2023 Plan Year

Retirees' Healthcare Enrollment Guide

Open Enrollment is October 17–28, 2022

This Retirees' Guide provides important information concerning your enrollment for healthcare benefits effective January 1, 2023.

What is New for 2023:

Healthcare Premiums:
There will be a 2% increase in premium for all medical, dental, and vision plans in 2023.

What is staying the same:

- Medical, Dental, Vision, and Prescription plans remain the same.
- Out-of-pocket expenses for the Medi-Comp plan remain the same.

See pages 21–23 for 2023 premiums

Long-term Care Insurance enrollment through Unum is available at anytime during retirement. Evidence of Insurability (EOI) is required. Enrollment packets are available on-line at **www.aacps.org/VoluntaryBenefits,** then click on Long Term Care. Any rate increase will be provided directly to existing participants.

What You Need to Do for 2023 Retiree Open Enrollment:

- Check out our Retiree Open Enrollment toolkit to view resources from our benefit vendors. Recorded presentations from CareFirst, SilverScript, and UCCI are available for your viewing. Visit **www.aacps.org/retireehealthcare**.
- For all enrolled participants, no action is required, unless you wish to make a change. If you wish to make a change in your coverage, please complete the Retiree Healthcare Application (page ix –detach from this guide), and return it to HR/Retirement by October 28, 2022.
- Will you or your spouse be 65 in January or February? Submit the Retiree Healthcare Enrollment Application during Open Enrollment along with a copy of your Medicare Part A&B card. Remember to apply for Part B in early October to ensure you receive your new medical and Rx ID cards.

Medical and Dental Comparison Charts can be found on pages 24–28. Other retiree healthcare documents and information are also posted on our website for easy access.

Go to **www.aacps.org/Retireehealthcare.**

Enrollment Calendar	
October 17–28	**Open Enrollment**
Week of Dec. 1	**Confirmation Statements mailed**
December 19 (approximate)	**New healthcare cards mailed to all medical plan participants**
January 1	**New benefit year begins**

What Is Open Enrollment?

This is the time of year when you have an opportunity to review your benefit elections and make changes that best suit you and your family's needs.

If you do not want to make changes to your benefit elections, you do not have to do anything—your current elections will remain in effect for the 2023 plan year. However, if you want to change your medical, dental, or vision coverage, complete a Retiree Healthcare Enrollment Application (located on page ix of this guide) and return it to Human Resources/Retirement by **October 28, 2022**. Please retain a copy of the form for your records.

If you are enrolling in the CareFirst BlueChoice Triple Option "Open Access", CareFirst BlueChoice HMO "Open Access", or United Concordia POS (point-of-service dental plan) Plans, remember to specify your physician's full name and/or location on the enrollment application. A primary care provider code (PCP) is helpful but not necessary. Provider information may be obtained from the CareFirst on-line provider directory.

Remember, if you are turning 65 in January or February, submit a Retiree Healthcare Enrollment Application during Open Enrollment, electing your AACPS medical supplemental coverage. Send a copy of your Medicare A/B card as well.

Confirmation Statements

In early December, AACPS will mail you a healthcare confirmation statement that will verify your coverage and premium rates for the 2023 plan year.

Note: This Retirees' Healthcare Enrollment Guide does not describe every plan provision in detail. The contracts in place determine how benefits will be paid. Refer to each plan's individual benefit booklet for more information at *www.aacps.org/retireehealthcare*.

About Retiree Healthcare Coverage

AACPS offers retirees a comprehensive healthcare benefit program that includes medical, prescription drug, mental health, dental, and vision benefits. You can find the plans available to you, based on where you reside, in the table on page 6 of this booklet.

Eligibility For Retiree Healthcare Coverage

AACPS retiree healthcare eligibility and funding are administered in accordance with Board Policy GAO and Administrative Regulation GAO-RA.

You are eligible to participate in the retiree healthcare program provided:

1. You are eligible to receive benefits from MSRA upon a service or vested disability retirement and you separate from employment with AACPS by reason of retirement.
2. You continue with AACPS helthcare benefits at the time of retirement or you were eligible, with 15 years of service or more, to defer your healthcare and you re-apply during open enrollment or within 31 days of a lifestyle change.

Funding of Retirement Benefits

The rate of funding of retiree benefits is established annually.

Funding for 2023

1. If you were hired by AACPS prior to 2002 funding for medical/prescription and dental coverage is 75%. There is no funding provided for vision benefits. See rates on pages 21–23.
2. If you were hired by AACPS after 2002 funding for medical/prescription benefits as follows (see rates on pages 21–23):
   a. If you had less than 10 years of AACPS service you do not qualify for retiree healthcare benefits with AACPS, except in the case of disability retirement.
   b. If you had 10 years of AACPS service but less than 15 years of AACPS service, funding for your selected medical plan is 25%.
   c. If you had 15 years of AACPS service but less than 20 years of AACPS service, funding for your selected medical plan is 50%.
   d. If you had 20 or more years of AACPS service, funding for your selected medical and dental plan is 75%.
   e. No Board funding is provided for Vision plan coverage.

Retirees Receiving Disability Retirement

If you are approved by the MSRA to receive Accidental Disability benefits you are eligible to receive AACPS retiree healthcare benefits regardless of length of service or employment date. If you are approved by the MSRA to receive Ordinary Disability benefits, ***you must have at least five (5) years of AACPS service*** to be eligible for AACPS healthcare benefits. In both types of disability, employees with less than 10 years of employment with AACPS shall receive retiree healthcare benefits at the lowest funding level provided to retirees, based on employment date. Employees with 10 or more years of service receive funding based on employment date as described earlier.

The portion of the premium not funded by AACPS is deducted from your pension payment. If the annuity is insufficient to cover the cost of your healthcare premium, you will be directly billed by an outside agency on a monthly basis. Failure to pay the premium timely may result in termination of healthcare benefits.

Eligible Dependents

Opposite and same sex spouses are eligible.

A surviving spouse who was not employed with AACPS may continue his or her retiree healthcare benefits after his or her spouse dies if the former AACPS employee had selected a retirement benefit payment option of 2, 3, 5, or 6 (under which surviving spouse pension benefits are provided).

If the surviving spouse later remarries, his or her new spouse is not eligible for AACPS retiree healthcare benefits.

In addition, children up to age 26 may be covered until the end of the month in which they turn 26 (coverage terminates at the end of the month of their 26th birthday).

- Children currently not covered may be added to the retirees' coverage with supporting documentation.
- The child does not have to be an IRS dependent for tax purposes.
- The eligible child may be married, but the child's spouse and/or children are not eligible to join the AACPS health plan.
- Children that are certified as disabled and covered prior to age 26 may continue to be covered by insurance carrier certification.

Lifestyle Changes

If you experience a qualifying lifestyle change during the calendar year, you have up to 31 days from the date of the event to make a change to your benefits.* In the case of divorce, AACPS Retirement Office must be notified immediately as a divorced spouse is not eligible for the AACPS Retiree Healthcare Plan. Any change you make must be consistent with the lifestyle change you have experienced. Please contact Human Resources/Office of Retirement to process the benefit change. The change in coverage will be effective the first of the month following the date of the qualifying event.

Qualifying lifestyle changes include:

- Marriage
- Birth or adoption of a child, placement of a child for adoption, or legal guardianship of a child;
- Divorce or annulment*;
- A change in your spouse's employment status that results in termination of healthcare benefits;
- Your dependent child's loss of eligibility due to turning age 26;
- Death of retiree, spouse, or other covered dependent;
- A change in the number of your dependents;
- A change in your or your dependent's residence;
- Your (or your dependent's) eligibility for COBRA or enrollment in Medicare/Medicaid;
- A significant change in the cost of coverage under another plan;
- An open enrollment for your spouse's benefit plans; or
- A mid-year offering for your spouse's plan.

You must complete a new retiree healthcare enrollment application when you experience a lifestyle change, become eligible for Medicare Part B, due to age or disability, or change your address. A healthcare application is provided at the end of this booklet.

* *Upon divorce, the divorced spouse is no longer eligible for AACPS retiree healthcare benefits. Immediately upon becoming divorced, the retiree MUST notify the Retirement Office so coverage can be terminated for the divorced spouse and covered step-children. The retiree must submit a Retiree Healthcare Enrollment Application and include the divorce documentation.*

Failure to notify AACPS immediately of a divorce may result in the retiree being held liable for any claims incurred by the divorced spouse.

Divorced spouses are eligible for COBRA.

A Note About Your Privacy

The Health Insurance Portability and Accountability Act (HIPAA) requires employers, healthcare providers, and insurance companies to follow certain standards for transmitting personal insurance information about covered participants. Human Resources/Benefits maintains an employers' "HIPAA Privacy Notice" that describes our compliance with HIPAA. Please see this notice on page v.

Please be advised that HR/Office of Retirement may require that you complete a consent form when a spouse, family member, friend, or other designee contacts our office to discuss a health insurance claim on your behalf.

Special Enrollment Rights Under HIPAA

HIPAA provides you with certain special enrollment rights pertaining to your healthcare coverage. If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your eligible dependents in this plan, provided you request enrollment within 31 days after the other coverage ends. The request for enrollment must be made in writing. You must also provide evidence of the prior coverage.

In addition, if you have a new dependent due to marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your eligible dependents, provided you request enrollment (in writing) within 31 days of the marriage, birth, adoption, or placement for adoption.

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

Important Medicare Information

Retired employees and their eligible spouses/dependents 65 or older or Medicare disabled are required to enroll in Medicare Parts A&B in order to participate in the AACPS Retirees' Healthcare Program. Upon receipt of the retiree's healthcare application and a copy of their Medicare card, AACPS will enroll the participant in an AACPS sponsored Medicare Supplemental Plan (per participant direction) and CVS Caremark SilverScript will enroll you in Part D benefits automatically (no action is required on your part unless SilverScript requires additional enrollment information from you). The effective date of this change normally runs concurrent with the effective date of your Part B coverage. Failure to provide a copy of your Medicare Part B card or evidence that it has been applied for may result in termination of Retirement Medical coverage.

Medicare is the primary payor on your medical and prescription bills and AACPS provides the secondary coverage.

Be advised that Social Security permits you to complete the enrollment process for Medicare Part B ninety days (90) in advance of your Medicare eligibility date. Please note AACPS will not commence your Supplemental coverage any sooner than your Part B effective date.

For example: if you are eligible for Medicare Part B on January 1, you may apply for Part B as early as 90 days in advance which is October 1. Your AACPS supplemental medical plan and Part B will be effective January 1. **IT IS IMPORTANT to apply at the beginning of the 90 day period to ensure your medical coverage, as well as SilverScript prescription benefits, commence with no delay.**

Medicare	Coverage
Part A	**Hospitalization** is provided to you automatically by Social Security at no cost the first of the month in which you turn 65. No application is required.
Part B	**Physician Services** AACPS requires you to apply for Part B to participate in the AACPS retiree medical over 65 program. There is a premium, for part B, which is income related and is deducted from your monthly Social Security Check.
Part D	**CVS Caremark SilverScript Prescription Program** SilverScript will enroll you automatically upon AACPS verification of your AACPS medical supplemental coverage. The law requires you to be able to opt out of this benefit within 21 days of your coverage commencing. If you waive out, no AACPS medical participation is available. High income earners may face a Part D premium surcharge.

Please Note: Medicare Parts A, B, and D as well as the AACPS supplemental plans, if elected, are effective the first of the month in which you turn age 65.

If you have applied for Medicare Disability status through Social Security and have been approved (even under age 65), please contact the HR/Office of Retirement as soon as possible so we may enroll you in the proper healthcare programs.

TRICARE Benefits

Many retirees and/or spouses who served in the military are eligible for TRICARE benefits. TRICARE at age 65 is called TRICARE for Life (TFL). TFL requires you to enroll in Medicare Parts A&B.

When Medicare becomes effective, and you are enrolled in both AACPS and Tricare, claims are paid in the following order: Medicare, AACPS, TRICARE. TRICARE always pays last unless the subscriber is on active duty.

Social Security Number Requirement

Our medical plan carriers are required by law to provide the Centers for Medicare and Medicaid Services with the Social Security numbers of participants in our medical plans (including dependents). Please be sure you provide this information as requested for your eligible dependents.

Medical Plan Options

The medical plan options that are available to you depend on whether you are under age 65, or 65 or older, or otherwise eligible for Medicare, as shown in the following table. Please note the service area for the plan option you are considering.

