\$230	In lieu of lenses and frames
Standard or Disposable	\$40	

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

PLAN EXCLUSIONS

- More than one eye exam (including refraction), two lenses, and one set of frames per person in a consecutive 12-month period.
- Non-prescription or prescription sunglasses.
- Replacement of lost, stolen, or broken lenses or frames.
- Special procedures (e.g., orthoptics, vision training) or medical/surgical eye treatments (e.g., eye infections or surgeries, which are instead covered by your medical plan).
- Employer-required eye exams.

ADDITIONAL FEATURES AND DISCOUNTS

- **MAIL-ORDER CONTACTS:** Order replacement contact lenses online with quick shipping at www.DavisVisionContacts.com.
- **DISCOUNTS:** Discounted lens options, plus up to 25 percent off regular fees (or 5 percent off specials) for LASIK surgery. Call 1-800-783-5602 for a list of participating LASIK providers.

OUT-OF-NETWORK SERVICES

If you see a non-Davis Vision provider, you must pay the full cost upfront. You can then submit a claim form to Davis Vision for reimbursement up to the plan's allowed amounts.

CONTACT INFORMATION

Upon enrollment, you will receive an ID card and claim forms. For more details, visit www.carefirst.com/mcps or call 1-800-783-5602 (Monday–Friday, 8:00 a.m.–8:00 p.m.).

■ Kaiser Permanente Vision Plan

In addition to medical and prescription coverage, Kaiser Permanente offers an in-network-only vision program. For complete plan details, visit www.montgomeryschoolsmd.org/departments/ersc/employees/benefits/health/medical/kaiser and click on the **Evidence of Coverage** link.

The in-network benefits include the following:

KAISER PERMANENTE VISION PLAN	COPAYS
EXAMS	
Optometrist Ophthalmologist	\$10 per visit \$15 per visit
LENSES AND FRAMES	
(Limited to a select group)	No charge for one pair per contract year
CONTACT LENSES	
(Limited to a select group)	No charge for initial fit and first purchase per contract year
LOW VISION AIDS	
(Unlimited low vision aids from available supply)	No charge
VISION HARDWARE ALLOWANCE	
	\$100 allowance per calendar year toward corrective eyeglasses, lenses, frames, and contacts at Kaiser Permanente Vision Centers

KAISER PERMANENTE VISION (HMO AND MEDICARE ADVANTAGE HMO) PLAN

Members will receive a \$200 allowance every 24 months for eyeglasses or contact lenses at Kaiser Permanente Vision Essentials locations.

PRESCRIPTION DRUG COVERAGE

Prescription drug eligibility depends on your medical plan and Medicare status:

- **NON-MEDICARE RETIREES:** If you choose a Cigna OAP plan or decline medical coverage, you are eligible for the CVS Caremark plan. If you choose the Kaiser Permanente HMO, you must enroll in the Kaiser Permanente prescription plan.
- **MEDICARE-ELIGIBLE RETIREES:** MCPS offers a Medicare Part D plan through SilverScript (a division of CVS Caremark). Kaiser members must enroll in the Kaiser Medicare Part D plan to maintain their Kaiser Medicare HMO medical coverage.

■ CVS Caremark Prescription Drug Plan (Non-Medicare)

- **SHORT-TERM MEDICATIONS:** Prescriptions for short-term illnesses (e.g., colds, flu, infections) are filled as a standard 30-day supply at any participating retail pharmacy using your CVS Caremark card.
- **LONG-TERM MAINTENANCE MEDICATIONS:** Prescriptions for chronic conditions (e.g., high blood pressure, arthritis, diabetes). You are allowed one initial fill and one refill at any participating retail pharmacy. Afterward, you must obtain your 90-day supply through a CVS retail pharmacy or the CVS Caremark Mail Service pharmacy.
- **SPECIALTY AND STEP THERAPY:** Certain long-term medications are subject to the specialty drug guideline management program or the generic drug step therapy program (see those sections for details).

IMPORTANT: You can purchase your 90-day supply of maintenance medication at a CVS pharmacy for the same copay 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 copay, plus the difference between the mail order and retail prescription cost.

CVS CAREMARK PLAN OPTIONS

MCPS retirees can choose between two CVS Caremark prescription plan options, both featuring a three-tier copay structure that rewards using generic and preferred brand-name drugs, as well as purchasing maintenance medications via CVS retail or mail order. (Important: These copays do not apply to drugs subject to specialty drug guidelines or step therapy).

