2022

Retiree Benefit Summary

EFFECTIVE JANUARY 1, 2022

- MEDICAL, DENTAL, VISION, PRESCRIPTION DRUG, AND LIFE INSURANCE BENEFITS

Benefits Plan Highlights

- There will be no changes to insurance vendors or plans for 2022.

Maryland's Largest School District

MONTGOMERY COUNTY PUBLIC SCHOOLS

Employee and Retiree Service Center ▪ 45 W. Gude Drive, Suite 1200, Rockville, MD 20850
301-517-8100 ▪ www.montgomeryschoolsmd.org/departments/ersc

VISION

We inspire learning by providing the greatest public education to each and every student.

MISSION

Every student will have the academic, creative problem solving, and social emotional skills to be successful in college and career.

CORE PURPOSE

Prepare all students to thrive in their future.

CORE VALUES

Learning
Relationships
Respect
Excellence
Equity

850 Hungerford Drive
Rockville, Maryland 20850
www.montgomeryschoolsmd.org

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

October 5, 2021

MEMORANDUM

To: Montgomery County Public Schools Retirees

Through: Mr. Krishna A. Tallur, Director
Employee and Retiree Service Center

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 Benefits Open Enrollment Monday, October 11, 2021, through Friday, November 5, 2021. During 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**.** Changes made during Open Enrollment will be effective January 1, 2022, which begins the new plan year.

It is important to understand your benefit choices and make sure you take any necessary action to take advantage of the options available to you. Please read this memorandum carefully. You should also acquaint yourself with the benefit offerings and premium costs by reviewing the attached *2022 Retiree Benefit Summary* and the *2022 Retiree Benefit Rate Schedules*.

Benefits Plan Highlights
There are no changes to insurance vendors or plans for 2022.

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 (October 11 - November 5, 2021), the Employee and Retiree Service Center (ERSC) must receive your changes by the close of business on Friday, November 5, 2021.

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.

Unbundling Your Benefit Plan
You 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 your individual needs. For example, if you have medical insurance through another source and only require prescription coverage, you may choose prescription coverage only. You and your eligible dependents must be enrolled in the same benefit plan components.

If you enroll in the Kaiser Permanente HMO, you also must select Kaiser's prescription coverage. Kaiser does not permit enrollment in its prescription coverage unless you also carry medical coverage with Kaiser. Moreover, the CVS/Caremark prescription plan is not available to Kaiser members.

If you cancel any component of coverage, you may reenroll during a future retiree Open Enrollment if that coverage was cancelled on or after July 1, 1998. Also, you will need documented proof that you have had other coverage for the 12 months immediately preceding reenrollment in the MCPS benefit plan.

Open Enrollment Benefit Webinars
ERSC will hold online Open Enrollment Benefit Webinars again this year. ERSC staff and representatives from the health plans will be available virtually to answer your benefit questions. Dates, times, and plan/vendor options are as follows:

BENEFIT WEBINAR DATES/TIMES	BENEFIT OPTIONS/VENDORS
Monday, October 11, 2021 4:00–6:00 p.m.	CareFirst Indemnity/Medicare Supplement, POS, and HMO medical plans
Tuesday, October 12, 2021 4:00–6:00 p.m.	Kaiser Permanente HMO medical and prescription plans for Medicare Advantage and non-Medicare-eligible retirees
Wednesday, October 13, 2021 4:00–6:00 p.m.	CareFirst Dental PPO & Aetna DMO
Thursday, October 14, 2021 4:00–6:00 p.m.	CVS/Caremark and SilverScript prescription drug plans

New This Year: Open Enrollment Virtual Assistance
In addition to the Open Enrollment Benefit Webinars, ERSC will offer individual assistance virtually from October 18–29, 2021. Retirees will be able to register for a 20-minute Zoom session with an ERSC representative. Please visit the Retiree Open Enrollment web page during Open Enrollment for more information and to sign up.

Retirees may make benefit plan changes between Monday, October 11, 2021, and Friday, November 5, 2021. To make and submit your benefits decisions, refer to this

booklet, the *2022 Retiree Benefit Summary*, which includes health plan comparison charts and MCPS Form 455-22, *Retiree Benefit Plan Enrollment*. Also, review the *2022 Retiree Benefit Rate Schedules*, which details the monthly cost of benefits at each cost sharing arrangement while factoring in Wellness Initiatives credits. Both of these booklets were mailed to you. They also will be made available online at *www.montgomeryschoolsmd.org/departments/ersc/retirees/benefits/* the week before Open Enrollment begins.

During Open Enrollment, ERSC staff members will be available to assist you Monday–Friday from 8:00 a.m. to 4:30 p.m. via email at ERSC@mcpsmd.org or from 8:00 a.m. to 4:15 p.m. by telephone at 301-517-8100.

KAT:RCJ:mjw

Attachment

Approved: 

Robert Reilly, Associate Superintendent of Finance

Montgomery County Public Schools

2022 RETIREE BENEFIT SUMMARY

Montgomery County Public Schools (MCPS) provides a comprehensive 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 *2022 Retiree Benefit Summary* provides an overview of the benefits available to eligible retirees, effective January 1, 2022. This summary includes information about eligibility for MCPS benefits, access to 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 this benefit summary, *the Retiree Benefit Rate Schedules*, and specific evidence of coverage documents that provide additional details about each plan.

During Open Enrollment, ERSC staff is available to assist you via email Monday–Friday, from 8:00 a.m.–4:30 p.m. and by telephone from 8:00 a.m.–4:15 p.m. Staff is available throughout the year to assist you via email or by telephone Monday–Friday from 8:00 a.m.–4:15 p.m. Our email address and telephone number are below:

Montgomery County Public Schools
Employee and Retiree Service Center
45 W. Gude Drive, Suite 1200
Rockville, Maryland 20850
ERSC@mcpsmd.org
301-517-8100

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 Medicare-eligible at your retirement, you will need to submit your Medicare Part A and B card to ERSC 60 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.

Table of Contents

About Your Benefits

WHO CAN PARTICIPATE IN OPEN ENROLLMENT?

Retirees:
- who currently are enrolled in an MCPS health plan; or
- 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?

Retirees with at least five cumulative years of MCPS-eligible service who*:
- have a current hire date that is prior to July 1, 2006, with no break in employment; or
- retired on or before July 1, 2011; or
- were hired prior to July 1, 2011, with at least 30 years of eligible service in the state core plan; or
- were hired prior to July 1, 2011, and were at least 55 years of age as of July 1, 2011

Retirees with at least 10 cumulative years of MCPS-eligible service who retired after July 1, 2011, and who*:
- were hired on or after July 1, 2006, and before July 1, 2019; and
- were under 55 years of age as of July 1, 2011

Retirees with at least 10 continuous years of MCPS-eligible service who were*:
- hired or rehired on or after July 1, 2019*

* from most recent hire or rehire date at the time of retirement

WHO IS INELIGIBLE FOR BENEFITS?

- If you or your dependents do not meet minimum eligibility requirements as outlined above, then you are ineligible for coverage under the MCPS plan.
- If you were not eligible for coverage as an active employee, you and/or your dependent(s) are not eligible for coverage after you retire.
- 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.
- If any dependents were not eligible at the time of your retirement, they are ineligible for coverage after you retire.