Healthcare Plan	Service Area	Coverage under 65	Coverage 65+
CareFirst BlueChoice HMO "Open Access" Plan	MD, DC and Northern VA	Yes	Yes* *(Medicare Supplement)*
CareFirst BlueChoice Triple Option "Open Access" Plan	National	Yes	Yes* *(Medicare Supplement)*
CareFirst BCBS PPN	National Bluecard; available only to retirees outside the service area of MD, DC, and N.VA	Yes	No
CareFirst BCBS Medi-Comp (Medicare Supplemental)	National	No*	Yes* *(Medicare Supplement)*

See 2023 co-pay information below in each plan description ** Coverage available if under age 65 and **Medicare disabled.***

Reminder — "Open Access" Plans

"Open Access" is a feature for BlueChoice and the Triple Option Plan. You are not required to obtain a referral. Continue to use BlueChoice specialists to receive in-network benefits.

BlueChoice HMO "Open Access" Plan

Eligible Retirees: All ages
Coverage Area: MD, DC, and Northern VA

You must select a Primary Care Physician (PCP) from the BlueChoice HMO network for yourself and each of your eligible dependents. Referrals are not required in the BlueChoice HMO "Open Access" Plan. To find out if your physician is a BlueChoice HMO network provider, visit **www.carefirst.com/aacps** and access the BlueChoice HMO provider directory.

If you move out of the local service area, you will be required to complete a new application and elect the CareFirst PPN program or the BlueChoice Triple Option Plan or the "Medi-Comp" Supplemental plan (if over 65).

Whether you are under or over age 65, the office visit co-payment is $10 for a PCP visit and $15 for a specialist visit. The emergency room co-payment is $85, but it is waived if you are admitted directly to the hospital.

If you are age 65 or older, the BlueChoice HMO "Open Access" Plan operates as a Medicare Supplemental program. This means that Medicare is your primary coverage and pays benefits first, and the BlueChoice HMO "Open Access" Plan is secondary. You must be enrolled in Medicare Parts A and B to participate. When you visit the doctor, you should present both your Medicare ID card and your BlueChoice HMO ID card.

See page 8–9 for information on emergency, urgent care, and the Away from Home Care Program for BlueChoice "Open Access" **and Triple Option** "Open Access" Plan **members.**

CareFirst BlueChoice Vision Benefits

See page 19 for additional details on the Davis Vision Plan.

Prescription Benefits for All AACPS-Sponsored Medical Plans

Prescription benefits for all medical plan options are provided through CVS Caremark Prescription Services and Caremark SilverScript (for over 65 retirees and dependents).

Refer to the CVS Caremark Prescription Plan section in this guide for more information.

Note: Co-pays required for 2023

	BlueChoice Triple Option "Open Access" Plan		
	Level 1 – BlueChoice HMO	Level 2 – Select PPO	Level 3 – Par/Non-Par
Annual Deductible (does not include co-payments)			
Individual	N/A	$200	$300
Family	N/A	$400	$600
Annual Out-of-Pocket Maximum			
Individual	$2,000	$2,000	$2,000
Family	$6,000	$4,000	$4,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Co-payments			
Primary	$15	$20	N/A
Specialist	$15	$20	N/A
Co-Insurance	N/A	You pay 10% after deductible	You pay 20% after deductible

BlueChoice Triple Option "Open Access" Plan

Eligible Retirees: All ages
Coverage Area: MD, DC, and Northern VA; Nationwide coverage Levels 2 & 3

The CareFirst BlueChoice Triple Option Plan is available to **all** retirees nationally. This plan offers both HMO and PPO network access, for one monthly premium. You have the flexibility to determine the level of care and your cost on any given day.

When you enroll, you must designate a PCP from the BlueChoice HMO network. Your PCP will direct your care (referrals are not required). Continue to use BlueChoice specialists for Level 1 care in Maryland, District of Columbia (DC), or Northern Virginia. With the BlueChoice Triple Option Plan, you also have the freedom to see a provider in the PPO network (Level 2) or Par/Non-Par providers (Level 3); however, different co-payments and deductibles apply.

Note: There are no changes to office visit co-pays for 2023.

Level 1: BlueChoice HMO — When you receive care from a BlueChoice HMO provider, there is no annual deductible and you receive the highest level of benefits for the lowest co-payment cost. Co-payments are $15 for PCP visits and specialist visits. Currently, over 95% of services our retirees receive are provided by doctors in the BlueChoice HMO network. This means your provider may be a Level 1 provider — therefore, you will be able to enjoy the lower co-pays in Level 1. See "How to Locate a Provider" to check if your provider is in the BlueChoice HMO network.

BlueChoice Triple Option "Open Access" Plan gives you important choices. If you need to see a specialist, you do not need a referral to see a doctor who participates in this plan.

Helpful Hint

Save Money With Level 1 Providers
The CareFirst BlueChoice Triple Option "Open Access" Plan gives you the freedom to decide which level of care you want when you need care. However, you'll save the most if you receive your care from a Level 1 – BlueChoice HMO network provider. Level 1 co-pays are just $15 for primary care and specialist visits, and there is no deductible! Many providers participate in the BlueChoice HMO network – ask your doctor if he or she participates, or visit **www.carefirst.com/aacps**.

Level 2: PPO (like the PPN in-network plan) This plan allows you to seek care from a Select PPO provider without a referral from your PCP for a $20 co-payment. Low deductibles and co-insurances apply for services such as inpatient and outpatient facility services. See "How to Locate a Provider" for information on PPO providers within Maryland, DC, Northern Virginia, and areas outside of the region.

***Level 3: Par/Non-Par (like the PPN out-of-network plan)* —** Allows you to seek care from participating and non-participating BlueCross BlueShield providers. Level 3 coverage is subject to a higher deductible and co-insurance amounts.

Co-payments, Deductibles, and Co-Insurance

Co-payments in each level do not apply toward satisfying your annual deductible; however, they do accumulate toward your annual out-of-pocket maximum. The deductibles and co-insurance in Levels 2 and 3 apply toward your annual out-of-pocket maximum. Also, all amounts that apply toward meeting the Level 2 annual out-of-pocket maximum also apply toward meeting the Level 3 annual out-of-pocket maximum, and vice versa.

Lab Benefits

To receive Level 1 benefits (100% coverage) you must use Lab Corp labs in the service area with an order from your Level 1 PCP or specialist. You may use Quest Diagnostics under Level 2 with a $20 co-pay (no deductible).

Chiropractic & Physical Therapy Benefits

If you wish to receive Level 1 benefits and pay a $15 co-payment per visit, you must use a BlueChoice provider. Your PCP may specify an appropriate number of visits on one order. For Level 2 benefits ($20 co-payment), no referrals are required.

Vision Benefits

See page 19 for additional details on the Davis Vision Plan.

Away from Home Care®

The Away From Home Care® program allows BlueChoice and BlueChoice Triple Option "Open Access" Plan members and their dependents to receive care when they are away from home for at least 90 consecutive days. The care can be provided by an affiliated Blue Cross and Blue Shield HMO outside of the CareFirst BlueChoice service area (MD, DC, No. VA). Whether it is extended out-of-town business or travel, college students out of state or families living apart, with the Away From Home Care® program, members can enjoy a full range of benefits. This includes, but is not limited to routine and preventive care. Your copay and benefits will be those of the affiliated HMO in the area where you are visiting.

If you would like more information or to enroll in the Away From Home Care® program, please call the Member Services number on your ID card and ask to be transferred to the Away From Home Care® Coordinator.

Note: Not all states participate in Away From Home Care and you must re-enroll every year.

Reminder

All CareFirst Medical plan participants may have an annual mammogram (up to allowed benefits) starting at age 40.

If you Move...

If you are a CareFirst BlueChoice HMO "Open Access" Plan participant (under or over 65) and you move outside the MD, DC, or Northern VA service area, you will need to enroll in the BlueChoice Triple Option "Open Access" Plan or the "Medi-Comp" Supplemental Plan (if over 65). Contact HR/Retirement for more information.

No wellness-related office visit co-payments apply for annual routine physicals, routine gynecological visits, well baby, and well child care visits for any medical plan options.

Emergency & Urgent Care

As a CareFirst BlueChoice HMO or BlueChoice Triple Option "Open Access" Plan member, your benefits include the BlueCard® program for out-of-area emergency and urgent care situations. The BlueCard® program is a benefit because when you see an out-of-area participating Blue Cross and Blue Shield physician or hospital for emergency or urgent care, you will only be responsible for paying out-of-pocket expenses (copayment) and your benefits will be paid at the in-network level. This relieves you of the hassle and worry of paying for the entire visit up-front and then filing a claim form later. The participating Blue Cross and Blue Shield physician or hospital will file the claim directly to their local Blue Cross and Blue Shield plan. In turn, the participating provider will be reimbursed directly on your behalf.

To use the BlueCard® program for out-of-area emergency and urgent care, please call (800) 810-BLUE (2583) to locate the nearest Blue Cross and Blue Shield physicians and hospitals. At the time of service, present your member ID card. If your physician or hospital does not bill its local Blue Cross Blue Shield plan for out-of-area emergency or urgent care, you will be required to pay for the services and submit a claim form directly to CareFirst. Obtain itemized receipts and contact Member Services when you return to obtain a claim form for consideration and reimbursement of charges.

You should always follow-up with your Primary Care Physician to make them aware of the emergency or urgent care situation.

When an emergency occurs, seek the care you need and ***contact your PCP within 24 hours***.

How to Locate a Provider

1. Go to **www.carefirst.com/aacps**
2. Under "Find a Doctor", click on "Search Now"
3. Log in as a member or continue as a guest
4. To modify location – click on "city, state or zip" box to add a zip code or city/state
5. Click on the "All Plans" box to select the plan, and choose BlueChoice HMO Open Access (Triple Option Level 1 and HMO), or BluePreferred (Triple Option Level 2 and PPN); for dental, select Preferred Dental (for PPO) or Traditional Dental; for Vision choose Select Vision or Davis Vision.
6. Browse by Category to select the type of healthcare provider you are seeking, such as Medical, Mental Health, Dental, Vision, Pharmacy.

OR

7. Skip plan selection and enter name of physician

Patient Protection Disclosure

BlueChoice HMO and BlueChoice Triple Option "Open Access" Plans require the designation of a primary care provider. You have the right to designate any primary care provider who participates in the BlueChoice HMO network and who is available to accept you or your family members.

For information on how to select a primary care provider, and for a list of the participating primary care providers, visit the plan websites for provider information. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from BlueChoice HMO and BlueChoice Triple Option "Open Access" Plans or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit the plan websites for provider information.

CareFirst BCBS Preferred Provider Network (PPN)

Eligible Retirees: Under age 65
Coverage Area: ***Outside*** MD, DC, and Northern VA

The CareFirst BCBS PPN is available to retirees and their covered spouses and dependents under the age of 65 who reside outside the Maryland, DC, and Northern Virginia service area. You have complete flexibility to see any provider within the BCBS PPN network, including specialists, and you are not required to designate a PCP. If you move or travel out of state and you require healthcare, contact 1-800-810-BLUE for access to the closest PPN provider. There are over 600,000 PPN providers in the U.S. Out-of-state residents can identify PPN providers at **www.bcbs.com**.

The plan encourages and pays for routine physicals, annual GYN exams, and routine screenings.

In-network

In-network office visits are $30. If you are hospitalized, you are covered at 100%. Participating providers are covered for in-hospital services.

Out-of-network

When you use a provider who does not participate in the PPN network, benefits are paid at a lower level. You must first satisfy a $200 individual annual deductible, and then benefits are paid at 80% of the plan's allowed benefit. The maximum out-of-pocket annual expense for out-of-network providers is $1,200 per year (individual), after which the plan pays benefits at 100% of the allowed benefit. There are no lifetime benefit maximums for in- or out-of-network benefits.

Emergency Room

Copayment equals $85, waived if admitted.

Have you considered...
enrolling in the CareFirst Triple Option Plan? Level 2 and 3 provide benefits out-of-state. Lower premiums and co-payments are available.

CareFirst BlueCross BlueShield (BCBS) "Medi-Comp" Plan

Eligible Retirees: Over age 65
Coverage Area: National

If you are over 65 or considered Medicare disabled, you may enroll in the CareFirst BCBS "Medi-Comp" plan as long as you are enrolled in Medicare Parts A and B. With this plan, Medicare Parts A and B are your primary health coverage program and the "Medi-Comp" plan is your secondary coverage. Your provider will submit claims to Medicare first, and any unpaid balance is then submitted to CareFirst BCBS for further benefit consideration.