- **PLAN OPTION A:** Lower copays, higher monthly premiums.
- **PLAN OPTION B:** Higher copays, lower monthly premiums.

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 copay 1 refill allowed for maintenance medications	\$10 copay
CVS Caremark Preferred Brand Name (no generic equivalent)*	\$15 copay 1 refill allowed for maintenance medications	\$30 copay
CVS Caremark Non-preferred Brand Name**	\$25 copay 1 refill allowed for maintenance medications	\$50 copay

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 copay 1 refill allowed for maintenance medications	\$20 copay
CVS Caremark Preferred Brand Name (no generic equivalent)*	\$25 copay 1 refill allowed for maintenance medications	\$50 copay
CVS Caremark Non-preferred Brand Name**	\$35 copay 1 refill allowed for maintenance medications	\$70 copay

*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 copay 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 copay is \$110. Important: 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.

MAINTENANCE MEDICATIONS AND 90-DAY SUPPLIES

You get an initial fill and one refill of a maintenance medication (up to a 30-day supply) at any retail pharmacy. After that, you must transition to a 90-day supply via CVS Caremark Mail Service or a CVS Pharmacy to keep the standard copay.

You can purchase your 90-day supply of maintenance medication at a CVS pharmacy for the same copay 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 copay, plus the difference between the mail order and retail prescription cost.

- **PENALTY:** Using a non-CVS retail pharmacy after the second fill means paying the retail copay plus the cost difference between mail order and retail.

HOW TO GET A 90-DAY SUPPLY

Have your doctor write a prescription for up to 90 days with up to three refills.

- **AT CVS PHARMACY:** Submit the prescription directly to the pharmacist.
- **VIA MAIL SERVICE:** Mail the original prescription and a completed Patient Profile/Order Form (from the ERSC website) to CVS Caremark. Allow 10–14 business days for delivery.

- » **TIP:** For immediate needs, get two prescriptions from your doctor: a 30-day supply for retail and a 90-day supply for mail order.
- **SWITCHING:** To switch an active mail order to a CVS retail pharmacy, call Customer Care at 1-800-378-7558.

REFILLS, FORMS, AND NETWORK COVERAGE

- **TOOLS:** Access forms, mail-order info, and refills on the CVS Caremark website, or refill via the automated phone service at 1-800-378-7558. Forms are also on the ERSC website.
- **OUT-OF-NETWORK:** If using a nonparticipating pharmacy, you must pay full price and submit a paper claim. Reimbursement only covers the network price minus your copay (usually less than retail). Check network participation with your pharmacist or the CVS website.

EXCLUSIONS, RESTRICTIONS, AND AUTHORIZATION

- **EXCLUSIONS:** Over-the-counter drugs, cosmetic drugs, experimental treatments, erectile dysfunction medications, and vitamins are excluded. Uncovered drugs can still be purchased at 100 percent of the CVS Caremark discounted cost.
- **PRIOR AUTHORIZATION (PA):** Required for anabolic steroids, certain acne treatments, fungal infection medications, and all specialty drugs. Doctors must contact PA staff at 1-800-626-3046 with an FDA-approved diagnosis. Approvals are valid for the life of the prescription (maximum one year).

BRAND-NAME VS. GENERIC RULES

- **BRAND-NAME DRUG PENALTY:** To get the lowest copay, choose generics. If you choose a brand-name drug when a generic equivalent exists, you must pay the generic copay plus the cost difference between the brand and generic drug.
- **MEDICAL NECESSITY WAIVER:** If a brand-name drug is medically necessary, your doctor must submit a justification letter on office letterhead alongside the prescription (sent via mail or fax to the CVS Caremark Department of Appeals in Phoenix, AZ).
 - » Simple statements of preference are insufficient; updates are required annually.
 - » If approved, you will pay the standard brand copay without penalty (**mail order only**).
- **NON-GENERIC BRAND COPAYS (MAIL ORDER):** For brand-name drugs with no generic equivalent:
 - » Preferred brands: Option A: \$30 | Option B: \$50
 - » Nonpreferred brands: Option A: \$50 | Option B: \$70

SPECIALIZED MEDICATION MANAGEMENT

GLP-1 Management (Diabetes/Weight Loss)

This program limits coverage of GLP-1 medications to approved uses under the plan.