ELIGIBLE DEPENDENTS

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

Eligible dependents include your—
- spouse, and
- eligible children who meet the following age requirements:
  - until the end of the month in which they turn 26 for medical and prescription coverage
  - until the end of the month in which they turn 24 for dental and vision coverage
  - until September 30 following their 23rd birthday for life insurance coverage

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

Spouse:
- Social Security number and
- valid marriage certificate or current joint tax return (signed by both parties or a copy of the confirmation of electronic submission)

Biological Children:
- Social Security number and
- valid birth certificate or valid birth registration

Stepchildren:
- Social Security number and
- valid birth certificate or valid birth registration and
- shared or joint custody agreement (court validated) up to age 18

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

- Social Security number and one of the following:
  - adoption documents (court validated)
  - guardianship or custody documents (court validated)
  - foster child documents (county, state, or court validated)

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 intellectual disability or physical disability, or
- he or she 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 at the end of the month in which he/she turns age 26 for medical and prescription coverage, and at the end of the month he/she turns age 24 for dental and vision benefits.

If you change your medical plan, you will be required to submit for review 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. If MCPS is not notified prior to—

- the dependent's 26th birthday, medical and prescription benefits will be cancelled;
- the dependent's 24th birthday, dental and vision coverage will be cancelled; and
- September 30 following the dependent's 23rd birthday, life insurance will be cancelled.

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 and any children who were not eligible at the time of your retirement are not eligible for coverage under the plan and may not be added after retirement. Spouses and/or dependents who were eligible for benefit coverage at the time of your retirement may be added or reenrolled with proof of other coverage during the previous 12 months.**

CHANGES IN COVERAGE

In general, eligible retirees may enroll in or make changes to health plans only during Open Enrollment. However, benefits changes due to a qualifying life event may be made during the plan year. Qualifying life events include:

- Divorce
- Loss or gain of alternative coverage
- Change of work status
- Relocation outside your current plan service area
- Retirement
- Death

If you experience a qualifying life event, you have 60 days from the date of the 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 before you submit the 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 all 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 during the plan year. If you choose to cancel coverage, you must cancel the entire retiree benefit plan (with the exception of life insurance coverage).

You **may** drop one or more components of your benefit plan during the annual Open Enrollment.

If ERSC receives your changes by the fifth of the month, they will go into effect on the first day of the following 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.

IF YOU SUBMIT YOUR ENROLLMENT FORM:	YOUR COVERAGE WILL BEGIN ON:
On or before January 5	February 1
Between January 6 and February 5	March 1
On February 10	April 1

It is your responsibility to promptly notify ERSC of all changes, including removal of coverage or death of dependents and changes to name, address, and phone number. Removing a dependent's coverage could change your coverage level and reduce your monthly premium.

LOSS OF NON-MCPS COVERAGE

You may enroll in an MCPS-provided benefits plan during the plan year if you or your benefits-eligible dependents lose coverage provided by a business or organization other than MCPS. Your benefits coverage will be effective the first of the month following your enrollment.

PAYING FOR COVERAGE

Benefit plan premiums are deducted from your or your surviving spouse's retirement check or are direct billed when the retirement check is not sufficient to cover the premium..

Refer to the *Retiree Benefit Rate Schedules* that will be mailed to your home address before Open Enrollment for your 2022 health coverage costs.

WHEN BENEFITS COVERAGE ENDS

Retiree coverage is provided to the retiree and eligible surviving spouse for life. Please keep in mind that your medical benefits change when you become eligible for Medicare. For more information about how Medicare affects your MCPS retiree benefits, see the section in this document titled "Enrollment in Medicare."

Benefits coverage for a dependent child's medical and prescription plans automatically ends at the end of the month in which he/she turns 26. Benefits coverage for a dependent child's dental and vision plans automatically ends at the end of the month in which he/she turns 24. For life insurance coverage, a dependent's coverage ends on September 30^{t} following his/her 23rd birthday.

CONTINUATION OF BENEFITS (COBRA)

If coverage ends, your dependent(s) may be eligible to continue coverage as provided under COBRA.

Under COBRA, your dependent(s) 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. If your dependents' coverage ends, he/she will receive a qualifying event

notice directly from Benefits Strategies, the MCPS third-party COBRA administrator.

Benefits may also be available through a State Health Insurance Exchange or the national *Affordable Care Act* website.

OUT-OF-AREA COVERAGE

Each health plan has different requirements when retirees travel or reside outside of the coverage area.

Retirees enrolled in the Kaiser Permanente Health Maintenance Organization (HMO) are required to live in the Kaiser Permanente service area (mid-Atlantic). 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. There is no authorization required for emergency services received in an emergency room while out of the Kaiser Permanente service area. 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 only for cases in which care is not administered in an emergency room.

If you are enrolled in the CareFirst BlueChoice HMO Open Access plan, any dependent or retiree who resides or attends school outside the service area will only be covered for urgent care or emergency services. You have access to the Away From Home Care (AFHC) Program, which 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 AFHC, contact CareFirst BlueChoice at 1-888-452-6403 for details and enrollment procedures. Enrollment in this program may alter copays and coverage to the plan available in that service area.

If you are enrolled in the CareFirst Exclusive Provider Option (EPO), an HMO plan for retirees living outside of the CareFirst BlueChoice service area, you may access care while traveling/visiting outside your specific service area by contacting a CareFirst customer service representative at 1-888-452-6403. Any dependent or retiree who resides or attends school outside the service area will only be covered for urgent care or emergency services. You have access to the AFHC Program, which 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 AFHC. To take advantage of AFHC, contact CareFirst BlueChoice at 1-888-452-6403 for details and enrollment procedures.

Members of the CareFirst BlueChoice POS plan have access to a national network of approximately 1 million PPO providers. This plan allows you to seek care in-network nationally. If you are covered by the CareFirst BlueChoice POS plan, you also have the option to see a nonparticipating provider, but your out-of-pocket expense will be higher if you do. If you receive services from a provider outside of the network, you will have to—

- pay the provider's actual charge at the time you receive care,
- file a claim for reimbursement, and
- satisfy a deductible and coinsurance.

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 always will 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 is determined by the courts.

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 (SSA) and are beginning the 25th month of entitlement, or
- have end-stage renal disease (ESRD).

You are eligible for Medicare the first day of the month that 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 or a benefit entitlement letter from SSA be submitted 60 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 October 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 Part B because you were actively employed, you must contact the SSA at least three months prior to your retirement date to enroll in Medicare Parts A and B to coincide with your retirement date. You must submit a copy of the Medicare card with Parts A and B to ERSC with your retirement forms. Instructions for enrolling online in Medicare Part B are available at *https://www.ssa.gov/pubs/EN-05-10531.pdf*. If you are enrolled in Medicare Part A, be sure to contact your local SSA office before enrolling online.

Once you apply for Medicare Part B, please visit *www.Medicare.gov*, register and create a username and password. This will allow you to track the progress of your Medicare Part B application at the SSA and provide you with access to a PDF version of your Medicare Part B card. Please email the pdf version of your Medicare Part B card to ERSC at *ersc@mcpsmd.org*.

If you and/or your covered dependent(s) become eligible for Medicare after you retire, you must contact the SSA at least three months before you become eligible 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 three months 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 ESRD, you must contact ERSC at 301-517-8100.