The CareFirst "Medi-Comp" plan covers expenses only after Medicare has paid. Plan benefits include hospital, physician, diagnostic, and major medical coverage. The CareFirst "Medi-Comp" plan pays benefits at 90% of the allowed benefit up to a maximum annual out-of-pocket cost of $750. The maximum possible out-of-pocket expense per year is $750. Home healthcare benefits are covered at 100% and are not subject to the $750 out-of-pocket.

Wellness benefits, including an annual physical exam and gynecological exam, are covered at 100%, no deductible per benefit period (every 12 months).

Please refer to the CareFirst BCBS "Medi-Comp" Plan benefit booklet on-line at **www.aacps.org/retireehealthcare,** go to Retiree Healthcare Benefits.

Emergency Room

After Medicare's primary, CareFirst's reimbursement is 90% of Allowed Benefit; the combined carrier payments will not exceed what CareFirst would have paid if it were primary.

FYI
Retirees enrolled in the CareFirst BlueCross BlueShield "Medi-Comp" Plan living in the Maryland, D.C., Northern Virginia area should review the benefits of participating in the CareFirst BlueChoice or BlueChoice Triple Option Medicare Supplemental Plans. Lower premiums and lower out-of-pocket expenses are available.

IMPORTANT NOTICE

Federal law requires a group health plan to provide coverage for the following services to an individual receiving plan benefits in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

The group health plan must determine the manner of coverage in consultation with the attending physician and patient. Coverage for breast reconstruction and related services will be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

CareFirst "My Account" Information

Go to **www.carefirst.com/aacps** and click on "My Account" to establish yourself as a new user if you have not yet enrolled. See your medical, prescription, vision, and dental claim activity, order on-line Explanation of Benefits (EOBs), and sumbit claims online. If you misplace your healthcare card, see your membership information on this website and order a new ID card.

Look for Blue365, a CareFirst program that has exclusive health and wellness discounts, fitness information, gym membership information, healthy eating options, and more.

Hearing Aids

Hearing aids are limited to one for each hearing-impaired ear every 36 months. CareFirst will reimburse 100% of allowed benefit. Contact CareFirst for more information.

Traveling Abroad?

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

Mental Health Benefits

All CareFirst Plans

If you or your covered dependent need help with mental health or substance abuse, benefits are available through CareFirst Behavioral Health. You must be enrolled in a CareFirst medical plan to access these benefits. You may reach CareFirst Behavioral Health at 1-800-245-7013. Care managers are available 24 hours a day, seven days a week for emergencies. You must call this number for inpatient admission authorization.

Although pre-authorization is not required for outpatient services, care managers can assist you with locating a network provider and can answer questions related to your mental health and substance abuse concerns, Monday through Friday, from 8:30 a.m. to 6:00 p.m. Benefits and care are provided on a confidential basis.

Wellness Benefits

Helpful Hint

Care Management Services — There When You Need Them

For our under 65 medical plans, your retiree healthcare coverage gives you more than just the basics. In addition to preventive care and comprehensive medical coverage, you have access to a wealth of tools and resources, such as voluntary care management programs. We encourage you to take advantage of these services and resources to help you lead a healthy lifestyle.

Our healthcare vendor partners with us to provide care management services to those who suffer from chronic conditions, such as diabetes, congestive heart failure, coronary heart disease, chronic obstructive pulmonary disease (COPD), and asthma. These voluntary programs may help you better understand your medications and how to take them correctly, and also help you access resources and information about your condition.

If you are enrolled in one of the CareFirst plans, services are provided through Healthways – CareFirst's disease management partner.

In addition, your medical provider may also be providing this service through their nursing team.

Medicare primary members are not eligible for case management services.

National Network for Important Vaccines

You can obtain the flu, shingles*, and pneumonia vaccines from a pharmacy no matter where you are located, at little or no cost to you. We suggest calling the pharmacy or clinic ahead of time to confirm availability and price.

For those on an "under 65 CareFirst plan," you will use your CareFirst Insurance card. Our pharmacy benefit manager, CVS/Caremark, has a national vaccine network of over 58,000 pharmacies that can provide these vaccines for you (such as CVS, Giant, Target, and more). Log into "My Account," and click on Drug and Pharmacy Resources to find participating pharmacies.

Only pharmacies contracted by CVS/Caremark for vaccination administration will display vaccination availability.

Check with your doctor or primary care provider if you have questions about whether to receive a vaccine, as there may be age and condition restrictions. Pharmacies located in Maryland require a doctor's order, or prescription, for the shingle and pneumonia vaccines.

For those on Medicare, the following vaccines are paid for by Medicare Part B (your Medicare card):
Flu Shot, Hepatitis B, Pneumonia
For a shingles shot, please use your SilverScript prescription card (Medicare Part D).

For more information about vaccines, visit **www.cdc.gov**.

*The shingles vaccine is a covered benefit for members who are 50 or older.

CareFirst Video Visit

CareFirst is now offering the ability to connect with a board-certified doctor 24/7 from your desktop, tablet or smartphone without an appointment. A CareFirst Video Visit costs the same as your co-pay for a sick office visit with your primary care provider. It's convenient, easy to use, private and secure.

CareFirst Video Visit is intended for the treatment of uncomplicated, non-emergency health concerns including, but not limited to: bronchitis, cough/sore throat, sinus infection, diarrhea, fever, pinkeye, cold/flu, and respiratory infection. Video Visit doctors are U.S. board-certified, licensed and credentialed, and have profiles so you can see their education and experience. They provide consultation, diagnosis and prescriptions.

Use Video Visit when: your doctor's office is closed, you are on vacation, you have children at home and cannot bring them to the doctor's office, or you feel too sick to drive.

It is recommended that you register now so you will be ready when you need to visit. There are two easy ways:

1. Go to **www.carefirst.com/videovisit** and click on any of the Video Visit links, or
2. Download the CareFirst Video Visit app.

Sign up now so access will be easier when you need it!

CVS Caremark Prescription Plan

SilverScript (a subsidiary of CVS Caremark) administers this Medicare Part D prescription drug coverage for Anne Arundel County Public Schools (AACPS) retirees and dependents eligible for Medicare. Review page 15 of this guide for more detailed information about this important plan.

Note: Under 65 retirees and dependents must use their current prescription drug coverage (CareFirst).

If you are enrolled in one of the AACPS-sponsored medical plan options, your benefits include a comprehensive prescription benefit program through CVS Caremark.

The CVS Caremark prescription program is a managed generic program for all AACPS-sponsored medical plans (including for participants who are eligible for Medicare).

Prescription Plan Co-payment Information for 2023

Note: 2022 co-payments will remain in place for 2023

This 4-tier design, common in employer plans, is intended to promote reasonable co-payments for you, and to encourage utilization of generic and plan preferred (Tier 2) brands. This design also assists AACPS in achieving savings on retiree prescription drugs because drug costs in Tier 1 and Tier 2 are less, sometimes significantly so, than the cost of drugs in Tier 3 and Tier 4. Remember, AACPS pays 100% of the drug costs less your co-payments if you are under age 65.

Most physicians are well acquainted with 4-tier prescription plans. Discuss your medications with your physicians. Caremark's formulary list is available after login at **www.caremark.com > My Plan and Benefits**, go to "Drug List". You may also contact CVS Caremark for more information.

Over 65 retirees are subject to the Medicare Part D formulary and the CVS Caremark drug formulary. If the Medicare D formulary does not cover the medication, the CVS Caremark formulary will cover the medication, in most scenarios, as specified under the formulary guidelines.

2023 Prescription Co-Pays for under and over 65 Medical Plans

	Up to 30 days of medication at a retail pharmacy	90-day supply of medication from CVS Caremark mail order*
Tier 1 Generic	$5	$10
Tier 2 Brand	$20	$40
Tier 3 Non-preferred brand	$35	$70
Tier 4 Specialty Medications	$75	$150

Speciality or injectables are available through the Caremark specialty program after a prior authorization process.

• Coverages vary contact CVS/Caremark for under 65 or SilverScript for over 65.

* *90-day supply of medication may be purchased at at CVS retail pharmacy or a Target Pharmacy through the Maintenance Choice program; mail order co-pay applies. CVS SilverScript participants may purchase 90-day supplies at other pharmacies but at higher co-pays.*

Have you considered?

Switch your brand maintenance medication to a generic if available. Maintenance medication can be obtained by mail order or at CVS Pharmacies.

Your increased use of Tier 1 (generic) drugs will save you money and help AACPS to contain costs.

"ExtraCare" Health Card

CVS Caremark participants, under age 65, are eligible for the CVS "ExtraCare" Health Card. This benefit provides a 20% discount at CVS retail stores for certain CVS brand pharmacy over the counter (OTC) products. You can use your key tags in combination with other CVS discount cards, rewards, and coupons (certain requirements apply). If you wish to request new or additional cards, contact CVS Caremark.

Obtaining Your Prescriptions

Retail

CVS Caremark's retail pharmacy network, which includes pharmacies at Target stores, is extensive and includes over 98% of pharmacies nationwide. You may fill short-term prescriptions for up to a 30-day supply, plus one refill, at any participating pharmacy.

Most other local retail pharmacies also accept CareFirst/Caremark and SilverScript.

CVS Retail "Maintenance Choice" Benefit

You may elect to fill your maintenance medications normally ordered through mail-order at convenient CVS retail stores and Target stores. You may receive up to a 90 day supply at the 4-Tier mail-order rate ($10/$40/$70/$150). This opportunity provides you with the flexibility of choice– either go through mail-order (convenience of home delivery) or fill your maintenance prescription at your local CVS or Target Pharmacy.

You may go to CVS stores for new prescriptions or even existing prescriptions. Simply contact CVS Caremark and let them know you wish to transfer an existing script to a CVS Pharmacy from Caremark's mail-order system or simply go to CVS or Target and tell them your prescription is currently at mail order and you wish to transfer the script to their store.

CVS Caremark SilverScript Maintenance Choice for retirees and dependents over 65

You may continue to get your 90-day supplies at CVS and Target retail pharmacies, however the SilverScript Plan permits you to get a 90-day supply at other pharmacies. Please note while the plan permits this feature, you are encouraged to continue to utilize your CVS retail benefit for lower co-pays. Higher co-pays will apply at other participating pharmacies for 90-day supplies.

Maintenance Medications Filled By Mail-Order

All medications that you take for over 90 days (i.e., maintenance medications) may be filled through CVS Caremark's mail-order service. To best utilize your mail-order benefit, you should ask your physician to write two prescriptions: one for your immediate needs (up to a 30-day supply through a retail pharmacy) and one that you will send to CVS Caremark's mail-order for up to a 90-day supply, plus up to three refills. First-time mail-order requests generally take 14 days for home deliveries.

After you receive your prescription from the mail-order service, refills are easy to order and take about seven calendar days for delivery. Refills are processed quickly through CVS Caremark's system and may be ordered three ways:

1. **On-line —** Log on to **www.carefirst.com** and click on "order and refills". Have your prescription number available (on your prescription) and credit card information ready. The on-line refill service is very user friendly and is the quickest delivery method.
2. **By phone —** Simply dial 1-800-241-3371; have your prescription number available (on your prescription), ID Number, and credit card information ready. For SilverScript, please call 1-888-512-8931.
3. **By mail —** Attach the refill label provided by CVS Caremark on a mail-order form (usually included with your original prescription when you receive it from CVS Caremark) and include your payment.

On-line Prescription Information

Under Age 65 Plans	Over 65 Plans (SilverScript)
1 Go to **www.carefirst.com/myaccount** and log in.	1 Go to **www.caremark.com**.
2 Go to "*Manage My Health*"	2 Establish your username and password.
3 Click on "*Drug and Pharmacy Resources*" Here you may view all of your personal pharmacy information, such as claims, coverage, order and refill information, drug forms, and pharmacy information.	3 Through **caremark.com**, you may review and place your mail-order refills, review benefits and plan formularies, and receive wellness information.

CVS Caremark SilverScript Plan For Retirees and Dependents Over Age 65

Caremark SilverScript Plan (a Medicare Park D Plan)

SilverScript (a subsidiary of CVS Caremark) administers prescription drug coverage for Anne Arundel County Public Schools (AACPS) retirees and dependents eligible for Medicare.