- **SMART LOGIC:** If automated system checks confirm an ICD-10 code for type 2 diabetes or previous paid claims for metformin/diabetes supplies, the medication is approved instantly.
- **PRIOR AUTHORIZATION REVIEW:** If smart logic criteria are not met, a formal prior authorization case review with documented diagnosis is required.

Specialty Drug Coverage

Specialty drugs treat complex conditions (e.g., multiple sclerosis, oncology, rheumatoid arthritis, Hepatitis C). They are managed under the **Specialty Guideline Management Program** to support appropriate use of specialty medications. Your physician must contact CVS Caremark directly to coordinate and initiate the approval process. Check drug categories at www.caremark.com or call the number on your ID card.

PRESCRIPTION PLAN MANAGEMENT

Generic Drug Step Therapy

To manage prescription costs, brand-name drugs for certain conditions (including high blood pressure and high cholesterol) require you to try a generic alternative first. If your medication is affected, contact your physician to coordinate your therapy. View affected drug classes at www.caremark.com.

Preferred Drug List

This is a list of preferred, brand-name medications selected by a clinical committee for inclusion on the plan's preferred drug list.

- **SAVINGS:** You can lower your out-of-pocket costs by asking your doctor to prescribe drugs from this list. They are not direct generic equivalents to non-preferred brands, but they are in the same therapeutic class to treat the same condition.
- **IMPORTANT:** Not all drugs on this list are covered by MCPS. The list is updated periodically, so check the current version at www.caremark.com.

PrudentRx Copay Program

- **HOW IT WORKS:** Non-Medicare-eligible retirees face a 30 percent coinsurance on certain specialty medications. The PrudentRx program covers this coinsurance charge and waives your copay (\$0 out-of-pocket) by securing copay assistance from drug manufacturers.
- **DRUG LISTS AND EXCEPTIONS:** Check if your medication is eligible at www.prudentrx.com/prudentes/. If it is not on the list, standard preferred or non-preferred brand copays apply.
- **ENROLLMENT:** Enrollment is automatic when you fill or pick up an eligible prescription at a CVS pharmacy; the cashier will prompt you to confirm your information.
- **OPT-OUT:** You can choose to opt out of the program by calling PrudentRx at **1-800-578-4403**.

Opioid Limits (MME)

To address the opioid epidemic, CVS Caremark uses Morphine Milligram Equivalents (MME) based on CDC guidelines to limit total prescribed opioid doses. If a prescription exceeds these limits, doctors must contact the Prior Authorization department at **1-800-294-5979**.

Diabetic Supplies

CVS Caremark covers test strips, lancets, swabs, and meters. (Insulin pumps and pump supplies are covered under your medical plan's durable medical equipment provisions).

- **SUPPLY LIMITS:**

- » **TEST STRIPS, LANCETS, OR ALCOHOL SWABS:** Up to 200 every 30 days (or up to 600 every 90 days via CVS retail or mail service).

- » **LANCET DEVICES:** Limit 1 per 180 days.

■ Kaiser Permanente Prescription Drug Plan (Non-Medicare and Medicare Retirees)

- **MEDICARE PART D REQUIREMENT:** Kaiser is a Medicare Part D provider, combining medical and prescription coverage. Enrolling in a separate, external Medicare Part D plan will terminate your entire Kaiser membership, including medical coverage.
- **COVERAGE LOCATIONS:** Prescriptions are covered at Kaiser Medical Center pharmacies, participating network pharmacies, or via Kaiser mail order.

MEDICATION SUPPLY LIMITS

- **SHORT-TERM MEDICATIONS (COLDS, INFECTIONS, ETC.):** Up to a 60-day supply at Kaiser or network retail pharmacies.
- **LONG-TERM MAINTENANCE MEDICATIONS (HIGH BLOOD PRESSURE, DIABETES, ETC.):** Up to a 90-day supply (non-Medicare) or 90-day supply (Medicare) depending on the method.

EXCLUSIONS AND SPECIAL RULES

- **EXCLUDED:** Over-the-counter cosmetics, experimental drugs, erectile dysfunction drugs, and vitamins.
- **DENTAL PRESCRIPTIONS:** Only antibiotics or pain medications are covered. For any other dental-written drugs, you must contact your Kaiser physician first to receive benefits.

RETAIL PHARMACY (UP TO 60-DAY SUPPLY*)

Present your Kaiser ID card at a participating pharmacy. (See www.kp.org for a list of major/independent network pharmacies).