Important note about the Medicare Part B premium as it applies to enrollment in a medical and/or prescription plan through MCPS: Since 2007, Medicare beneficiaries with high incomes have paid higher monthly premiums than the standard monthly premium

for Medicare Part B. Using the income reported for the previous two years on your Internal Revenue Service (IRS) income tax returns, the SSA determines if you will have an income-related monthly adjustment amount (IRMAA). The IRMAA is effective from January 1 through December 31 each calendar year. The SSA refigures your Medicare Part B premium amount each year when the IRS updates the information. At the time of your Medicare Part B enrollment, if the SSA determines that you must pay a higher Medicare Part B premium, you are advised to contact the SSA to find out if you qualify for one of its eight life-changing events that might reduce your IRMAA. Additional information is available by reviewing the SSA publication "Medicare Premiums: Rules for Higher-Income Beneficiaries," found at *www.ssa.gov/benefits/medicare/*.

COORDINATION OF MEDICARE BENEFITS

To ensure the proper coordination of Medicare benefits, members of CareFirst and Kaiser Permanente must submit a copy of their Medicare cards to ERSC 60 days prior to the effective date of their Medicare coverage.

If you are a Kaiser Permanente member, you have additional requirements. Kaiser will send its Medicare application to you two to three months prior to your or your dependent's 65th birthday. Complete and return the application to ERSC. Kaiser Permanente Medicare includes enrollment in Kaiser Medicare Part D (prescription drug benefit program). If you enroll in another Medicare Part D plan, your Kaiser Permanente Medicare membership (prescription and medical) will be terminated on the start day of your new Medicare Part D plan.

All of the medical plans will update Medicare with all pertinent information, and your health provider will submit medical claims first to Medicare. Medicare determines the allowed amount, pays the Medicare portion of the claim (80 percent), and then submits the claim to your medical plan for secondary payment (20 percent of the Medicare-allowed amount).

Medicare Eligibility and POS Medical Plan

Retirees and/or covered dependents enrolled in the CareFirst BlueChoice Advantage POS plan may not remain on the plan once they are eligible for Medicare. If you are enrolled 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. You will then have the following two options:

Option (1): You and your covered dependent(s) will be transferred automatically to the CareFirst BlueChoice Advantage Indemnity/Medicare Supplemental Plan.

For the non-Medicare individual(s), the CareFirst Indemnity plan will be the default medical coverage. With this plan, the non-Medicare-eligible individual will have a yearly deductible and co-insurance for all medical services. For the Medicare-eligible individual, Medicare will be the primary medical plan and the CareFirst BlueChoice Advantage plan will be the secondary coverage. If you do not elect Option 2, you and your covered dependent(s) will be transferred automatically to this option.

Option (2): You may choose to enroll in the CareFirst BlueChoice HMO Open Access medical plan offered by MCPS as long as you reside within the plan's Maryland service area. If you reside outside the Maryland service area, you may choose the CareFirst Exclusive Provider Option (EPO) plan. This is an HMO plan for retirees living outside of the CareFirst service area.

You 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. You and your covered dependent(s) will be transferred to the new plan with a start date of the Medicare effective date.

If you do not meet the deadline for Option 2, you and your covered dependent(s) will be enrolled automatically in the CareFirst BlueChoice Advantage Indemnity/Medicare

Supplemental plan and may not make changes until the next Open Enrollment.

MEDICARE PART D

MCPS offers a Medicare prescription drug benefit program, Medicare Part D, to Medicare-eligible individuals through SilverScript, a Caremark owned company. Private, Medicare-approved Part D prescription plans also are available, but if you opt to enroll in a private plan, neither you nor your dependents will be able to enroll or continue in the SilverScript/ Caremark Part D plan.

If you or your spouse enroll in another Medicare Part D plan while enrolled in the MCPS sponsored SilverScript/Caremark prescription drug plan, the SilverScript/Caremark prescription drug plan will be terminated on the start date of the other Medicare Part D plan.

Kaiser Permanente Medicare includes enrollment in Medicare Part D. If you enroll in another Medicare Part D plan, your Kaiser Permanente Medicare membership (including medical) will be terminated on the start date of your other 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 OR if you fail to maintain coverage with Medicare.

Benefit Forms Access

Forms to enroll in benefits, make changes, and file claims are available online. Most forms are available in Adobe Portable Document Format (PDF) and require Adobe Reader to download. There are several ways to access benefits forms:

SEARCH THE MCPS WEBSITE

The MCPS website includes a search box in the upper right corner of every MCPS web page. Enter a form name, number, or keyword in this search box to see a list of results to match your search. Navigate to the form you need.

SEARCH THE MCPS FORMS DIRECTORY

All MCPS forms are available on the MCPS forms directory web page, which can be found at *www.montgomeryschoolsmd.org/departments/forms*. Enter a form name, number, or keyword in the search box to see a list of results that match your search. Navigate to the form you need.

USE THE ERSC FORMS WEB PAGE

ERSC maintains a forms web page where links to all retiree benefits forms are compiled. This web page is located at *www.montgomeryschoolsmd.org/departments/ersc/retirees/forms*. You can browse for forms by benefit type. For example, a CareFirst claim form would be located in the "health benefits" section under "medical forms."

USE THE DIRECT LINK

The following is a direct link to the benefit enrollment form, MCPS Form 455-22, *Retiree Benefit Plan Enrollment: ww2.montgomeryschools*md.org/departments/forms/pdf/455-22.pdf.

Please note: If you are not making changes to your benefits plan during Open Enrollment, please do not submit MCPS Form 455-22.

SUBMITTING BENEFITS FORMS

All forms must be submitted to ERSC. Forms can be submitted in the following ways:

- Mail: 45 W. Gude Drive, Suite 1200, Rockville, Maryland 20850
- Email: ERSC@mcpsmd.org
- Fax: 301-279-3651 or 301-279-3642

If you choose to submit a form via email, please note that you must submit an electronically signed Adobe PDF file. You also may scan a copy of your form with your original signature and attach it to an email.

Your Benefits at a Glance

The chart below is a brief overview of your benefit options for 2022. For more information, refer to the appropriate section in this benefits summary.

Benefit	Your Options
Protecting Your Health	
Medical Point-of-Service (POS) Health Plan	• CareFirst BlueChoice Advantage (POS)
Health Maintenance Organizations (HMO) Health Plans	• CareFirst BlueChoice HMO Open Access • CareFirst Exclusive Provider Option (EPO) *(an HMO plan for retirees living outside of the CareFirst service area)* • Kaiser Permanente HMO
Indemnity (PPO) Plan	• CareFirst BlueChoice Advantage Indemnity/Medicare Supplemental Plan—fee-for-service plan
Prescription Drug	• CVS Caremark Prescription Drug Option A or B (only available to CareFirst BlueChoice 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 Shelter Savings Plan	Fidelity—Participants in the MCPS 403(b) plan become eligible for distributions, without penalty, upon attaining age 59½ (regardless of employment status) or separation from service after attaining age 55. For directions to obtain distributions, please visit *www.NetBenefits.com/mcps*.
457(b) Deferred Compensation Plan	Fidelity—Participants in the MCPS 457(b) plan become eligible for distributions upon separation from service or attaining age 59½. For directions to obtain distributions, please visit *www.NetBenefits.com/mcps*. ***Note: 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

Each year, if you are a non-Medicare eligible retiree who is covered by an MCPS-provided medical insurance plan through CareFirst or Kaiser Permanente, you can reduce your contributions to your health insurance by participating in the Wellness Initiatives program. To receive these incentives, you must complete a biometric health screening and a health risk assessment **between the first day of fall Open Enrollment and the Friday before the next Open Enrollment begins a year later.** After you complete your biometric health screening and/or health risk assessment, the incentive(s) will go into effect January 1 of the calendar year that follows the deadline. If you retire after having completed your screening and assessment as an *employee*, you will need to complete them again by the deadline—as a *retiree*—to receive the rate reductions for the next calendar year.