If you are eligible for Medicare, you will:

- Receive a new SilverScript ID card for prescription coverage
- Provide your pharmacist with your new SilverScript ID card
- Pay the same co-pays as you currently pay for prescription drugs
- Continue to use your current participating pharmacy
- Not opt out of the SilverScript Medicare D prescription drug plan
- Not enroll in an individual Medicare Part D prescription drug plan

Why SilverScript?

Because of the Affordable Care Act and some of the recent changes to Medicare, AACPS can provide you with the same prescription coverage you have now at a significant savings by moving to the SilverScript group Medicare Part D prescription drug plan. It's similar to the way medical coverage works for Medicare-eligible retirees and dependents. Medicare Part D prescription coverage is the primary coverage. AACPS provides additional coverage that "wraps around" or acts as "secondary" coverage to your group Medicare Part D prescription drug plan and brings the benefits up to the level that you are used to.

How It Affects You

The SilverScript plan applies to Medicare-eligible retirees and dependents. If you are eligible for Medicare, your prescription benefits will be provided through SilverScript. Aside from using a new ID card, the changes are mainly behind the scenes:

- If a drug is not covered by the group Medicare Part D prescription drug plan, it will be covered by the "wrap around" portion of the plan (as long as it's covered by the AACPS plan now).
- You can continue to use your current pharmacy.

Current SilverScript Participants

You will continue to use your plan for 2023. No re-enrollment is required.

New over 65 or Medicare Eligible Participants

Remember to apply for Medicare A&B as soon as you are within 90 days of your Medicare effective date. AACPS sends this reminder to you approximately 120 days in advance. Complete the AACPS Retiree Healthcare Enrollment Application and return it along with a copy of your Medicare card as soon as you receive it.

One Prescription Plan, One ID Card, Two Parts

With the SilverScript plan, your SilverScript card will take care of processing your benefits through both the group Medicare Part D prescription drug plan and the AACPS "wrap around" plan. You must use your SilverScript ID card. You may NOT use your CareFirst Medical coverage card.

It is helpful to know that your coverage is made up of two parts—a group Medicare Part D Prescription Drug Plan with premiums paid by AACPS and a "wrap around" plan provided by AACPS to mirror your existing prescription drug coverage. When you use your SilverScript card, the system puts these two parts together – there's nothing you need to do.

SilverScript 101

Your SilverScript Plan

The two parts of the plan should be seamless to you. However, because a portion of the plan is a group Medicare Part D prescription drug plan, Medicare requires that you receive additional information, such as explanation of benefits.

About Medicare Prescription Drug Plans

Medicare coverage is made up of various parts. If you are eligible for Medicare, you are covered by Medicare Part A (hospital care) and should be enrolled in Medicare Part B (physician services). Medicare Part D is voluntary prescription drug coverage. You will be enrolled in a group Medicare Part D prescription drug plan by AACPS. Because you are eligible for Medicare, you will receive a huge amount of advertising from insurance companies encouraging you to enroll in their Medicare Part D prescription drug plans.

Since you have already been enrolled in the SilverScript plan, do not enroll in an individual Medicare Part D prescription drug plan.

What You Need to Do (and Not Do)

Things to Avoid

Do Not Opt Out

Because part of your new prescription drug coverage is a Medicare Part D prescription drug plan, SilverScript is required to send you a letter giving you a chance to opt out or cancel your enrollment in prescription drug coverage. You will receive this "opt out" letter from SilverScript prior to your enrollment.

- ***Do not opt out.*** If you opt out, medical and prescription drug coverage for you and your dependents will terminate. If you re-enroll later, you may be subject to late enrollment penalties which will mean higher premiums for life. AACPS will not cover these premium penalties.
- ***Ignore the opt out letter***. As long as you do nothing, your coverage in the SilverScript plan will continue as intended. If SilverScript needs additional information from you, please respond so your enrollment is not delayed.

<u>Do Not Enroll</u> in any Individual Medicare Prescription Drug Plan

- ***Do not enroll in an individual Medicare Part D prescription drug plan.*** All retirees and dependents eligible for Medicare will be automatically enrolled by AACPS in the group Medicare Part D prescription drug plan, which will work in conjunction with the AACPS supplemental prescription drug coverage.

  Please note that if you do enroll in an individual Medicare Part D prescription drug plan, Medicare will not allow you to join the AACPS group plan, therefore, your AACPS medical and pharmacy coverage will terminate for you and your enrolled dependents.

Things to Do

Make Sure We Have Your Street Address

- If you have a P.O. Box on file with the AACPS Office of HR Retirement, please contact us right away. ***Medicare will not send mail to a P.O. Box***, so you may miss important information about this plan.
  - ➡If this mailing was sent to your P.O. Box, call the HR/ Office of Retirement at 410-222-5224 and provide your street address.
  - ➡If you cannot provide a street address, you may contact SilverScript at 1-888-512-8931 to "attest" that you are a U.S. resident.

Watch for Mailings From SilverScript

- You will be receiving a number of mailings required by Medicare regulation. Some of the information about Medicare prescription coverage may be potentially confusing because it pertains only to the Medicare portion of your coverage – not your full AACPS coverage, including the supplemental plan. If you have a question about any information you receive, call SilverScript. This phone number is on the back of your SilverScript card.

- ***Mailings – Things to Keep in Mind***
  The following is a list of some of the mailings you will receive and some things to keep in mind about them:

  Opt out letter
  Ignore this letter; DO NOT opt out.

  Summary of benefits
  This summary shows your co-pay structure.

  Welcome/confirmation of enrollment letter
  You can keep this confirmation for your files. There is nothing you need to do.

  Formulary
  This is an abridged version of the formulary. Call SilverScript if you have a question about whether your prescription is covered.

  Evidence of coverage
  This document provides more details about your coverage.

  Pharmacy directory
  SilverScript is a subsidiary of CVS Caremark and uses the same network.

  ID cards/Welcome Kit
  Each Medicare-eligible participant will receive their own SilverScript card.

  Monthly Explanation of Benefits
  You will receive an explanation of benefits each month listing all of your prescriptions filled that month.

  Coordination of Benefits Survey
  You will receive a request to let SilverScript know of any other coverage you have each year. If your AACPS plan is your only coverage, the correct answer is that you do not have other coverage.

Premiums

You will not send premiums to SilverScript. AACPS pays the cost of coverage for both the Medicare portion of the plan and the wrap coverage. Your premium that you pay for AACPS medical benefits includes prescription drug coverage.

For lower income retirees: Social Security may determine you are paying too much for your prescription premium. If that is the case, AACPS will reduce your monthly healthcare premium as appropriate for the designated time period.

For higher income retirees: If you pay an additional amount for your Medicare Part B premium due to your income, you will receive a letter from Medicare indicating the Income Related Monthly Adjustment Amount (IRMAA) that applies to your Medicare Part D prescription drug coverage. This additional amount will be withheld from your Social Security check, or Medicare will send you a bill that you must pay. You are responsible for this additional payment

No Action Required

All retirees and dependents eligible for Medicare will be automatically enrolled in the group Medicare prescription drug plan that works in conjunction with the AACPS "wrap" plan.

ID Cards

You will continue to use your existing SilverScript card(s) for 2023. AACPS requires your AACPS Medicare supplemental coverage and SilverScript coverage to commence the same date. If you are turning age 65 or are Medicare disabled, please ensure you apply for Medicare A&B in a timely fashion so your enrollment is not delayed.

Dental Plan Options

CareFirst BlueCross BlueShield Preferred Provider Organization (PPO) Dental Plan

The CareFirst BCBS Dental Plan PPO directory contains the participating providers. You may visit **www.carefirst.com** to access provider network information.

Benefits are available on an in- and out-of-network basis. The PPO plan provides a higher level of coverage when using a preferred provider. When a non-preferred provider is used, reimbursement is lower. There is no in-network deductible for services; however an out-of-network deductible of $50 per member (no more than $150 per family) applies. The annual benefit per covered member is $1,500. The following benefits are covered at in-network coverage:

- Routine examinations (cleanings) are covered at 100% of the approved benefit amount.
- Fillings, extractions, and root canals are covered at 80% of the approved benefit amount.
- Other services, such as crowns, bridgework, and periodontics, are covered at 80% of the approved benefit amount.
- Orthodontic benefits are covered for children and adults at 50% of the approved benefit, up to a lifetime orthodontia maximum of $1,500.

If you have questions about the PPO Dental Plan, call CareFirst BCBS at 1-866-891-2802.

CareFirst BlueCross BlueShield Traditional Dental Plan

You may see any dentist with the Traditional Dental Plan. The yearly benefit maximum per person is $1,500, after you satisfy the yearly deductible of $25 per member (maximum $50 family). This deductible does not apply to routine cleanings.

- Preventive maintenance services, including oral examinations and routine cleanings, are covered once every six months at 100% of the BCBS approved benefit.
- Other services, such as fillings, root canals, and extractions, are covered at 100% of the approved benefit.
- Crowns and oral surgery are covered at 80% of the approved benefit.
- Benefits for bridges and dentures are covered at 50% of the approved benefit.
- Orthodontic benefits are covered at 50% of the approved benefit for dependents and adults, up to the $1,500 lifetime orthodontia maximum.

If you have questions about the Traditional Dental Plan, call CareFirst BCBS at 1-866-891-2802.

Dental POS Plan Through United Concordia

United Concordia's Dental Plan is a Point-of-Service (POS) plan that gives members greater flexibility to access dental care.

You may enroll in the United Concordia Plan if you live in the plan's service area of MD, DC, Northern VA, and PA (network providers may be limited in some areas).

With the United Concordia POS, you must select a primary care dentist. To find a participating dental provider, visit United Concordia's website at **www.unitedconcordia.com** or refer to a provider directory.

The United Concordia POS provides comprehensive dental coverage with no annual deductible and no annual maximum benefit for in-network services. United Concordia will reimburse up to a maximum of $1,000 per family member per contract year for out-of-network services. ***There is no out-of-network coverage for orthodontic benefits under this plan.***

If you have questions about the United Concordia POS plan, call United Concordia at 1-866-357-3304.

CareFirst BlueCross BlueShield Select Vision Plan

This plan allows you to use optometrists, ophthalmologists, or retail outlets. Eye exams are covered up to 100% of the CareFirst BCBS approved benefit (one exam every 12 months). Reimbursements for lenses and frames, and contacts are at the same reimbursement (see CareFirst Dental and Vision Comparision Chart).

Please refer to the CareFirst Dental & Vision Options Summary or contact BCBS at 1-866-595-6215 for vision plan questions or claim inquiries.

If you are a BlueChoice HMO or BlueChoice Triple Option "Open Access" member, additional discounts are available to you through the Davis Vision Plan (see next paragraph) or contact 1-800-783-5602.

Note: Patient may be balanced billed for eye exams, lenses, frames, and contact lenses.

Davis Vision Benefits
(for BlueChoice and Triple Option members)

In addition to the CareFirst Vision Plan, BlueChoice HMO and BlueChoice Triple Option "Open Access" Plan members also have the core Blue Vision benefit through Davis Vision under their medical plan. These benefits entitle members to an annual eye exam and discounts on glasses or contact lenses at participating Davis Vision providers. Members are responsible for a $10 copay for the eye exam.

To locate a participating Davis Vision provider, go to **www.carefirst.com** and utilize the "Find a Doctor" feature or call Davis Vision at 1-800-783-5602 for a list of network providers closest to you. Be sure to ask your provider if he or she participates with the Davis Vision network before you receive care.

Please refer to the CareFirst Dental and Vision Options Summary for a detailed summary of the Davis discount benefits.

Vision Plan

If you are enrolled in the BlueChoice HMO or the Triple Option medical plans and enrolled in Select Vision you are automatically a part of the expanded vision network to include more Davis Vision providers—94,000+ providers across the country.

Your medical card will have the stand-alone vision plan listed as "SV" (Select Vision) on the front. Make sure you point this out to the provider as proof of your enrollment in that coverage and ask them to process your visit through that plan. They should be able to confirm your eligibility by calling 1-800-628-8549.