MAIL ORDER SERVICE (UP TO 90-DAY SUPPLY)

Used for maintenance medications. Ask your doctor for a 90-day prescription with refills. Allow seven business days for delivery.

- **FIRST FILL RULE:** Fill new maintenance drugs at a Kaiser Medical Center pharmacy first to consult with a pharmacist before switching to mail order.
- **NON-MEDICARE COPAY:** \$10
- **MEDICARE-ELIGIBLE COPAY:** \$3

**Brand-name drugs are covered at these copays only when a generic version is unavailable. Medicare-eligible participants can receive up to a 90-day supply at retail.*

	KAISER MEDICAL CENTER PHARMACY	MAIL ORDER	KAISER NETWORK PHARMACY
Kaiser Non-Medicare	\$10 copay (up to 60-day supply)	\$10 copay (up to 90-day supply)	\$15 copay (up to 60-day supply)
Kaiser Medicare	\$5 copay (up to 60-day supply)	\$3 copay (up to 90-day supply)	\$10 copay (up to 60-day supply)

■ SilverScript/Caremark Medicare Part D Plan (Medicare-Eligible Retirees)

- **OVERVIEW:** SilverScript (a CVS Caremark division) covers Medicare-eligible retirees and dependents (except those on Kaiser Medicare).
- **NETWORK REQUIREMENT:** You must use one of the more than 68,000 nationwide network pharmacies (retail, mail, long-term care, home infusion) for full coverage. Call your pharmacy beforehand to verify network status, or call Customer Care if they are out of network.

90-DAY MAINTENANCE MEDICATIONS

You can get a 90-day supply of maintenance medications for the same copay through either the CVS Caremark Mail Service or a CVS retail pharmacy.

- **USING NON-CVS PHARMACIES:** You are allowed two initial fills at another (non-CVS) retail pharmacy. After that, if you do not switch to a CVS pharmacy or mail order, you must pay your standard copay plus the price difference between the retail and mail order cost.

MAIL ORDER SERVICE

- Delivery to your choice of location (home, office, vacation site) with **free standard shipping**.
- 24/7 internet and refill-by-phone automated services.
- A 24-hour, toll-free hotline to speak with a registered pharmacist.

CONTACT INFORMATION

- **SILVERSCRIPT CUSTOMER CARE:** 1-866-270-3817 (available 24/7)
- **TTY USERS:** 1-866-236-1069

Prescription copayments are as follows:

PLAN A	CVS RETAIL PHARMACY (30-DAY SUPPLY)	NON-CVS RETAIL PHARMACY (90-DAY SUPPLY)	CVS NETWORK SERVICE PHARMACY (UP TO 90-DAY SUPPLY)
Generics	\$5	\$15	\$10
Brand/Preferred Brand	\$15	\$45	\$30
Non-Preferred Brand	\$25	\$75	\$50

PLAN B	CVS RETAIL PHARMACY (30-DAY SUPPLY)	NON-CVS RETAIL PHARMACY (90-DAY SUPPLY)	CVS NETWORK SERVICE PHARMACY (UP TO 90-DAY SUPPLY)
Generics	\$10	\$30	\$20
Brand/Preferred Brand	\$25	\$75	\$50
Non-Preferred Brand	\$35	\$105	\$70

ENROLLMENT AND U.S. RESIDENCY REQUIREMENTS

- **WELCOME PACKET:** Once enrolled in the MCPS SilverScript/Caremark Part D plan, you will receive a packet outlining benefits, support, and options to decline coverage.
- **RESIDENCY REQUIREMENT:** You must live in the United States. If you use a P.O. Box, you must provide proof of physical U.S. residency upon written request. Failure to declare your physical address will result in canceled coverage, and you can only re-enroll during Open Enrollment.

OUT-OF-POCKET LIMITS AND COST SHARES

- **2025 CAPS:** Medicare applied a \$2,000 True Out-of-Pocket (TrOOP) limit. Once reached, members entered the Catastrophic phase with a \$0 cost share. CVS Health updated its systems to support this and allow an optional Maximum Out-of-Pocket (MOOP) limit on enhanced benefits.
- **2026 CAPS:** The TrOOP limit is \$2,100. Once met, you pay a \$0 copay only on formulary-covered Part D claims. You will continue to pay a copay for drugs covered under the enhanced benefit.