BIOMETRIC HEALTH SCREENINGS

Biometric health screenings monitor for disease and assess risk for future medical problems. By completing a biometric health screening of your blood pressure, blood sugar, body mass index (BMI), and cholesterol, you will be eligible for a 1 percent increase in MCPS contributions toward your health insurance. This means that your contribution to your health insurance will be reduced by 1 percent if you complete the biometric screenings within the above timeframe. Your health screening may be completed by your primary care physician (PCP) during your annual physical **or** at one of your medical plan's health screenings sponsored by Well Aware.

CareFirst BlueChoice plan members—If you opt to have your physician complete your health screening, your physician must complete and sign a CareFirst Health and Wellness Evaluation form. You will need to log in to the CareFirst website to access and submit the online form. Instructions are available on the Wellness Initiatives for Retirees web page at *www.montgomeryschoolsmd.org/departments/ersc/retirees/benefits/wellness-initiatives.aspx*.

HEALTH RISK ASSESSMENT

Health risk assessments are online surveys that ask basic health and lifestyle questions to provide you with a baseline of your current health status. If you complete a health risk assessment by the deadline, your contribution to your health insurance will be reduced by 1 percent.

Your online health risk assessment must be completed through the medical plan in which you are enrolled. If you have not already done so, you will need to create an online account with your medical plan. To set up your account, visit your medical plan's website (listed below) and complete a simple registration process:

- Carefirst—*www.carefirst.com*
- Kaiser Permanente—*www.kp.org*

MCPS will **not** receive the results of your biometric health screening or health risk assessment. Your health insurance carrier will only indicate whether you have completed your screening and/or assessment. Your personal information is protected by the federal *Health Information Portability and Accountability Act*.

DIABETES SUPPLIES

If you have diabetes and enroll in your medical plan's diabetes case management program, copayments for diabetic supplies (not including medications) will be waived for a year.

Medical Coverage

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

Point-of-Service (POS) option:
- CareFirst BlueChoice Advantage (POS Plan)

Health Maintenance Organization (HMO) options:
- CareFirst BlueChoice HMO Open Access
- CareFirst Exclusive Provider Option (EPO) (an HMO for retirees living outside of the CareFirst area)
- Kaiser Permanente HMO

Indemnity Plan (traditional fee-for-service) option:

- CareFirst BlueChoice Advantage Indemnity/ Medicare Supplemental Plan

POINT-OF-SERVICE (POS) PLAN

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 PCP 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.

With this plan, you have the option to go to any medical provider and facility. However, when choosing in-network providers, your level of benefit coverage will be greater than opting to receive services outside the network.

The POS plan does not require you to obtain a referral to visit a participating in-network physician or specialist for medically necessary care. Refer to the POS comparison chart later in this document for more details.

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

CareFirst BlueChoice Advantage POS Plan

The BlueChoice Advantage POS plan offers in- and out-of-network benefits and has the added advantage of access to either the local BlueChoice (POS) network or the national BluePreferred (PPO) network.

Benefits of BlueChoice Advantage:

- Access to more than 1 million providers nationally
- No PCP selection required
- No PCP referral required to see a specialist
- Pay copays when you receive care from an in-network provider
- Preventive services, including well child visits, annual adult physicals, and routine cancer screenings

The BlueChoice Advantage POS offers you the flexibility and freedom to choose from both in- and out-of-network providers.

When care is rendered in Maryland, D.C., or Northern Virginia, use the CareFirst BlueChoice network to receive the highest level of coverage and pay lower out-of-pocket costs.

Members seeking care outside the CareFirst service area will lower costs by using a national BluePreferred provider. You will still have the option to seek service outside the BluePreferred network, but will pay a higher out-of-pocket expense if you do. If you receive services from a provider outside of the network, you must—

- pay the provider's actual charge at the time you receive care,
- file a claim for reimbursement, and
- satisfy a deductible and coinsurance.

HEALTH MAINTENANCE ORGANIZATIONS (HMOs)

An HMO offers a full range of services provided or authorized by your PCP or by an in-network specialist. You may receive benefits only 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 later in this document for more details.

CareFirst BlueChoice HMO Open Access—Maryland Area Access

CareFirst BlueChoice is an individual practice HMO in which you select a PCP from a list of participating doctors at *www.carefirst.com/mcps* or by telephoning CareFirst at 1-800-545-6144. Your PCP will offer 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. Pre-authorization is 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 CareFirst BlueChoice directly online or by phone at 1-800-545-6199.

Specialty care benefits are covered as follows:

- Chiropractic manipulation: 20 visits/year, $15 copay/visit
- Diabetic education/training: $15 copay (benefits are paid at 100 percent of the allowed amount)
- Physical, speech, and occupational therapy: 30 visits/year, $15 copay/visit, 100 percent of allowed amount
- Away From Home Care*

CareFirst BlueChoice HMO Open Access Diabetic Supplies for Medicare Part B Enrollees—CareFirst BlueChoice HMO Open Access covers diabetic supplies only for retirees enrolled in Medicare Part B. Copays for diabetic supplies are waived for Medicare-enrolled HMO plan members. To confirm network participation for a particular pharmacy or copay for a particular supply, you may check with your pharmacist or visit the online pharmacy service at *www.carefirst.com*.

**Away From Home Care (AFHC) provides benefits for CareFirst BlueChoice HMO Open Access plan participants residing outside of their local HMO service area for 90 days or more. Some areas of the country do not participate in AFHC. To take advantage of the program, contact CareFirst at 1-888-452-6403 for details and enrollment procedures. AFHC enrollment may alter copays and coverage to the plan available in that service area.*

CareFirst Exclusive Provider Option (EPO)

Like the local HMO option, CareFirst is offering an HMO option for retirees living outside the CareFirst Maryland access area—a national plan.

Your PCP will offer 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. Pre-authorization is 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 visit by phone at 1-800-545-6199 or online at *www.carefirst.com/mcps*.

Specialty care benefits are covered as follows:

- Chiropractic manipulation: 20 visits/year, $15 copay/visit
- Diabetic education/training: $15 copay (benefits are paid at 100 percent of the allowed amount)
- Physical, speech, and occupational therapy: 30 visits/year, $15 copay/visit, 100 percent of allowed amount

Kaiser Permanente HMO

Kaiser Permanente is a center-based HMO with more than 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. You should 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.

Kaiser Permanente Additional Benefits

Silver and Fit Membership—This no-cost gym membership at participating fitness centers also includes up to three at-home fitness kits. Learn more at *silverandfit.com*.

Transportation—Kaiser Permanente's Medicare Advantage includes 24 one-way rides for non-urgent medical appointments at Kaiser Medical Centers and contracted facilities.

Brain HQ—These online exercises that you can do on a computer or mobile device improve cognitive function (including memory, attention, and processing speed) as well as daily life (safe driving, improved balance, and better mood). Once you become a Kaiser Permanente Medicare Advantage Member, you will receive a new member welcome kit with instructions to set up your no-cost account.

INDEMNITY/MEDICARE SUPPLEMENTAL PLAN

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

CareFirst BlueChoice Advantage Indemnity/Medicare Supplemental Plan

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 choose the CareFirst BlueChoice Advantage Indemnity/Medicare Supplemental 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 participant(s) are not, also may choose to enroll in the CareFirst Indemnity/Medicare Supplemental plan. In this case, the plan provides primary coverage for the non-Medicare-eligible individual(s) and secondary coverage to the Medicare-eligible individual. The primary coverage benefits are similar to those listed on the non-Medicare Indemnity chart for the CareFirst BlueChoice Advantage plan on page 19 of this booklet.