Features	Select Vision Plan *(Includes In & Out of Network Benefits)*	BlueVision Plus (Davis Vision*)
	Plan Pays:	*You Pay:*
Eye Exam	100% of Allowed Benefit once annually	No Copay
Frames	$45	Plan pays up to $45 or up to $95 at Visionworks *(plus 20% discount on balance with all Davis Vision Providers)*
Lenses		
Single Vision Lenses	$52	No Copay
Bifocal Lenses	$82	No Copay for lined bifocals
Trifocal Lenses	$101	No Copay for lined trifocals
Contacts (in lieu of eyeglasses)		
Contact Lenses – Medically indicated	$352	Plan pays up to $352
Cosmetic	$97	Plan pays up to $97

Vision options continued

Vision Options

Features	Select Vision Plan *(Includes In & Out of Network Benefits)*	BlueVision Plus (Davis Vision*)
	Plan Pays:	*You Pay:*
Additional Lens Benefit		
Tinting of Plastic Lenses (Solid/Gradient)	N/A	$15
Scratch-Resistant Coating	N/A	Covered
Polycarbonate Lenses (Children/Adults)**	N/A	$0/$35
Ultraviolet Coating	N/A	$15
Blue Light Filtering	N/A	$15
Anti-Reflective Coating (Standard/Premium/Ultra/ Ultimate)	N/A	$40/$55/$69/$85
Progressive Lenses (Standard/ Premium/Ultra/ Ultimate)	N/A	$65/$105/$140/$175
High-Index Lenses (1.67/1.74)	N/A	$60/$120
Polarized Lenses	N/A	$75
Plastic Photochromic Lenses	N/A	$70
Scratch Protection Plan: Single Vision I Multifocal Lenses	N/A	$20 I $40
Blended Segment Lenses	N/A	$20
Photochromic Lenses	N/A	$20
Oversize Lenses	N/A	Covered

**The Davis Vision Network has 94,000+ providers nationwide including Retailers (Walmart, Sam's Club, Costco, Vision Works, Target, JC Penney, My Eye Dr., Pearle Vision and America's Best), 1-800-CONTACTS and glasses.com.*

***Polycarbonate lenses are covered for dependent children, monocular patients and patients with prescriptions +/- 6.00 diopters or greater.*

Core Davis Vision ***(Included in BlueChoice HMO OA and BlueChoice Triple Option)***	
	You Pay:
Routine Eye Exam	$10
Frames	
Priced up to $70 retail	$40
Priced above $70 retail	$40, plus 90% of the amount over $70
Lenses	
Single Vision	$35
Lined Bifocal	$55
Lined Trifocal	$65
Contact Lenses	Discount available

Retirees' Monthly Healthcare Costs

effective January 1, 2023

To determine your rates for Retiree Medical Coverage	Use Rate Table
You have at least 20 years AACPS service working in a permanent position	**A**
You have at least 15 years and up to 20 years AACPS service working in a permanent position	**B**
You have at least 10 years and up to 15 years AACPS service working in a permanent position	**C**
You have less than 10 years AACPS service in a permanent position	Not eligible for retiree healthcare

A — 75% BOE Funding

Medical Options	Individual	Individual Medicare	Parent Child	Retiree Spouse	Retiree/ Spouse 1 Individual 1 Medicare	Retiree/ Spouse 2 Medicare	Family
BlueChoice HMO "Open Access" Plan							
100% Premium	$691.77	$599.76	$1,070.63	$1,600.07	$1,291.52	$1,199.51	$1,963.86
Board's Share	$518.83	$449.82	$802.97	$1,200.05	$968.64	$899.63	$1,472.89
Retiree's Share	**$172.94**	**$149.94**	**$267.66**	**$400.02**	**$322.88**	**$299.88**	**$490.97**
BCBS Triple Choice "Open Access" Plan							
100% Premium	$730.75	$633.55	$1,349.44	$1,757.88	$1,364.30	$1,267.07	$2,130.74
Board's Share	$548.06	$475.16	$1,012.08	$1,318.41	$1,023.22	$950.30	$1,598.05
Retiree's Share	**$182.69**	**$158.39**	**$337.36**	**$439.47**	**$341.08**	**$316.77**	**$532.69**
BCBS PPN							
100% Premium	$807.41	Not Available	$1,496.98	$1,949.78	Not Available	Not Available	$2,355.92
Board's Share	$605.56		$1,122.73	$1,462.33			$1,766.94
Retiree's Share	**$201.85**		**$374.25**	**$487.45**			**$588.98**
CareFirst BCBS Medi-Comp Plan							
100% Premium	Not Available	$783.59	Not Available	Not Available	Not Available	$1,567.21	Not Available
Board's Share		$587.69				$1,175.41	
Retiree's Share		**$195.90**				**$391.80**	

Benefits are effective January 1, 2023.

Retirees' Monthly Healthcare Costs

effective January 1, 2023

B — 50% BOE Funding

Medical Options	Individual	Individual Medicare	Parent Child	Retiree Spouse	Retiree/ Spouse 1 Individual 1 Medicare	Retiree/ Spouse 2 Medicare	Family
BlueChoice HMO "Open Access" Plan							
100% Premium	$691.77	$599.76	$1,070.63	$1,600.07	$1,291.52	$1,199.51	$1,963.86
Board's Share	$345.88	$299.88	$535.31	$800.03	$645.76	$599.75	$981.93
Retiree's Share	**$345.89**	**$299.88**	**$535.32**	**$800.04**	**$645.76**	**$599.76**	**$981.93**
BCBS Triple Choice "Open Access" Plan							
100% Premium	$730.75	$633.55	$1,349.44	$1,757.88	$1,364.30	$1,267.07	$2,130.74
Board's Share	$365.37	$316.77	$674.72	$878.94	$682.15	$633.53	$1,065.37
Retiree's Share	**$365.38**	**$316.78**	**$674.72**	**$878.94**	**$682.15**	**$633.54**	**$1,065.37**
BCBS PPN							
100% Premium	$807.41	Not Available	$1,496.98	$1,949.78	Not Available	Not Available	$2,355.92
Board's Share	$403.70		$748.49	$974.89			$1,177.96
Retiree's Share	**$403.71**		**$748.49**	**$974.89**			**$1,177.96**
CareFirst BCBS Medi-Comp Plan							
100% Premium	Not Available	$783.59	Not Available	Not Available	Not Available	$1,567.21	Not Available
Board's Share		$391.79				$783.60	
Retiree's Share		**$391.80**				**$783.61**	

C — 25% BOE Funding

Medical Options	Individual	Individual Medicare	Parent Child	Retiree Spouse	Retiree/ Spouse 1 Individual 1 Medicare	Retiree/ Spouse 2 Medicare	Family
BlueChoice HMO "Open Access" Plan							
100% Premium	$691.77	$599.76	$1,070.63	$1,600.07	$1,291.52	$1,199.51	$1,963.86
Board's Share	$172.94	$229.13	$267.66	$400.02	$402.06	$458.25	$490.96
Retiree's Share	**$518.83**	**$370.63**	**$802.97**	**$1,200.05**	**$889.46**	**$741.26**	**$1,472.90**
BCBS Triple Choice "Open Access" Plan							
100% Premium	$730.75	$633.55	$1,349.44	$1,757.88	$1,364.30	$1,267.07	$2,130.74
Board's Share	$182.69	$231.77	$337.36	$439.47	$414.46	$463.51	$532.68
Retiree's Share	**$548.06**	**$401.78**	**$1,012.08**	**$1,318.41**	**$949.84**	**$803.56**	**$1,598.06**
BCBS PPN							
100% Premium	$807.41	Not Available	$1,496.98	$1,949.78	Not Available	Not Available	$2,355.92
Board's Share	$201.85		$374.24	$487.44			$588.98
Retiree's Share	**$605.56**		**$1,122.74**	**$1,462.34**			**$1,766.94**
CareFirst BCBS Medi-Comp Plan							
100% Premium	Not Available	$783.59	Not Available	Not Available	Not Available	$1,567.21	Not Available
Board's Share		$274.72				$549.47	
Retiree's Share		**$508.87**				**$1,017.74**	

Benefits are effective January 1, 2023.

Retirees' Monthly Healthcare Costs

effective January 1, 2023

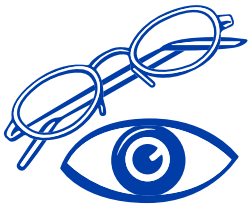
To determine your rates for Retiree Dental Coverage	Use Rate Table
You have at least 20 years AACPS service working in a permanent position	**D**
You have at least 10 years AACPS service working in a permanent position	**E**

D

	Individual	Parent/Child	Retiree/Spouse	Family
Dental Options				
BCBS Traditional Dental				
100% Premium	$38.59	$63.27	$79.83	$120.74
Board's Share	$28.94	$47.45	$59.87	$90.56
Retiree's Share	**$9.65**	**$15.82**	**$19.96**	**$30.18**
BCBS Dental PPO				
100% Premium	$35.90	$58.84	$74.26	$112.32
Board's Share	$26.93	$44.13	$55.70	$84.24
Retiree's Share	**$8.97**	**$14.71**	**$18.56**	**$28.08**
Dental HMO				
100% Premium	$16.99	$28.32	$33.98	$45.31
Board's Share	$12.74	$21.24	$25.49	$33.98
Retiree's Share	**$4.25**	**$7.08**	**$8.49**	**$11.33**

E

Dental Options				
BCBS Traditional Dental				
100% Premium	$38.59	$63.27	$79.83	$120.74
Board's Share	$0.00	$0.00	$0.00	$0.00
Retiree's Share	**$38.59**	**$63.27**	**$79.83**	**$120.74**
BCBS Dental PPO				
100% Premium	$35.90	$58.84	$74.26	$112.32
Board's Share	$0.00	$0.00	$0.00	$0.00
Retiree's Share	**$35.90**	**$58.84**	**$74.26**	**$112.32**
Dental HMO				
100% Premium	$16.99	$28.32	$33.98	$45.31
Board's Share	$0.00	$0.00	$0.00	$0.00
Retiree's Share	**$16.99**	**$28.32**	**$33.98**	**$45.31**



All retirees use this table for Vision Plan rates

	Individual	Parent/Child	Retiree/Spouse	Family
Vision Plan				
BCBS Select Vision				
100% Premium	$4.03	$5.24	$7.08	$8.26
Board's Share	$0.00	$0.00	$0.00	$0.00
Retiree's Share	**$4.03**	**$5.24**	**$7.08**	**$8.26**

Benefits are effective January 1, 2023.

BlueChoice HMO Open Access vs. BlueChoice Triple Option Open Access

Anne Arundel County Public Schools—Retirees Under and Over 65

ANNE ARUNDEL COUNTY PUBLIC SCHOOLS

	BlueChoice HMO	BlueChoice Triple Option
Networks	BlueChoice	BlueChoice for Level 1 PPO for Level 2 All others for Level 3
PCP Required	Yes	Yes for Level 1
Referrals Required	No	No
Medical Copays	$10 PCP/$15 Specialist	$15 PCP/Specialist for Level 1 $20 PCP/Specialist for Level 2 N/A for Level 3
Deductibles	N/A	N/A for Level 1 $200 Individual/$400 Family for Level 2 $300 Individual/$600 Family for Level 3
Medical Out-of-Pocket Maximum	$2,000 Individual $6,000 Family	$2,000 Individual/$6,000 Family for Level 1 $2,000 Individual/$4,000 Family for Level 2 $2,000 Individual/$4,000 Family for Level 3
Coinsurance	100% coverage with the exception of AI/IVF services which are covered at 50% AB*	100% for Level 1 90% for Level 2 80% for Level 3
Independent Labs	LabCorp	LabCorp for Level 1 All other Labs for Level 2 & 3
Emergency Room	$85 copay; waived if admitted	$85 copay; waived if admitted, Levels 1, 2 & 3
Inpatient Hospital	No charge when approved	100% AB* for Level 1 90% AB* after deductible for Level 2 80% AB* after deductible for Level 3
Occupational, Physical, Speech Therapy	Limited to a combined 30 visits per condition per year	Limited to a combined 30 visits per condition per year for Level 1 Limited to 100 visits combined for Levels 2 & 3
Chiropractic Care	Limited to 20 visits per year	Limited to 20 visits per year for Level 1 Unlimited visits for Levels 2 & 3
Acupuncture	Limited to 24 visits per year	Limited to 24 visits per year for Level 1 Unlimited visits for Levels 2 & 3
Prescription Drug Copays	**Retail:** $5 Generic; $20 Preferred Brand; $35 Non-preferred Brand; $75 Preferred Specialty; $75 Non-preferred Specialty. **Mail Order or CVS Retail Maintenance Choice:** $10 Generic; $40 Preferred Brand; $70 Non-preferred Brand; $150 Preferred Specialty; $150 Non-preferred Specialty	

The main differences between the BlueChoice HMO Open Access plan and the BlueChoice Triple Option Open Access plan are:

1. With the BlueChoice plan you must stay within the BlueChoice network of providers.
2. The BlueChoice Triple Option plan gives you the freedom to move between the BlueChoice network (Level 1), the PPO network (Level 2) and the Par/Non-par providers (Level 3).
3. There is less out of pocket with the BlueChoice HMO plan.