KEY 2026 TrOOP RULES

- All Part D primary benefit formulary drugs apply to the TrOOP.
- Part D claims from any pharmacy delivery channel count toward the TrOOP (mail, retail, paper, long-term care, home infusion, and assisted living).
- If your plan has a Part D deductible, dollars spent on it count toward the \$2,100 TrOOP limit.

DEFINED CONTRIBUTION PLANS—403(B)/457(B)

■ Plan Withdrawals and Age Rules

- **403(B) PLAN:** Withdrawals can begin while employed at age 59½. If you separate from service, IRS penalties apply to withdrawals made before age 59½ (exceptions apply; see www.irs.gov).
- **457(B) PLAN:** Penalty-free withdrawals can begin while employed at age 59½, or upon separation from service at any age.
- **MCPS RE-EMPLOYMENT RULE:** If you separate from service and are re-employed by MCPS in any capacity, penalty-free withdrawals are not allowed if you are under age 59½.

■ Taxes and Required Minimum Distributions (RMDs)

- **TAXES:** Withdrawals are taxable in the year taken, except for qualified Roth distributions, which are generally tax-free.
- **RMDs:** The IRS mandates annual required withdrawals or you will face penalties. RMDs begin when you retire or based on your birth year:
 - » **AGE 73:** If turning 73 currently or later.
 - » **AGE 72:** If you turned 72 in 2022 or earlier.
 - » **AGE 70½:** If you turned 70½ in 2019 or earlier.
 - » **MORE INFORMATION:** Visit www.irs.gov.

■ Requesting a Withdrawal

Contact your specific account vendor directly:

- **FIDELITY INVESTMENTS:** 1-800-343-0860
- **OTHER VENDORS:** Find contact details at www.NetBenefits.com/mcps.

■ Beneficiary(ies)

- Update 403(b)/457(b) beneficiary/ies by contacting Fidelity Investments directly at 1-800-343-0860.

LIFE INSURANCE

■ Life Insurance Continuation at Retirement

- **ELECTION:** At retirement, you can choose to continue or cancel your basic employee term life insurance.
- **RESTRICTIONS:** If you cancel, you cannot re-enroll later. If you are not actively enrolled in the policy at the time of retirement, you cannot continue or enroll in it.
- **VALUE:** Term life insurance has no cash value.

■ Coverage Reductions and Caps

Upon retirement, your coverage amount reduces annually based on your active employee basic life insurance amount:

- **AT RETIREMENT:** Reduces to **42.5 percent** of the active amount.
- **YEARS TWO THROUGH FIVE (POST-RETIREMENT):** Reduces by **7.5 percent** of the active amount each year on your retirement anniversary.
- **FIFTH YEAR AND BEYOND:** Locks in at **12.5 percent** of the active amount for your lifetime (as long as premiums are paid).
- **MAXIMUM CAP:** MCPS retiree basic life plans are capped at a maximum payout of **\$212,500**.

See example of this reduction in chart below:

• EXAMPLE: Term life insurance value was \$154,000 as an active employee.	
	Retiree Term Life Insurance Value
1st Year	\$65,450
2nd Year	\$53,900
3rd Year	\$42,350
4th Year	\$30,800
5th Year	\$19,250

■ Life Insurance Premiums and Administration

- **COST SHARING:** You and MCPS share the cost of term life insurance. Monthly premiums are deducted directly from your retirement check and are subject to change. Rates can be viewed on the ERSC website.
- **BENEFICIARIES:** Update your beneficiaries using MCPS Form 455-22, *Retiree Benefit Plan Enrollment*.

IMPORTANT: This form only updates your term life insurance, not your pension or 403(b)/457(b) plans. They must be updated separately through your pension system and plan vendor.

- **RE-ENROLLMENT:** If you did not elect to continue coverage at the time of retirement, you cannot re-enroll later.
- **DEATH NOTIFICATION:** Family members or beneficiaries must notify ERSC in the event of your death.

■ Accelerated Death Benefit

- **OVERVIEW:** If your life expectancy is 12 months or less, you can receive an advance payment of up to 80 percent of your term life benefit to use for any purpose. Remaining benefits are paid to beneficiaries upon death.
- **HOW TO APPLY:** Submit the *Accelerated Benefit Option Claim Form* available on the ERSC website at www.montgomeryschoolsmd.org/departments/ersc/employees/benefits/life-insurance/employee/. Send the employer portion directly to ERSC.

RETIREE BENEFIT RATES AND COST SHARES

Your benefit costs are based on your MCPS hire date, years of eligible service, and retirement date.