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 CareFirst Medicare Supplemental 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 CareFirst Medicare Supplemental 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 percent of the Medicare-allowed amount and your MCPS-sponsored supplemental plan will pay the other 20 percent. If you receive care from a nonparticipating 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 CareFirst Medicare Supplemental 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.

CareFirst will update Medicare with all pertinent information and your health provider will submit medical claims first to Medicare. Medicare determines the eligible amount, pays the Medicare portion of the claim (80 percent), and then submits the claim to CareFirst for secondary payment (20 percent of the Medicare-eligible amount). A chart outlining the benefits paid by Medicare and the Medicare Supplemental Plan is included in this booklet.

CareFirst Medicare Supplemental Plan and Diabetic Supplies for Medicare Part B Enrollees—Diabetic supplies are covered for Medicare Part B enrollees under the CareFirst medical plan or the Medicare Part D prescription plan. If you are enrolled in the CareFirst Medicare Supplemental Plan, you must choose to receive your diabetic supplies through either of these plans. You must contact the member services toll-free number on the back of your insurance card to obtain a list of approved providers. You will be responsible for any copays 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 have copays when they are provided by in-network providers. 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 copays outlined in the HMO and POS comparison charts on the following pages. Out-of-network coverage remains unchanged, and coinsurance is 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 copayments. For more information about Medicare coverage of preventive services, see the booklet "Your Guide to Medicare's Preventive Services," available at *https://www.medicare.gov/Pubs/pdf/10110-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 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: • 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*

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
Immunization 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*

Health Maintenance Organization (HMO) Plans	CareFirst BlueChoice HMO Open Access (Maryland service area) and CareFirst EPO (outside Maryland service area)	Kaiser Permanente HMO
Annual Deductible	None	None
Preventive Care		
Routine Physical Exam	$10 copay*	Covered in full
Well Baby/Child Care	$10 copay*	Covered in full (under age 5)
Childhood Immunizations	$10 copay*	Covered in full (under age 5)
Physician Services		
Physician Office Visit	$10 copay	$10 copay
Specialist Office Visit	$15 copay	$15 copay
Lab Work and X-rays	Covered in full	Covered in full
Allergy Shots	$10 copay ($15 copay for specialist)	$10 copay
Maternity Care		
Prenatal and Postnatal Care	$15 copay, no charge once pregnancy is confirmed*	$10 copay, no charge once pregnancy is confirmed*
Physician Services	Covered in full	Covered in full
Hospital Services	Covered in full	Covered in full
Emergency Services (when medically necessary)		
Urgent Care Centers	$15 copay	$15 copay
Emergency Room	$100 copay (waived if admitted)	$100 copay (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	Covered in full
Professional Services	Covered in full	Covered in full
Surgical Procedures	Covered in full	Covered in full
Specialty Care/Consultation	Covered in full	Covered in full
Anesthesia	Covered in full	Covered in full
Radiology and Drugs	Covered in full	Covered in full
Intensive Care	Covered in full	Covered in full
Coronary Care	Covered in full	Covered in full
Hospital Services—Outpatient		
Surgical Procedures	Covered in full	$15 copay
Professional Fees	$15 copay	Covered in full
Mental Health/Substance Abuse Services		
Inpatient Days	Covered in full	Covered in full
Outpatient Visits	$10 copay	$10 copay
Other Services		
Catastrophic Illness	Covered in full	Covered in full
Durable Medical Equipment	You pay 25%**	Covered in full
Home Health Care	Covered in full	Covered in full
Hospice Care	Covered in full	Covered in full
Skilled Nursing Care	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.*

Open Point-of-Service (POS) Plan	CareFirst BlueChoice Advantage (POS)	
	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	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	$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.*

Non-Medicare Indemnity Plan	CareFirst BlueChoice Indemnity Medicare Supplemental Plan
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 Care (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

**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.*

Montgomery County Public Schools

Medicare Supplemental Chart*

2022	Medicare	CareFirst BlueChoice HMO**	CareFirst BlueChoice Advantage Medicare Supplemental	Kaiser Medicare HMO**
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%	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	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	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)**	Covered in full	Covered in full	Medicare-covered preventive care covered in full

**Benefits provided per calendar year unless otherwise specified.*
***HMOs provide standard benefit package. Reimbursement is obtained from Medicare up to the limits shown.*

Montgomery County Public Schools

Medicare Supplemental Chart*

2022	Medicare	CareFirst BlueChoice HMO**	CareFirst BlueChoice Advantage Medicare Supplemental	Kaiser Medicare HMO**
Hospitalization: Days 1–60	**Pays all but 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
Days 91–150	**Pays all but Part A deductible**	Pays Part A Deductible	Pays Part A Deductible	Pays Part A Deductible
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	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%

**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 applicable section in this document for more information).

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 Fidelity directly to change beneficiaries.

Dental Coverage

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

- CareFirst Dental Plan (PPO)
- Aetna Dental Maintenance Organization (DMO)

Kaiser Permanente medical plan members are automatically enrolled in the Kaiser Permanente dental plan. They have the option of also enrolling in either the PPO plan or DMO plan.

You may change dental plans only during Open Enrollment or if a DMO participant and you move outside the Aetna DMO service area.

CAREFIRST DENTAL PREFERRED PROVIDER ORGANIZATION (PPO)

If you enroll in the CareFirst Dental PPO plan, you have the freedom to select the dentist of your choice. This plan offers in- and out-of-network benefits.

You can access in-network provider information by calling 1-888-755-2657 or visiting CareFirst's website at *www.carefirst.com/mcps*.

- Under Find a Doctor, click **Search Now.**
- Log in to My Account.
- Select Dental.
- Search by Name or Specialty.

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 nonparticipating (out-of-network) dentist, you receive a less generous level of benefits. Reimbursement is based on the schedule of dental benefits and is subject to deductibles, copays, and reasonable and customary charges. Prophylaxis, including scaling and polishing, is covered up to two times per calendar year.

There is no orthodontic coverage for retirees or their dependents.

AETNA DENTAL MAINTENANCE ORGANIZATION (DMO)

If you wish to enroll in the Aetna DMO plan, you must enroll with a primary DMO dentist 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).

KAISER PERMANENTE DENTAL PLAN

The Kaiser Permanente medical and prescription plan includes a schedule of benefits for in-network dental care. Participants pay $30 for a dental exam and cleaning and as much as $493 for a metallic crown. This option is not available to those who are not Kaiser Permanente members.

Refer to the chart on the next page for more information about your PPO and DMO dental options. For details about the Kaiser Permanente dental plan, visit *www.montgomeryschoolsmd.org/departments/ersc/employees/benefits/health/medical/kaiser.aspx* and click on the Evidence of Coverage link.

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** **Class II** **Class III**	 None $50 $50	 None $100 $100	 None None 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 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

As a participant in the Davis Vision plan, you have access to care through either our network of independent, private practice doctors (optometrists and ophthalmologists) or select retail partners for vision services. 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 **Contact Lenses:** Medically Necessary** Standard or Disposable	 $20 $35 $45 $120 $230 $40	Two lenses during any consecutive 18-month period (in lieu of contact lenses) In lieu of lenses and 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

Value Added Features—Replacement contacts (after initial benefit) through *www.DavisVisionContacts.com* mail order contact lens replacement service ensures easy and convenient online purchasing and quick shipping direct to your door.