* AB =Allowed Benefit

CareFirst BlueChoice

CST3425-1N (9/19)

PPO (PPN) vs. BlueChoice Triple Option Open Access

Anne Arundel County Public Schools—Retirees Under 65

ANNE ARUNDEL COUNTY PUBLIC SCHOOLS

	PPO	BlueChoice Triple Option
Networks	PPO	BlueChoice for Level 1 PPO for Level 2 All others for Level 3
PCP Required	No	Yes for Level 1
Referrals Required	No	No
Medical Copays	$30 PCP/$30 Specialist	$15 PCP/Specialist for Level 1 $20 PCP/Specialist for Level 2 N/A for Level 3
Deductibles	$0—In-Network $200 Individual/$400 Family—Out-of-Network	N/A for Level 1 $200 Individual/$400 Family for Level 2 $300 Individual/$600 Family for Level 3
Medical Out-of-Pocket Maximum	$1,200 Individual/$2,400 Family	$2,000 Individual/$6,000 Family for Level 1 $2,000 Individual/$4,000 Family for Level 2 $2,000 Individual/$4,000 Family for Level 3
Combined Medical and Prescription Out-of-Pocket Maximum	$6,350 Individual $12,700 Family	$6,350 Individual $12,700 Family
Coinsurance	100%—In-Network 80%—Out of Network	100% for Level 1 90% for Level 2 80% for Level 3
Independent Labs	PPO Providers—In-Network Other providers—Out of Network	LabCorp for Level 1 All other Labs for Level 2 & 3
Emergency Room	$85 copay; waived if admitted	$85 copay; waived if admitted, Levels 1, 2 & 3
Inpatient Hospital	100% AB*—In-Network 80% AB* after deductible—Out-of-Network	100% AB* for Level 1 90% AB* after deductible for Level 2 80% AB* after deductible for Level 3
Occupational, Physical, Speech Therapy	Limited to 100 combined visits between PT and OT. Speech therapy has no maximum.	Limited to a combined 30 visits per condition per year for Level 1 Limited to 100 visits combined for Levels 2 & 3
Chiropractic Care	Unlimited Visits	Limited to 20 visits per year for Level 1 Unlimited Visits for Levels 2 & 3
Acupuncture	100% AB—In-Network 80% AB after deductible—Out of Network	Limited to 24 visits per year for Level 1 Unlimited Visits for Levels 2 & 3
Prescription Drug Copays	**Retail:** $5 Generic/ $20 Preferred Brand/$35 Non-Preferred Brand/$75 Preferred Specialty/$75 Non-preferred Specialty **Mail Order or CVS Retail Maintenance Choice:** $10 Generic/ $40 Preferred Brand/ $70 Non-Preferred Brand/$150 Preferred Specialty/$150 Non-preferred Specialty	

The main differences between the PPO plan and the BlueChoice Triple Option Open Access plan are:

1. The BlueChoice Triple Option plan gives you the freedom to move between the BlueChoice network (Level 1), the PPO network (Level 2) and the Par/Non-par providers (Level 3).
2. Copays with the BlueChoice Triple Option plan are less than the PPO plan.
3. Premiums for 2023 are significantly less for the BlueChoice Triple Option vs. the PPO plan.

* AB =Allowed Benefit

CareFirst BlueChoice

CST3426-1N (9/19)

Medi-Comp Plan

Medicare Eligibles/Retirees Over 65—January 2023

Product Line	Medi-Comp	
Services	**Medicare Covers**	**Medi-Comp**
Part A Hospital Deductible	60 days of inpatient hospital care, except for a $1,408 deductible.	After Medicare's primary payment, CareFirst's reimbursement is 90% of Allowed Benefit; the combined carrier payments will not exceed what CareFirst would have paid if it were primary
Inpatient Days 61–90	30 additional days of hospital inpatient care, except for a $352 per day copayment.	After Medicare's primary payment, CareFirst's reimbursement is 90% of Allowed Benefit; the combined carrier payments will not exceed what CareFirst would have paid if it were primary
Lifetime Reserve Days	60 additional "lifetime reserve" days of inpatient hospital care, except for a $704 per day copayment.	After Medicare's primary payment, CareFirst's reimbursement is 90% of Allowed Benefit; the combined carrier payments will not exceed what CareFirst would have paid if it were primary
Skilled Nursing Facility	100 days of inpatient care in a skilled nursing facility, except for the $176 per day copayment for days 21–100.	After Medicare's primary payment, CareFirst's reimbursement is 90% of Allowed Benefit; the combined carrier payments will not exceed what CareFirst would have paid if it were primary
Inpatient Medical/Surgery	80% of the Medicare-approved amount for in-hospital surgery and medical care, after the annual $198 deductible has been met.	After Medicare's primary payment, CareFirst's reimbursement is 90% of Allowed Benefit; the combined carrier payments will not exceed what CareFirst would have paid if it were primary
Outpatient Surgery	80% of the Medicare-approved amount for outpatient hospital visits and surgery, for medical conditions after the annual $198 deductible has been met.	After Medicare's primary payment, CareFirst's reimbursement is 90% of Allowed Benefit; the combined carrier payments will not exceed what CareFirst would have paid if it were primary
Emergency Services	80% of the Medicare-approved amount for minor surgery and emergency first aid provided in a physician's office or hospital outpatient department, after the annual $198 deductible has been met.	After Medicare's primary payment, CareFirst's reimbursement is 90% of Allowed Benefit; the combined carrier payments will not exceed what CareFirst would have paid if it were primary
Diagnostic Services	Covers clinical laboratory services at 100% of the Medicare-approved amount. 80% of the Medicare-approved amount for diagnostic X-rays or pathology examinations provided in a physician's office or hospital outpatient department, after the $198 deductible has been met.	Medicare covers in full For outpatient minor surgery or accidental injury: After Medicare's primary payment, CareFirst's reimbursement is 90% of Allowed Benefit; the combined carrier payments will not exceed what CareFirst would have paid if it were primary For all other cases: After Medicare's primary payment, CareFirst's reimbursement is 90% of Allowed Benefit; the combined carrier payments will not exceed what CareFirst would have paid if it were primary
Radiation/Chemotherapy Services	80% of the Medicare-approved amount for radiation/chemotherapy services provided in an office or hospital outpatient department, after the $198 deductible has been met.	After Medicare's primary payment, CareFirst's reimbursement is 90% of Allowed Benefit; the combined carrier payments will not exceed what CareFirst would have paid if it were primary
Diabetic Self-Management	80% of the Medicare-approved amount for blood glucose monitors, testing strips, lancet devices, after the $198 annual deductible has been met.	After Medicare's primary payment, CareFirst's reimbursement is 90% of Allowed Benefit; the combined carrier payments will not exceed what CareFirst would have paid if it were primary

Product Line	Medi-Comp	
Services	**Medicare Covers**	**Medi-Comp**
PREVENTIVE SERVICES		
Annual Physical	One Annual Wellness visit every 12 months. There is no coinsurance, copayment or deductible.	Covered by Medicare
Routine GYN	No coinsurance, copayment or deductible for Pap Smears, Pelvic and clinical breast exams. Covered once every 2 years. Covered once a year for women at high risk.	100% of the Allowed Benefit the year Medicare does not pay
Prostate Cancer Screening Exam	80% of the Medicare-approved amount for digital rectal exam for men age 50 and older after the $198 annual deductible has been met. 100% for the PSA test; 80% for other related services. Covered once a year.	Pays 100% of Medicare Part B deductible and coinsurance.
Colorectal Cancer Screening Procedures	No coinsurance, copayment or deductible for screening colonoscopy or screening flexible sigmoidoscopy.	Covered by Medicare
Mammography Screening	No coinsurance, copayment or deductible. One baseline between ages 35–39. Once every 12 months for age 40 and older.	Covered by Medicare
Bone Mass Measurement	No coinsurance, copayment or deductible. Once every 24 months for persons at high risk for osteoporosis.	Covered by Medicare

Examples:

Medicare Claim $5,000 Facility Charge	$5,000.00 Medicare Allowed Amount $1,408.00 Part A Deductible **$3,592.00 Medicare Paid**	**CareFirst Claim $5,000 Facility Charge**	$5,000.00 Allowed Amount $4,500.00 90% of Allowed Benefit –$3,592.00 Medicare Paid Amount **$ 908.00 CareFirst Payment Amount**	**Member Liability $500**
Medicare Claim $500 Provider Charge	$250.00 Medicare Allowed Amount $198.00 Part B Deductible **$ 52.00 Medicare Paid**	**CareFirst Claim $500 Provider Charge**	$250.00 Allowed Amount $225.00 90% of Allowed Benefit –$ 52.00 Medicare Paid Amount **$173.00 CareFirst Payment Amount**	**Member Liability $25**
Medicare Claim $500 Provider Charge	$250.00 Medicare Allowed Amount $198.00 Part B Deductible **$ 52.00 Medicare Paid**	**CareFirst Claim $500 Provider Charge**	$30.00 Allowed Amount $27.00 90% of Allowed Benefit –$52.00 Medicare Paid Amount **$ 0.00 CareFirst Payment Amount**	**Member Liability $198**

Out-of-pocket

After Medicare's primary payment, CareFirst's reimbursement is 90% of Allowed Benefit; the combined carrier payments will not exceed what CareFirst would have paid if we were primary, up to a $750 out-of-pocket. Reimbursement is then 100% of Allowed Benefit; the combined carrier payments will not exceed what CareFirst would have paid if we were primary for the remaining calendar year.

Prescription drugs

Covered through the CVS Caremark SilverScript Program. Refer to the 2023 Retirees' Healthcare Enrollment Guide.

Note: Medicare's deductibles and/or coinsurance amounts are subject to change effective 1/1/2023. As of the print date, we do not have the information from Medicare for 2023. Should Medicare's deductibles and/or coinsurance change 1/1/2023, CareFirst will increase the amount covered to reflect the change in the deductibles and/or coinsurance.

Dental Options

Retirees Over/Under 65 and Medicare Eligibles

Benefits	CareFirst Traditional	CareFirst PPO		Concordia Plus DHMO MD/ DC2060*
		In-Network	Out-of-Network	In-Network
	Plan Pays	Plan Pays	Plan Pays	Plan Pays
Oral Examination	100% of AB	100% of AB	80% of AB	$5 copay
Routine Cleaning	100% of AB	100% of AB	80% of AB	100%
Sealants (limited to permanent molars–until end of year in which a member turns 19)	100% of AB	100% of AB	80% of AB	100%
Bitewing X-ray	100% of AB	100% of AB	80% of AB	100%
Palliative Treatment	100% of AB	100% of AB	80% of AB	95%
Other X-rays as required	100% of AB	100% of AB	80% of AB	100%
Space Maintainers	100% of AB	100% of AB	80% of AB	95%
Fillings	100% of AB	80% of AB	60% of AB**	100%
Simple Extractions	100% of AB	80% of AB	60% of AB**	75%-85%
Pulpotomy	100% of AB	80% of AB	60% of AB**	75%-80%
Direct Pulp Caps	100% of AB	80% of AB	60% of AB**	75%-80%
Root Canals	100% of AB	80% of AB	60% of AB**	75%-80%
Apicoectomy	80% of AB**	80% of AB	60% of AB**	75%-80%
Oral Surgical Services	80% of AB**	80% of AB	60% of AB**	75%-85%
Surgical Extractions	80% of AB**	80% of AB	60% of AB**	75%-85%
Oral Surgery	80% of AB**	80% of AB	60% of AB**	75%-85%
General Anesthesia	80% of AB**	80% of AB	60% of AB**	See note 1
Periodontics	50% of AB**	80% of AB	60% of AB**	50%-65%
Crown	80% of AB**	80% of AB	60% of AB**	60%-80%
Prosthetic Appliances (including implants)	50% of AB	80% of AB	60% of AB**	60%-80% Implants not covered
Orthodontics Children and Adults	50% of AB	50% of AB	35% of AB	See note 3
Annual Deductible	$25 Ind./$50 Family	None	$50 Ind./$150 Family	None
Annual Benefit Maximum	$1,500	$1,500		None/See note 2
Ortho Lifetime Maximum	$1,500	$1,500		See note 3

(AB Allowed Benefit)

Under the Concordia Plus DHMO (MD/DC 2060*) Plan, out-of-network services are reimbursed up to a maximum amount, based on the fee schedule provided by United Concordia.