- **MEDICARE-ELIGIBLE:** These factors determine your premium cost-share percentage.
- **NON-MEDICARE-ELIGIBLE:** These factors determine your base cost share, but your final rate may increase or decrease depending on your participation in the Wellness Initiatives program (biometric screening and health risk assessment).
- **WHERE TO FIND RATES:** Review the *Retiree Benefit Rate Schedules* booklet (mailed to your home address in early October) or on the ERSC Retiree Benefits web page at www.montgomeryschoolsmd.org/departments/ersc/retirees/benefits/. The rate schedules also are available during Open Enrollment at: www.montgomeryschoolsmd.org/departments/ersc/retirees/benefits/open-enrollment.aspx.

Determining Your Cost-Share Percentage

GRANDFATHERED GROUP (38 PERCENT RETIREE/62 PERCENT MCPS)

You pay this base cost share if you retired on or before July 1, 2011. You also qualify for this cost-share percentage if you retired after July 1, 2011, have at least five cumulative years of service, and meet one of the following:

- Hired before July 1, 2011, and were at least age 55 as of July 1, 2011.
- Hired before July 1, 2006 (with no break in service).
- Hired before July 1, 2011, and retired with 30 or more years of eligible service in the state core plan. (If this applies, look for the “Twenty or More Years of Active Employment” rates in the rate schedule).

NON-GRANDFATHERED GROUP

If you do not meet the grandfathering rules, your eligibility depends on your hire date:

- Hired July 1, 2006–June 30, 2019: Requires at least 10 cumulative years of service to qualify for retiree benefits.
- Hired/rehired on or after July 1, 2019: Requires at least 10 continuous years of service at retirement to qualify for benefits. Base cost shares for this tier are detailed in the accompanying chart.

MCPS ELIGIBLE SERVICE UPON RETIREMENT	RETIREE PAYS	MCPS PAYS
10 up to 15 years	62%	38%
15 up to 20 years	52%	48%
20 or more years	38%	62%

IMPORTANT WEBSITE AND TELEPHONE NUMBERS

- **Employee and Retiree Service Center:** 240-740-8100
www.montgomeryschoolsmd.org/departments/ersc
- **Department of Controller/MCPS iPayment Business Center:** 240-740-7510
www.montgomeryschoolsmd.org/departments/accounting
- **Division of Human Resources and Talent Management:** 240-740-7010
www.montgomeryschoolsmd.org/departments/personnel
- **Aetna Dental Plan (DMO):** 1-800-843-3661
www.aetna.com
- **Aetna Large Case Pension, Inc.:** 1-800-952-2700
- **Cigna Open Access Plus Plan**
Cigna Open Access Plus In-Network HMO Plan
Cigna Indemnity Plan: 1-800-Cigna24
www.MyCigna.com
- **CareFirst Preferred Dental (PPO) In-network:** 1-888-755-2657
www.carefirst.com/mcps
- **CVS Caremark Prescription Plan:** 1-800-378-7558
www.caremark.com
- **COBRA: Voya :** 1-888-401-3539
- **Davis Vision/Blue Vision Plus (provided through CareFirst):** 1-800-783-5602
www.carefirst.com/mcps
- **Kaiser Permanente HMO and Prescription Plans:** 1-800-777-7902
www.kp.org
- **Maryland State Retirement Agency: 1** 800-492-5909
sra.maryland.gov
- **Maryland State Retirement Agency—Local Member Services:** 410-625-5555
- **MCPS 403(b)/457(b) Plans**
Fidelity Investments: 1-800-343-0860
www.netbenefits.com/mcps
- **MCPS Retirees Association**
www.mcpsra.org
- **Medicare:** 1-800-633-4227
www.medicare.gov
- **MetLife:** 1-800-638-6420
www.metlife.com/mybenefits
- **SilverScript (Part D):** 1-866-270-3817
www.caremark.com
- **Social Security Administration:** 1-800-772-1213
www.ssa.gov

Retiree Benefit Plan Enrollment

Employee and Retiree Service Center (ERSC)
MONTGOMERY COUNTY PUBLIC SCHOOLS
45 West Gude Drive, Suite 1200 • Rockville, Maryland 20850

INSTRUCTIONS

Complete, sign electronically or manually on both sides of this form, and return to the Employee and Retiree Service Center (ERSC). You may fax the signed form to 301-279-3651 or 301-279-3642, or email a PDF of the signed form to ERSC@mcpsmd.org. This form must be signed at the bottom of pages 1 and 2. Please do not mail copies to ERSC once you have faxed or emailed 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 445-1B, *Change in Personal Information for MCPS Retirees and Former Employees* with your benefit enrollment form. Benefit enrollment confirmations are sent to the address on file.