The vision plan enables participants to purchase lens option services at discount prices. The plan also provides LASIK surgery discounts of up to 25 percent off the provider's usual and customary fees or 5 percent off advertised specials, whichever is lower. For additional information on LASIK surgery, please call 800-783-5602 for a list of participating Davis Vision providers.

Out-of-Network Vision Services—Please be aware that non-Davis Vision providers will expect the entire payment up-front. You may then seek reimbursement by submitting a claim form to Davis Vision. You will be reimbursed up to your allowed amounts.

Need More Information?—Visit *www.carefirst.com/mcps* to access the Davis Vision website or call 1-800-783-5602. Hours of operation are—

- Monday–Friday, 8:00 a.m.–8:00 p.m.
- Saturday, 9:00 a.m.–4:00 p.m.

When you enroll in the vision plan, you will receive a vision plan ID card and claim forms.

KAISER VISION PLAN

In addition to medical and prescription coverage, Kaiser Permanente offers a vision program. For details about this vision plan, visit *www.montgomeryschoolsmd.org/departments/ersc/employees/benefits/health/medical/kaiser.aspx* and click on the Evidence of Coverage link. You will find the vision plan information on page 118. The in-network-only benefits are as follows:

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
Medically necessary contact lenses (Limited to a select group)	No charge
Low vision aids: (Unlimited low vision aids from available supply)	No charge
Vision hardware allowance	$100 allowance per calendar year towards corrective eyeglasses, lenses, frames and contacts at Kaiser Permanente Vision Centers

Prescription Drug Coverage

Two prescription drug plans are offered to MCPS retirees who **are not eligible** for Medicare. These are the CVS Caremark prescription plan and the Kaiser Permanente prescription plan. Eligibility for a plan depends on which medical plan you choose. If you enroll in a 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.

If you **are eligible** for Medicare, MCPS offers a Part D prescription plan through SilverScript, a division of CVS/Caremark. Kaiser Permanente is also a Medicare Part D provider; if you are a Kaiser Permanente member and wish to have a prescription drug benefit, you must enroll in the Kaiser Medicare Part D prescription plan in order to maintain medical coverage through the Kaiser Medicare HMO plan.

CVS CAREMARK PRESCRIPTION DRUG PLAN

(for non-Medicare-eligible retirees)

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.

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

For long-term maintenance medications, you are allowed one initial fill and one refill at any participating retail pharmacy. After that, you only may fill your 90-day supply of long-term maintenance medications at a CVS pharmacy or through the CVS Caremark Mail Service pharmacy.

Some long-term medications are subject to the specialty drug guideline management program or the generic drug step therapy program. Refer to the sections “Specialty Drug Coverage” and “Generic Drug Step Therapy” for information about each program.

Please Note
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.

MCPS offers retirees the opportunity to choose between two prescription plan options administered by CVS Caremark:

- Plan Option A has lower copays but higher monthly premiums.
- Plan Option B has higher copays, but lower monthly premiums.

Both options have a three-tier copay structure and provide financial incentives for using generic drugs, using preferred brand name drugs, and purchasing maintenance medications through a CVS pharmacy or CVS Caremark's mail order pharmacy. These copay structures apply only to those drugs not subject to the specialty drug guidelines or generic drug step therapy. Prescription copayments are as follows:

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. Note: 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.

Coverage for over-the-counter drugs, cosmetic drugs, experimental drugs, drugs to treat erectile dysfunction, 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, and medication to treat fungal infections all require prior authorization
- All specialty medications (see the "Specialty Drug Coverage" section for details)

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).

To take advantage of the lowest copay available, 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 copay 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 and is not subject to the generic drug step therapy program, you will be charged the brand-name copay 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
Fax: 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:

1. For any preferred brand-name drug that does appear on CVS Caremark's Primary Preferred Drug list (updated quarterly), Option A has a $30 copay and Option B has a $50 copay.
2. For nonpreferred brand-name drugs that do **not** appear on CVS Caremark's Primary Preferred Drug list, Option A has a $50 copay and Option B has a $70 copay.

Specialty Drug Coverage—Drugs used to treat certain conditions are considered specialty drugs. These conditions may include multiple sclerosis, oncology, allergic asthma, human growth hormone, Hepatitis C, psoriasis, rheumatoid arthritis, and respiratory syncytial virus, but other conditions may be included as well. In an effort to maximize your access to these drugs as well as the cost-effectiveness to both you and MCPS, these drugs are subject to the Specialty Guideline Management Program. Under this program, you still have access to the specialty drugs prescribed by your physician. However, you must go through the proper process in order to obtain these medications. To initiate this process and ensure these prescriptions are filled, your physician needs to contact CVS Caremark to coordinate efforts.

For additional information or to see if your medication is in this category, call the toll-free number on the back of your CVS Caremark ID card or visit *www.caremark.com*.

***Generic Drug Step Therapy*—**The CVS Caremark plan requires a generic drug step therapy program as part of its prescription plan to assist you and MCPS in managing prescription costs. Brand-name drugs that are used to treat certain conditions, including but not limited to high blood pressure and high cholesterol, are subject to the generic first step therapy requirements. If you take a prescription drug that is affected by this program and have not contacted your physician, please do so promptly. CVS Caremark maintains a list of all affected drug classes on their website at *www.caremark.com*.

Primary Preferred Drug List—For drugs that are not subject to the specialty guideline management program or the generic drug step therapy program, CVS Caremark offers a Primary Preferred Drug List. The Primary Preferred Drug List is a list of preferred, brand-name medications that have been reviewed carefully 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 Preferred Drug List. The medicines on the Primary Preferred Drug List are not equivalents of nonpreferred brand-name medicines, but are medicines in the same therapeutic category used to treat the same condition.

Remember, not every drug listed on the Primary Preferred Drug List is covered by MCPS. Also, CVS Caremark updates the Primary Preferred Drug List periodically, so you may need to work with your doctor and Caremark to determine which covered drug you will need to use in the future. The complete list is available on the CVS Caremark website at *www.caremark.com*.

Morphine Milligram Equivalent (MME) Based Limits—In response to the opioid epidemic in the United States, CVS Caremark has adopted use of the Morphine Milligram Equivalent. MME is a calculation that converts all opioids to the same units—a morphine equivalent dose—so that the total amount of opioids prescribed can be limited. The limits are based on guidelines recently published by the Center for Disease Control (CDC). If a written prescription exceeds the allowed limits, physicians will need to contact CVS Health Prior Authorization department at 1-800-294-5979.

Using a CVS Pharmacy and/or 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 copay. Thereafter, you must either use the CVS Caremark Mail Service pharmacy or fill your maintenance medication prescription at any CVS pharmacy. When using a CVS pharmacy or the CVS Caremark Mail Service pharmacy, you can obtain up to a 90-day supply of medication for the same copay. 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 copay 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 for up to a 30-day supply 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.

The CVS Caremark 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 nonparticipating 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 copay. Most major pharmacies participate in the CVS Caremark network.

Please ask your pharmacist or refer to the CVS Caremark 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 to—

- 200 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 600 strips, swabs, and lancets every 90 days through either a CVS pharmacy or the CVS Caremark Mail Service pharmacy.