* The above DHMO Plan percentages are approximate and used for comparison purposes only. Please refer to the United Concordia (UCCI) Schedule of Benefits for actual copayment amounts. All coverage is subject to the Plan's exclusions and limitations.

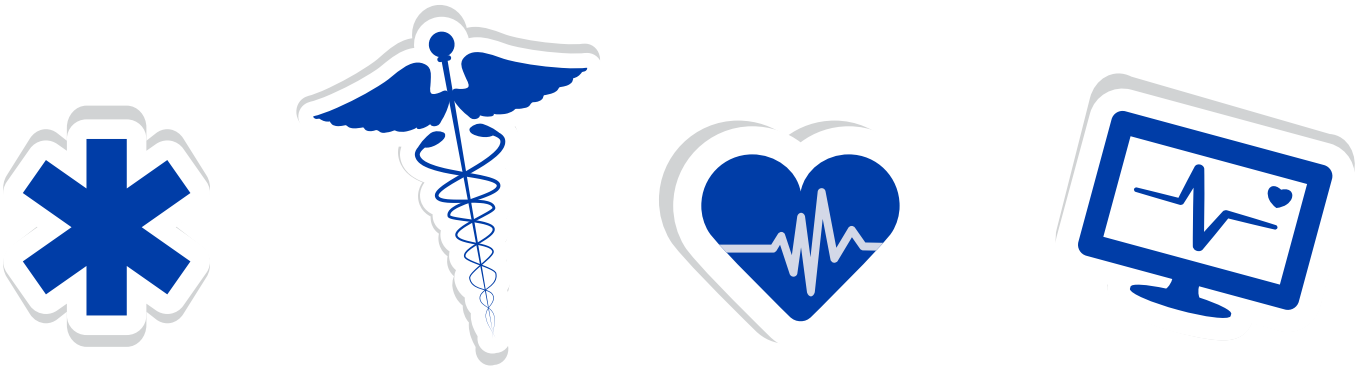
** After Deductible

Note 1—General Anesthesia is considered integral to other procedures under this plan and is not covered separately.

Note 2—No annual maximum for in-network services. United Concordia will reimburse up to a maximum of $1,000 per family member per contract year for out-of-network services.

Note 3—After $2,900 member copayment satisfied, benefits applicable to in-network services; provider should submit pre-treatment estimate. United Concordia will not reimburse covered members for any orthodontic services performed out-of-network.

Appendix



Important Contact Information

Medical Plans	Phone	Website Information
CareFirst BlueChoice HMO CareFirst BlueChoice Triple Option Plan	1-866-595-6215	www.carefirst.com/aacps
CareFirst BCBS Preferred Provider Network (PPN) *Claim and benefit questions* *Out-of-state PPN providers*	 1-866-595-6215 1-800-810-BLUE	 www.carefirst.com/aacps www.bcbs.com
CareFirst Behavioral Health	1-800-245-7013	www.carefirst.com
CareFirst "Medi-Comp" Supplemental Plan	1-866-595-6215	www.carefirst.com/aacps
CVS Caremark Prescription Drug Plan *Claim and benefit questions* *Mail-order prescription service*	1-800-241-3371	www.carefirst.com/myaccount and log in. Go to "Manage my Health," then click on "Drug & Pharmacy Resources." If over 65, go to www.caremark.com
CVS Caremark SilverScript	1-888-512-8931	www.caremark.com
Dental Plans		
CareFirst Traditional Dental Plan	1-866-891-2802	www.carefirst.com/aacps
CareFirst PPO Dental Plan	1-866-891-2802	www.carefirst.com/aacps
United Concordia Dental POS Plan	1-866-357-3304	www.unitedconcordia.com
Vision Plan		
CareFirst Vision	1-866-595-6215	www.carefirst.com
Davis Vision	1-800-783-5602	
Other		
Questions/Issues about your retirement check? *Maryland State Retirement Agency*	1-800-492-5909 410-625-5555	www.sra.state.md.us
Benefits Questions or Address Changes? *Human Resources/Office of Retirement*	 410-222-5224 or 1-800-909-4882	 email: retirement@aacps.org
Associations For Former AACPS Employees		
Anne Arundel Retired School Personnel Association (AARSPA) *All retirees of AACPS are welcome to join. Contact Leslie Schell.*	410-969-0129	
TAAAC Retired *All retired teachers are welcome to join. Contact Erin Sakalas.*	 443-433-3654	

Important Notice From Anne Arundel County Public Schools About Your Prescription Drug Coverage And Medicare

Notice of Creditable Coverage

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Anne Arundel County Public Schools (AACPS) and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. AACPS has determined that the prescription drug coverage offered by the AACPS Prescription Plan CVS Caremark is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered Creditable Coverage.

   Note: effective January 1, 2015 going forward, Medicare eligible retiree members will be group enrolled into a Medicare Part D plan through CVS Caremark SilverScript that is expected to pay out as much as standard Medicare prescription drug coverage.

Because your existing coverage through AACPS Prescription Plan with CVS Caremark is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 through December 7. This ***may*** mean that you ***may*** have to wait to join a Medicare drug plan and that you ***may*** pay a higher premium (a penalty) if you join later. You ***may*** pay that higher premium (a penalty) as long as you have Medicare prescription drug coverage. However, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible for a two (2)month Special Enrollment Period (SEP) because you lost creditable coverage to join a Part D plan.

In addition, if you lose or decide to leave employer/union sponsored coverage, you will be eligible to join a Part D plan at that time using an Employer Group Special Enrollment Period.

You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area.

Your Share Of Prescription Cost—For The 2023 Plan Year

	Medical Option	Deductible	Retail	Mail Order	Maximum You Could Pay Per Benefit Year
AACPS Plans	• CareFirst BlueChoice Triple Option "Open Access" Plan • CareFirst BlueChoice HMO "Open Access" Plan • CareFirst BCBS "Medi-Comp" Plan	None	You pay: $5 generic $20 brand-name $35 Non-pref brand $75 Speciality	You pay: $10 generic $40 brand name $70 Non-pref brand $150 Specialty *applies for mail-order or CVS 90-day supplies*	Unlimited
Medicare	Standard Medicare Part D Prescription Drug Benefits	$505	You pay: 5% or 25%[1] of the prescription cost (depending on where you are in accumulating drug costs during the year)		Unlimited You pay first $7,400 in out-of-pocket spending, then 5% thereafter

Remember, the insurance companies who offer Medicare Part D plans may have benefit structures that are different from the Standard Medicare Part D structure shown above.

1 For 2023, Medicare Part D participants will receive a 70% discount from pharmaceutical manufacturers on the total cost of Medicare Part D-covered brand-name drugs purchased while in the coverage gap. The full retail cost of the brand-name drugs, minus the Medicare Part D plan payment equal to 5% of the brand-name drug cost, will still apply to satisfying your $7,400 in out-of-pocket spending before reaching the 5% catastrophic coverage level, even though the 70% was paid by pharmaceutical manufacturers. In addition, Medicare Part D participants will pay 25% of the cost of Medicare Part D-covered generic drugs purchased while in the coverage gap.

Please note if you drop your AACPS prescription coverage, you may have to wait until the following October to rejoin for the upcoming January.

If you decide to join a Medicare drug plan, your AACPS coverage will be affected. Read on for more information about what happens to your current coverage if you join a Medicare drug plan.

If you do decide to join a Medicare drug plan and drop your AACPS prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

You should also know that if you drop or lose your coverage with AACPS and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (incur a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium may go up by at least 1% of the base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may consistently be at least 19% higher than the base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage…

Contact the Human Resources Retirement Office at 410-222-5224. NOTE: You will receive this notice each year. You will also receive it before the next period you can join a Medicare drug plan, and if this coverage through AACPS changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).

Date:	September 2022
Name of Entity/Sender:	Anne Arundel County Public Schools
Contact:	Office of HR Operations
Address:	2644 Riva Road, Annapolis, MD 21401
Phone Number:	410-222-5224 • 1-800-909-4882

Anne Arundel County Public Schools | Division of Human Resources

Notice of Privacy Practices

Responsible Office for Administration
Office of HR Operations – Benefits
410-222-5221/5206/5219

Contact Information
Anne Arundel County Public Schools
Office of Human Resources Operations
Attn: Office of Retirement
2644 Riva Road, Annapolis, MD 21401| 410-222-5224

This notice describes how medical information about you may be used and disclosed, and how you may gain access to this information. Pleased review this notice carefully.

This notice applies to the privacy practices of all Anne Arundel County Public Schools (AACPS) health plans. Please be advised since these plans are affiliated (related) entities, we might share your protected health information and the protected health information of others on your insurance policy as needed for payment or Healthcare operations in regards to the plans listed below:

CareFirst Medical, Dental, and Vision Plans, CVS Caremark Prescription Plan, UCCI Dental Plan, and the AACPS Flexible Spending Account Program.

Our Legal Duty

AACPS is required by law to maintain the privacy of your protected health information (PHI). We are obligated to provide you with a copy of this Notice of our legal duties and of our privacy practices with respect to PHI, and we must abide by the terms of this Notice. We reserve the right to change the provisions of our Notice and make the new provisions effective for all PHI that we maintain. If we make a material change to our Notice, we will mail a revised Notice to the address that we have on record for the policyholder.

Effective Date

This Notice of Privacy Practice became effective on April 14, 2003.

Uses and Disclosure of Medical Information

Payment: We may use or disclose your PHI to pay claims for services provided to you, and to fulfill our responsibilities for plan coverage and providing plan benefits. For example, we may disclose your PHI to pay claims for services provided to you by doctors, hospitals, pharmacies and others for services delivered to you that are covered by your health plan. We might also use this information to determine your eligibility for benefits, coordination of benefits, to obtain premiums, to determine medical necessity, and to issue explanations of benefits.

Healthcare Operations: We might use and disclose your PHI for all activities as defined by the HIPAA Federal Regulations. For example, we might use and disclose your protected health information to determine premiums for the health plans, to conduct quality assessment, to engage in care and case management, and to manage our business.

Business Associates: We contract with individuals and entities (Business Associates) to perform certain types of services. To perform these functions or services, our Business Associates will receive, create, maintain, use or disclose PHI, but only after we require the Business Associates to agree in writing to contract terms designed to appropriately safeguard your information. For example, we may disclose your PHI to a Business Associate to administer claims or to provide service support, utilization management, coordination of benefits, or pharmacy benefit management.

Other Covered Entities: We may use or disclose your PHI to assist other covered entities in connection with payment activities and certain healthcare operations. For example, we may disclose or share your PHI with other insurance carriers in order to coordinate benefits.

Other Possible Uses/ Disclosures of Protected Health Information

In addition to uses and disclosures for payment and healthcare operations, we may use/or disclose your PHI for the following purposes (this list is not completely inclusive):

Personal Representatives: We may disclose PHI to the patient or patient's personal representative. That could be a legal guardian, or a person designated by you to act on your behalf in making decisions related to your healthcare.

Required by Law: We may use or disclose your PHI when we are required to do so by law. For example, such information may be disclosed to the U.S. Department of Health & Human Services upon request for determining whether we are in compliance with federal privacy laws as well as for requests pursuant to workers' compensation or similar programs. This could also include releasing information to a medical examiner as authorized by law and law enforcement officials in compliance with a legal order.

To You or with your Authorization: We must disclose your PHI as described in the Individual Rights section of this notice. You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose not listed in this notice. If you provide such authorization, you may revoke it in writing at any time.

Public Health & Safety/Military and National Security: We might use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to the U.S. Department of Health & Human Services upon their request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your PHI to authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or other crimes.