Name _____ Employee ID# _____ SSN # _____
Address: Street _____ City _____ State _____ Zip _____
Home Phone _____ - _____ - _____ Email _____ Retiree Date of Birth ____/____/____
Retirement Date ____/____/____ (new and existing retirees) Spouse Date of Birth ____/____/____

SECTION II: RETIREE ENROLLMENT INFORMATION

- | | |
|--|---|
| ☐ Open Enrollment
☐ Transfer to active spouse, ID# _____
(must include MCPS Form 455-20, <i>Employee Benefit Plan Enrollment</i>)
☐ Transfer to retired spouse, ID# _____
(must include MCPS Form 455-22, <i>Retiree Benefit Plan Enrollment</i>)
☐ Qualifying Life Event
☐ Change from POS to Medicare
☐ Drop dependent(s) | ☐ Deceased dependent—date of death ____/____/____
☐ Change of Beneficiary only—
skip to SECTION VII, LIFE INSURANCE BENEFICIARY DESIGNATION
☐ I cancel/decline all benefit plan enrollment
effective ____/____/____ (Date of cancellation must adhere to
deadline rules in RBS)—skip to SECTION VI, LIFE INSURANCE OPTION |
|--|---|

SECTION III: RETIREE LEVEL OF HEALTH COVERAGE

- ☐ Individual ☐ Two-Party* ☐ Family* *Complete Section V on reverse

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. **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

- ☐ Cigna Open Access Plus In-Network (OAPIN)
 (with Care Management)
☐ Cigna Open Access Plus In-Network (OAPIN)
 (without Care Management)
☐ Kaiser Permanente

OPEN POINT-OF-SERVICE (POS) PLANS¹

- ☐ Cigna Open Access Plus (OAP)
 (with Care Management)
☐ Cigna Open Access Plus (OAP)
 (without Care Management)

INDEMNITY/MEDICARE SUPPLEMENTAL PLANS

- ☐ Cigna Indemnity/Medicare Supplemental Plan
☐ I **decline** medical coverage
☐ No change to **medical plan**

¹When a retiree or dependent becomes Medicare-eligible, this health plan does not coordinate with Medicare. At the time of Medicare Part B enrollment, a plan change will be required. When no plan change is submitted, coverage will default to the Indemnity/Medicare Supplemental Plan.

CATEGORY B (Prescription Drug Plans)—Please select one

- ☐ Caremark (available to all non-Medicare-eligible retirees **except** Kaiser HMO members) ☐ Option A ☐ Option B
☐ SilverScript/Caremark Part D plan for Medicare-eligible participants (available to ages 65 + only) ☐ Option A ☐ Option B
☐ Kaiser (**only** available to Kaiser HMO members)
☐ I **decline** prescription drug coverage
☐ No change to **prescription drug plan**

CATEGORY C (Dental Plans)—Please select one

- ☐ CareFirst 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**

CATEGORY D (Vision Plan)—Please select one

- ☐ Davis Vision (provided through CareFirst)
☐ I **decline** vision coverage
☐ No change to **vision plan**

SIGNATURE REQUIRED ON PAGES 1 AND 2

I understand that my electronic submission of this form, and my electronic signature, are intended to be, constitute, and are equivalent to my personal signature.

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						☐ / ☐
Child						☐ / ☐
Child						☐ / ☐

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 reenroll once life insurance is cancelled.)
- ☐ Change of beneficiary only
- ☐ 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.

☐ **Primary**

Name _____

Address _____

Share _____ % Relationship _____ Date of Birth ____/____/____

☐ **Primary** ☐ **Contingent**

Name _____

Address _____

Share _____ % Relationship _____ Date of Birth ____/____/____

☐ **Primary** ☐ **Contingent**

Name _____

Address _____

Share _____ % Relationship _____ Date of Birth ____/____/____

☐ **Primary** ☐ **Contingent**

Name _____

Address _____

Share _____ % Relationship _____ Date of Birth ____/____/____

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

SIGNATURE REQUIRED ON PAGES 1 AND 2

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Signature _____ Date ____/____/____