KAISER PERMANENTE PRESCRIPTION DRUG PLAN *(for non-Medicare-eligible and Medicare-eligible retirees)*

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 copay structure. Kaiser Permanente is a Medicare Part D provider. If you are enrolled in Medicare and the Kaiser Permanente Medicare plan, this plan includes both prescription benefits through Medicare Part D and medical benefits. If you enroll in another Medicare Part D plan, your Kaiser Permanente Medicare membership, including medical coverage, will be terminated on the start date 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, drugs to treat erectile dysfunction, 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 $10 copay ($5 for Medicare) 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 $15 copay ($10 for Medicare) 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 their 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 a $10 copay for non-Medicare participants and a $3 copay 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 in order 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	$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 a 60-day supply)	$3 copay (up to a 90-day supply)	$10 copay (up to a 60-day supply)
	$7.50 copay (up to a 90-day supply)		$15 copay (up to a 90-day supply)

SILVERSCRIPT/CAREMARK MEDICARE PART D PRESCRIPTION DRUG PLAN *(for Medicare-eligible retirees)*

SilverScript, a division of CVS/Caremark, provides prescription coverage for Medicare-eligible retirees and their dependents (unless enrolled in the Kaiser Medicare plan). More than 68,000 pharmacies nationwide make up the pharmacy network. These include retail, mail service, long-term care, and home infusion pharmacies. You must use a network pharmacy to receive full benefit coverage on your prescriptions. If you need a prescription before you receive your pharmacy directory, call your pharmacy to make sure they are in the network. If your pharmacy is not in the network, contact Customer Care at the number below.

Mail order service provides many benefits:

- Enjoy the ease of having a prescription delivered to the location of your choice—home, office, vacation site, etc.;
- Greater convenience with mail service of up to a 90-day supply of medication—including free standard shipping;
- Personal service with a 24-hour, toll-free hotline to speak with a registered pharmacist about any questions or concerns you may have;
- Internet and refill-by-phone services to order prescription refills 24 hours a day, 7 days a week.

You may contact SilverScript® Customer Care at 866-270-3817, 24 hours a day, 7 days a week. TTY users should call 1-866-236-1069.

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. 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 (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

Once you have enrolled in the MCPS SilverScript/Caremark Part D prescription plan, you will receive a welcome packet from SilverScript, which outlines benefits, provides customer support information, and explains the option to decline benefits.

To participate in SilverScript, you must live in its service area, which is the United States. **If you use a Post Office Box as your mailing address, you will need to provide proof that you live in the U.S. SilverScript will send you a written request asking you to contact SilverScript directly to declare your physical address.** If you do not, your prescription coverage will be canceled. You may reenroll only during an Open Enrollment period.

Defined Contribution Plans—403(b)/457(b)

Applying for Distribution of Funds from the 403(b) and/or 457(b) Plans

Participants enrolled in the 403(b) plan may begin withdrawals at age 59½ while still employed. IRS penalties will apply if you separate from service and make withdrawals before age 59½. There are exceptions. Consult *www.irs.gov* for further information.

If you have a 457(b), you may begin penalty-free withdrawals at age 59½ while still employed or upon separation from service at any age. If 403(b) and/or 457(b) plan participants separate from service and then become re-employed by MCPS in any capacity, penalty-free withdrawals are not permitted if they are under age 59½.

Amounts withdrawn from the 403(b) and/or 457(b) accounts are taxable in the year of withdrawal. Required Minimum Distributions (RMDs) are annual withdrawals that the IRS mandates participants take or face penalties beginning the year you turn 72 (age 70½ if born before July 1, 1949) or retire. For more information on RMDs, please visit *www.irs.gov*.

To request a withdrawal, contact the vendor for your account(s). If your vendor is Fidelity Investments, contact them at 1-800-343-0860. If you have another vendor, contact information is available at *www.NetBenefits.com/mcps*.

Life Insurance

Life Insurance Continuation at Retirement

At retirement, you may elect either to continue your basic term employee term life insurance coverage or to cancel the coverage. If you elect to cancel your coverage, you are not permitted to reenroll. Term life insurance has no cash value.

When you retire, your term life insurance coverage amount reduces to 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, your term life insurance amount will reduce by 7.5 percent of the active life amount. On the fourth anniversary of your retirement, the term life insurance amount becomes 12.5 percent of the active term life amount and will remain at that level for your lifetime as long as the premiums are paid.

The chart below includes an example of the term life insurance reduction.

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

You and MCPS share the cost of your term life insurance coverage. The monthly premium for term life insurance is deducted directly from your retirement check. Rates for retiree term life

insurance are subject to change. See the *Retiree Benefit Rate Schedules* at *www.montgomeryschoolsmd.org/departments/ersc/retirees/benefits/* for the 2022 retiree term life insurance monthly rates.

Remember to update your beneficiary information as your personal situation changes. To make term life insurance beneficiary updates, complete 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 reenroll in term life insurance after you retire.

A family member should notify ERSC in the event of a death.

Accelerated Death Benefit

MCPS term life insurance plans offer an accelerated death benefit. This benefit provides a payment of up to 80 percent of your term life insurance benefit if your life expectancy is 12 months or less and the payment can be used for any purpose. Any remaining term life insurance benefits will be paid to your beneficiary(ies) after your death.

Should the need arise and you wish 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.

Retiree Benefit Rates

Retiree benefit plan costs depend on the year you were hired with MCPS, your years of eligibility service, and the year you were hired/rehired, and the year you retire(d). If you are eligible for Medicare, these specifics alone determine the cost share (percentage) you will pay for your retiree benefits and the percentage MCPS will pay. If you *are not* yet eligible for Medicare, these specifics determine your *base* cost share.

Rates for non-Medicare-eligible retirees also depend on Wellness Initiatives program participation during the previous plan year *(see page 9)*. Accordingly, rates for these retirees may be higher or lower than their base cost share. Base cost share, then, refers to the percentage you would pay if you did not participate in the Wellness Initiatives program (i.e., you did not complete a biometric health screening or health risk assessment within the announced timeframe).

You can determine your 2022 benefit cost by either reviewing the *Retiree Benefit Rate Schedules* booklet that will be mailed to you the first week of October, or by visiting *www.montgomeryschoolsmd.org/departments/ersc/retirees/benefits/* and clicking on the link to benefit rates at the top of the page. The resulting screen will include rate charts detailing the monthly cost of benefits at each of the cost-sharing arrangements and again while factoring in Wellness Initiatives credits or charges.

Determining Your Cost Share

Those who retired on or before July 1, 2011, pay a base cost share of 36 percent of the cost of retiree benefits and MCPS pays 64 percent. This cost-sharing arrangement, which was revised as of July 1, 2011, still applies to these retirees.

Those who retire(d) after July 1, 2011, who meet one of the conditions below and have at least five cumulative years of eligible service with MCPS upon retirement are grandfathered in to the earlier cost-sharing arrangement:

- Anyone whose most recent hire date—without a break in service—was prior to July 1, 2011, who was at least 55 years old as of July 1, 2011, or
- Anyone whose most recent hire date—without a break in service—was prior to July 1, 2006, or
- Anyone whose most recent hire date—without a break in service—was prior to July 1, 2011, who retire(d) with at least 30 years of eligible service in the state core plan.

If you retired on or before July 1, 2011, or the above conditions apply to you, you can find the cost of your 2022 benefits in the *Retiree Benefit Rate Schedules*, which will be mailed to you and posted online prior to Open Enrollment. Locate the appropriate page that describes your coverage scenario and refer to the rates labeled, "Twenty or More Years of Active Employment."