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

Your Rights

Right to Inspect and Copy: You have the right to inspect and copy your PHI that is contained in a "designated record set." This information contains your medical and billing records, as well as other records that are used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set. You may request access to your health records in an electronic format if they are available electronically. You may request that your electronic health records be transmitted directly to you or someone you designate. You may be charged a fee for access to electronic health records, but this amount must be limited to the cost of labor involved in responding to your request. To inspect and copy your PHI, in paper or electronic form, you must make your request in writing to the Privacy Officer, through the HR Department.

Restriction Requests: You have the right to request a restriction on the PHI we use or disclose about you for treatment, claim payment, or healthcare operations. In addition, you have the right to restrict disclosure of PHI to the health plan for payment or health care operations (but not for carrying out treatment) in situations where you have paid the health care provider out-of-pocket in full. To request a restriction, you must make your request, in writing, to the Privacy Officer through the HR Department. We are not required to agree to any restriction that you may request, unless it involves a situation described above where you paid a provider out-of-pocket in full. If we do agree to the restriction, we will comply with the restriction unless the information is needed to provide emergency treatment to you.

Right to Request Confidential Communications: If you believe a disclosure of your PHI may endanger you, you may request that we communicate with you regarding your information in an alternative manner or at an alternative location. For example, you may ask that we only contact you at your work address or via your work e-mail.

Right of an Accounting: You have a right to an accounting of certain disclosures of your PHI that are made for reasons other than treatment, claim payment, or healthcare operations. This includes an accounting of disclosures of electronic health records, even those used for treatment, payment, and health care operations. No accounting is required for disclosures you authorized. You should know that most disclosures of your PHI will be for purposes of treatment, claim payment or healthcare operations, and therefore, will not be subject to accounting. You may request an accounting of disclosures for the previous six years (previous three years, if it was a disclosure of electronic health records). For these requests, you must submit your request, in writing, to the Privacy Officer through the HR Department.

Right to Amend: You may request us to amend your information if you believe that PHI is incorrect or incomplete. This office may deny your request if the information you want to amend is not maintained by us, but by another entity.

Breach of Unsecured PHI

You must be notified in the event of a breach of unsecured PHI. A "breach" is the acquisition, access, use, or disclosure of PHI in a manner that compromises the security or privacy of the PHI. PHI is considered compromised when the breach poses a significant risk of financial harm, damage to the individual's reputation, or other harm to you. This does not include good faith or inadvertent disclosures or when there is no reasonable way to retain the information. You must receive a notice of the breach as soon as possible and no later than 60 days after the discovery of the breach.

Questions and Complaints

If you have questions in regards to your PHI, you may contact:

Contact Office: AACPS Office of HR Operations
Telephone: 410-222-5224/5221/5219
or 1-800-909-4882
Fax: 443-458-0669
Address: 2644 Riva Road, Annapolis, MD 21401

You may notify our office if you believe your PHI privacy rights have been violated. You may file a written complaint with the above address or contact us at the designated phone numbers.

You may also file a written complaint with the Secretary of the U.S. Department of Health & Human Services. This complaint may be submitted to:

Department of Health & Human Services
801 Market Street, Suite 9300
Philadelphia, PA 19107-3134

Please be advised we will not penalize you in any way if you choose to file a complaint with us or the U.S. Department of Health & Human Services.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact:

www.marylandattorneygeneral.gov/Pages/CPD/HEAU/compOLBillEquipDispute.aspx

Health Education and Advocacy Unit
Office of the Attorney General
200 St Paul Place, 16th Floor
Baltimore, Maryland 21202
Phone: (410) 528-1840 or toll-free 1 (877) 261-8807
En español: 410-230-1712; Fax: (410) 576-6571
heau@oag.state.md.us
www.marylandattorneygeneral.gov/Pages/CPD/HEAU

RETIREE HEALTHCARE ENROLLMENT FORM INSTRUCTIONS

Complete ALL Sections:

Section 1 Complete the Retiree Information in full (name, social security number, home address [please provide mailing address, not vacation address], home phone, retirement date if applicable).

Section 2 Place an "X" to indicate Type of Activity associated with completing the application. A change in coverage level may only be made if it is a qualifying lifestyle change (i.e., marriage, birth, death, etc.) and the change must be made within 31 days immediately following the event. Supporting documentation should be furnished for birth (copy of birth certificate), divorce (divorce decree), or marriage license (marriage certificate). If filling out Change in Coverage, please be sure to specify the reason where noted and date event occurred. The Retirement Office will fill out effective date.

Section 3 Place an "X" to indicate both your medical plan selection (or waiver of coverage) and your level of coverage.

Section 4 Place an "X" to indicate both your dental plan selection (or waiver of coverage) and your level of coverage.

Section 5 Place an "X" to indicate both your vision plan selection (or waiver of coverage) and your level of coverage.

Section 6 Fill out the information for all eligible dependents covered. Check under "add" or "remove", fill out the name, sex, date of birth, and Social Security Number for each dependent. Fill out age and handicapped status as indicated. Complete doctor's name must be filled in for BlueChoice Triple Option "Open Access" Plan, BlueChoice HMO "Open Access", and UCCI POS (Dental). Refer to **www.CareFirst.com**, or **www.ucci.com**, to select the proper plan, and to look for your doctor's name and location and information. Place an X in the coverages (**M**edical, **D**ental, **V**ision) you have selected for each member added. Dependents are covered up to the end of the month in which they turn 26.

Section 7 Other Insurance Information—Indicate "NO" if you do not have any other health coverage. If you check "YES", be sure to supply who is covered, date of birth, name of employer, insurance company, and policy number as applicable.

Section 8 If this section does not apply, please specify "NO". If you are covered by Medicare, please fill out the requested information—Medicare Claim Number, Parts A & B effective dates, as well as same information on spouse. ***Important: Please provide a copy of Medicare card and forward with application. Upon receipt, CVS Caremark SilverScript will automatically enroll you in Medicare Part D to participate in the AACPS over 65 retiree Rx program. If you decline this coverage, no AACPS medical coverage will be available.***

Section 9 Please sign and date where indicated on the front of this application to certify that you have completed the form in full, that all information is true, and that you agree to the conditions of enrollment. **THIS APPLICATION MUST BE FILLED OUT IN ITS ENTIRETY.**

HR/Retirement requires supporting documentation when a retiree adds a dependent (spouse or under age 26) during Open Enrollment (i.e. copy of marriage certificate or birth certificate). Please submit this with your Retiree Healthcare Enrollment Application.

ANNE ARUNDEL COUNTY PUBLIC SCHOOLS

Retiree Healthcare Enrollment Application

See page vii for instructions.

1 RETIREE INFORMATION

Last Name, First Name, MI		
Home Address (no P.O. Box)		
City, State, Zip Code	Email	
Social Security No.	Home Phone (Area Code + No.)	Retirement Date

2 TYPE OF ACTIVITY

☐ New applicant ☐ Open Enrollment ☐ Medicare Eligible

☐ **Lifestyle change in coverage**

(Must Complete Below – see documentation requirements on page vii)

Reason: _____

Date of event: _____ Effective date: _____ *(See #2 on page vii)*

☐ Add dependent *(See #2 on page vii)* ☐ Remove dependent *(See #2 on page vii)*

☐ Name change ☐ Address change

Healthcare Options

3 Medical

☐ BlueChoice HMO "Open Access"* (***under 65***) 1901076

☐ BlueChoice HMO "Open Access"* (***over 65 or Medicare Disabled***) 1901077

☐ CareFirst BlueChoice Triple Option "Open Access"* (***under 65***) 1901080

☐ CareFirst BlueChoice Triple Option "Open Access"* (***over 65 or Medicare Disabled***) 1901081

☐ CareFirst BCBS PPN[1] out-of-area plan (***under 65***) 1901084

☐ CareFirst BCBS Medi-Comp (***over 65 or Medicare Disabled***) 1901088

☐ No Coverage

Level of Coverage:

☐ Individual ☐ Retiree/Spouse ☐ Parent/Child ☐ Family

4 Dental

☐ CareFirst BCBS Traditional 17G2 ☐ UCCI POS* 811032001

☐ CareFirst BCBS PPO 17G2 ☐ No Coverage

Level of Coverage:

☐ Individual ☐ Retiree/Spouse ☐ Parent/Child ☐ Family

5 Vision

☐ CareFirst BCBS Select Vision (12 mos.)

☐ No Coverage

Level of Coverage:

☐ Individual ☐ Retiree/Spouse ☐ Parent/Child ☐ Family

6

	Status		Last Name, First Name, MI	Sex		Age	Handicapped▲		Date of Birth	Social Security No.	Medical	Dental	Options**		
	Add	Remove		F	M		Y	N	MM / DD / YY		Dr.'s First & Last Name*	Dr.'s Name (UCCI)*	M	D	V
Retiree									/ /	- -					
Spouse									/ /	- -					
Child									/ /	- -					
Child									/ /	- -					

* ***Doctor's full name is required for BlueChoice Triple Option "Open Access" (Level 1), BlueChoice HMO "Open Access", and UCCI POS. Please see Section 6 information on back for further guidance.***

** ***Place "x" in the coverage you have selected for each member.***

[1] *CareFirst BCBS PPN (under 65) for out of area members only.*

▲ *Adult Child Only*

7 OTHER INSURANCE INFORMATION

Do you or your spouse have any other health insurance policy other than through AACPS? ☐ Yes ☐ No	If YES, name of person(s) covered:	Date of Birth
Name of Employer		
Insurance Company	Policy Number	Expiration Date

8 MEDICARE INFORMATION *Complete if Applicable*

	If YES, Medicare No.	Part A effective date	Part B effective date	Part D
Are you eligible for Medicare? (age 65+) ☐ Yes ☐ No ***If yes, attach a copy of Medicare card*** Are you Medicare Disabled? (under 65) ☐ Yes ☐ No				See Note Below
Spouse (age 65+) ☐ Yes ☐ No Child *(if Medicare disabled)* ☐ Yes ☐ No Spouse (under 65) ☐ Yes ☐ No ***If yes, attach a copy of Medicare card***				See Note Below

NOTE: CVS Caremark SilverScript will enroll you automatically in Medicare Part D coverage to participate in the AACPS Rx over 65 program. If you decline coverage, no AACPS medical coverage will be available.

9 RETIREE SIGNATURE

I certify the information in this application is true and complete.
I agree to the enrollment conditions outlined on the reverse side of this application.

Signature _____ Date (mm/dd/yy) _____

Please make a copy of this form for your records.

Return original to: Anne Arundel County Public Schools, Human Resources/Retirement Office, 2644 Riva Road, Annapolis, MD 21401 | 410-222-5224 or 1-800-909-4882.

CONDITIONS OF ENROLLMENT

1. Applicant requests the elections for him/herself and eligible dependents.
2. Applicant authorizes AACPS to deduct from retirement earnings the amount required to participate in elected plans. ***Note: Retirement earnings should be sufficient to cover benefit selections***.
3. Applicant agrees to the terms specified in the applicable health benefits certificate or other official description for benefits elected.
4. Applicant has carefully read and agrees to the terms in this application and other enrollment information, including the definitions and eligibility provisions for dependents.
5. Applicant understands that this coverage will remain in effect until the next open enrollment period, unless a family/lifestyle status change occurs dictating a change in coverage.
6. The Group Master Contract will determine the rights and responsibilities of member(s) and will govern in the event it conflicts with any benefits comparison, summary, or other description.
7. AACPS Human Resources/Benefits complies with the Health Insurance Portability Account Act (HIPAA) of 2003. To ensure the privacy of protected healthcare information, members or covered dependents seeking healthcare claim assistance may be required to furnish written authorization directing release of such information to HR/ Retirement Office staff members or from associated AACPS healthcare vendors.

AACPS Retiree Healthcare Benefits forms and information are available on-line at **www.aacps.org/retireehealthcare**.

The following items can be accessed:

- Retiree Healthcare Enrollment Application
- 2023 Retiree Healthcare Enrollment Guide
- CareFirst information, such as Medicare Supplement Benefits Information, BlueChoice HMO, and Triple Option Summaries.
  A link to **www.carefirst.com** is also provided.
- 2023 Dental and Vision Options
- United Concordia (UCCI) Summary of Benefits and a link to **www.ucci.com**
- www.caremark.com
- Summary of Benefits Coverage

Questions regarding retiree healthcare can be directed to:

Human Resources/Retirement office:

410-222-5224 or 1-800-909-4882 | Retirement@aacps.org
(within U.S. Only)

ANNE ARUNDEL
COUNTY PUBLIC SCHOOLS

Division of Human Resources
Office of Retirement