If your most recent hire date was on or after July 1, 2006, and before July 1, 2019, and you do not meet the grandfathering requirements, you must have at least 10 *cumulative* years of eligible service with MCPS to be eligible for retiree benefits. If your most recent hire or rehire date was on or after July 1, 2019, you must have at least 10 *continuous* years of eligible service with MCPS at the time of retirement to be eligible for retiree benefits. The base cost share of your retiree benefits is as follows:

MCPS ELIGIBLE SERVICE UPON RETIREMENT	RETIREE PAYS	MCPS PAYS
10 up to 15 years	60%	40%
15 up to 20 years	50%	50%
20 or more years	36%	64%

Please Note

All retiree benefit rate combinations can be found in the *Retiree Benefit Rate Schedules*, which are mailed to retirees the first week of October. The rate schedules also are available during Open Enrollment at:

http://www.montgomeryschoolsmd.org/departments/ersc/retirees/benefits/open-enrollment.aspx

Important Websites and Telephone Numbers

Employee and Retiree Service Center
301-517-8100
www.montgomeryschoolsmd.org/departments/ersc

Office of Human Resources and Development
301-279-3204
www.montgomeryschoolsmd.org/departments/personnel

Aetna Dental Plan (DMO)
www.aetna.com
1-800-843-3661

Aetna Large Case Pension, Inc.
1-800-952-2700

CareFirst BlueChoice Advantage POS Plan
CareFirst BlueChoice HMO Open Access Plan/ Exclusive Provider Option (EPO)
CareFirst BlueChoice Advantage Indemnity/ Medicare Supplemental Plan
1-800-545-6199
www.carefirst.com/mcps

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: Benefit Strategies
1-888-401-3539
www.benstrat.com

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
https://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
https://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

MCPS Form 455-22
October 2020

INSTRUCTIONS: All new retirees must make a selection in each category. 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 e-mail 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 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, *Change in Personal Information* with your benefit enrollment form. Benefit enrollment confirmations are sent to the address on file.

Name _____ Employee ID # _____ 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 MCPS plan (must include MCPS Form 455-20: *Employee Benefit Plan Enrollment*)
- ☐ Reenrollment/Qualifying Event (if coverage was canceled after 7-1-98)
- ☐ 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

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

- ☐ CareFirst BlueChoice HMO/CareFirst Exclusive Provider Option (EPO) (an HMO option for retirees living outside the CareFirst service area)
- ☐ Kaiser Permanente HMO

OPEN POINT-OF-SERVICE (POS) PLANS[1]

- ☐ CareFirst BlueChoice Advantage

INDEMNITY/MEDICARE SUPPLEMENTAL PLANS

- ☐ CareFirst BlueChoice Advantage 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 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[2]**

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[2]**

CATEGORY D (Vision Plan)—Please select one

- ☐ Davis Vision (provided through CareFirst)
- ☐ I ***decline*** vision coverage
- ☐ No change to **vision plan[2]**

[1]When a retiree or dependent becomes Medicare-eligible, your health plan will coordinate with Medicare. At that time, plan changes will be required.
[2]If you are a new retiree, you may not select "No Change to Plan."

SIGNATURE REQUIRED 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.
on pages 1 and 2 _____ _____/_____/_____ (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						☐/☐
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.

☐ No change

☐ **Primary**

Name _____

Address _____

Share _____ % Relationship _____

☐ **Primary** ☐ **Contingent**

Name _____

Address _____

Share _____ % Relationship _____

☐ **Primary** ☐ **Contingent**

Name _____

Address _____

Share _____ % Relationship _____

☐ **Primary** ☐ **Contingent**

Name _____

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. 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 REQUIRED _____ ____/____/____
on pages 1 and 2 *Signature* *Date*

Printed name _____ Employee ID # _____

MCPS NONDISCRIMINATION STATEMENT

Montgomery County Public Schools (MCPS) prohibits illegal discrimination based on race, ethnicity, color, ancestry, national origin, nationality, religion, immigration status, sex, gender, gender identity, gender expression, sexual orientation, family structure/parental status, marital status, age, ability (cognitive, social/emotional, and physical), poverty and socioeconomic status, language, or other legally or constitutionally protected attributes or affiliations. Discrimination undermines our community's long-standing efforts to create, foster, and promote equity, inclusion, and acceptance for all. Some examples of discrimination include acts of hate, violence, insensitivity, harassment, bullying, disrespect, or retaliation. The Board prohibits the use of language and/or the display of images and symbols that promote hate and can be reasonably expected to cause substantial disruption to school or district operations or activities. For more information, please review Montgomery County Board of Education Policy ACA, *Nondiscrimination, Equity, and Cultural Proficiency*. This Policy affirms the Board's belief that each and every student matters, and in particular, that educational outcomes should never be predictable by any individual's actual or perceived personal characteristics. The Policy also recognizes that equity requires proactive steps to identify and redress implicit biases, practices that have an unjustified disparate impact, and structural and institutional barriers that impede equality of educational or employment opportunities.

For inquiries or complaints about discrimination against MCPS staff *	**For inquiries or complaints about discrimination against MCPS students ***
Office of Human Resources and Development Department of Compliance and Investigations 45 West Gude Drive, Suite 2100, Rockville, MD 20850 240-740-2888 DCI@mcpsmd.org	Office of the Chief of Districtwide Services and Supports Student Welfare and Compliance 850 Hungerford Drive, Room 162, Rockville, MD 20850 240-740-3215 SWC@mcpsmd.org
For inquiries or complaints about sex discrimination under Title IX, including sexual harassment, against students or staff*	
Title IX Coordinator Office of the Chief of Districtwide Services and Supports Student Welfare and Compliance 850 Hungerford Drive, Room 162, Rockville, MD 20850 240-740-3215 TitleIX@mcpsmd.org	

**Inquiries, complaints, or requests for accommodations for students with disabilities also may be directed to the supervisor of the Office of Special Education, Resolution and Compliance Unit, at 240-740-3230. Inquiries regarding accommodations or modifications for staff may be directed to the Office of Human Resources and Development, Department of Compliance and Investigations, at 240-740-2888. In addition, discrimination complaints may be filed with other agencies, such as: the U.S. Equal Employment Opportunity Commission, Baltimore Field Office, GH Fallon Federal Building, 31 Hopkins Plaza, Suite 1432, Baltimore, MD 21201, 1-800-669-4000, 1-800-669-6820 (TTY); or U.S. Department of Education, Office for Civil Rights, Lyndon Baines Johnson Dept. of Education Bldg., 400 Maryland Avenue, SW, Washington, DC 20202-1100, 1-800-421-3481, 1-800-877-8339 (TDD), OCR@ed.gov, or www2.ed.gov/about/offices/list/ocr/complaintintro.html.*

This document is available, upon request, in languages other than English and in an alternate format under the *Americans with Disabilities Act*, by contacting the MCPS Office of Communications at 240-740-2837, 1-800-735-2258 (Maryland Relay), or PIO@mcpsmd.org. Individuals who need sign language interpretation or cued speech transliteration may contact the MCPS Office of Interpreting Services at 240-740-1800, 301-637-2958 (VP) or MCPSInterpretingServices@mcpsmd.org. MCPS also provides equal access to the Boy/Girl Scouts and other designated youth groups.

Montgomery County Public Schools
Employee and Retiree Service Center (ERSC)
45 West Gude Drive, Suite 1200
Rockville, MD 20850

Nonprofit Org.
U. S. Postage
PAID
Suburban, MD
Permit No. 201

Maryland's Largest School District

MONTGOMERY COUNTY PUBLIC SCHOOLS

Published by the Department of Materials Management for the Employee and Retiree Service Center
0156.22 • Editorial, Graphics & Publishing Services • 8.21 • 14,686