ANNE ARUNDEL COMMUNITY COLLEGE

Open Enrollment and Benefits Reference Guide

Plan Year | Jan. 1, 2017, to Dec. 31, 2017

Open Enrollment | Oct. 17, 2016, to Nov. 11, 2016

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THIS BOOK IS NOT A CONTRACT: This book is a summary of general benefits available to Anne Arundel Community College employees and reflects applicable Federal Health Reform Regulations as of August 2015. Wherever conflicts occur between the contents of this book and the contracts, rules, regulations or laws governing the administration of the various programs, the terms set forth in the various program contracts, rules and regulations, or laws shall prevail. Space does not permit listing all limitations and exclusions that apply to each plan. If you have specific questions about a particular plan. before enrolling in it, call Human Resources or refer to the contact information for phone numbers and websites for each of the plans. Benefits provided can be changed at any time without consent of the participants.

101 COLLEGE PARKWAY ARNOLD, MARYLAND 21012-1895

MEMORANDUM

TO: All Benefit Eligible Employees

FROM: Jennifer M. Petraska, PHR, Benefits Manager

DATE: Oct. 17, 2016

SUBJECT: Benefits Open Enrollment

ACTION REQUIRED -
RETURN YOUR FORM TO
HUMAN RESOURCES, LUDL 106,
BY **FRIDAY, NOV. 11, 2016**

Welcome to your Open Enrollment and Benefits Reference Guide for 2017! This guide contains everything you need to know about your health benefits for the upcoming 2017 calendar year. Review it now for any upcoming changes and then retain it to refer to throughout the 2017 calendar year.

Open Enrollment for medical, dental, vision and life insurance benefits begins **Oct. 17, 2016** and continues through **Nov. 11, 2016**. Open Enrollment is your opportunity to review your current medical, dental, vision and life insurance benefits elections and make decisions for the upcoming calendar year.

During Open Enrollment, employees may:

- Enroll in a medical, dental or vision plan if not currently enrolled.
- Change medical and/or dental plans, or cancel existing coverage.
- Add eligible dependents or remove dependents.

In addition,

- Employees may apply for new or increased coverage in the supplemental life insurance, spouse/domestic partner life insurance and dependent life insurance plans.
- Employees who want to participate in the Flexible Spending Account (FSA) plan for 2017, must sign up for a FSA during the Open Enrollment period.

To enroll or make plan changes, contact Human Resources (ext. **2425** or **humanresources@aacc.edu**) or attend one of the benefits fairs to obtain an Election Form.

Complete and sign the enclosed authorization form if:

- You do not wish to make any changes to your current medical, dental or vision insurance elections.
- You have no coverage and wish to continue no coverage through Dec. 31, 2017.
- You no longer wish to contribute to a Flexible Spending Account and have no other changes to make to your current medical, dental or vision elections.

We are happy to announce that there will be no rate changes to the medical, dental and vision plans for 2017. In addition, medical plan co-payments and deductibles will remain unchanged for calendar year 2017. See page 3, 2017 Highlights, of your guide for important details and a few minor updates for next year.

Plan to attend one of the benefits fairs to meet with vendor representatives. Flu shots will be available on a first-come, first-served basis for employees.

The Open Enrollment deadline is Nov. 11, 2016.
All forms and supporting documentation must be received by the Human Resources office by the deadline.

As a reminder, once Open Enrollment ends, benefit changes are permitted only within 31 days of a qualifying event.

If you have any questions concerning benefit choices or upcoming fairs, contact the Human Resources staff, extension **2425** or **humanresources@aacc.edu**.

Benefits Fairs/Flu Shots

For further information on how options offered by the college can best meet your health requirements and to assist employees in making informed choices, representatives from Human Resources and the college's insurance carriers (CareFirst, Caremark & CIGNA) will be on site:

DATE	TIME	LOCATION	WELLNESS-FLU SHOTS
Tuesday, Oct. 18	**2 p.m. to 4 p.m.**	**GBTC 409**	
Wednesday, Oct. 19	**12 p.m. to 4 p.m.**	**CADE 219**	**Flu Shots will be from noon to 4 p.m. in the same location, CADE 219.**
Friday, Oct. 21	**9 a.m. to 12 p.m.**	**AMIL 405**	
Friday, Oct. 28	**9 a.m. to 1 p.m.**	**CADE 219**	**Flu shots will be from 9 a.m. to 1 p.m. in the same location, CADE 219**

All employees are encouraged to drop in when convenient to discuss personal questions, review updated provider directories and obtain plan details.

2017 Highlights

Rates

- We are pleased to announce there will be NO increases in employee contributions from the 2016 premiums for calendar year 2017. There are NO rate changes to the medical, dental and vision plans for 2017.
- The college will continue to pay the full cost of the CIGNA Dental and VSP vision insurance plans for all full-time employees and for eligible part-time employees hired prior to Feb. 15, 1994.

Health Insurance Plans

- There are no changes to the medical plan design, co-pays or deductibles for 2017.
- There are no plan design changes in the prescription, dental and vision benefits for 2017.

CareFirst Members Only

- All employees enrolled in the EPO plan with CareFirst will receive new cards for 2017. The cards will be in the name of each covered dependent.
- All employees enrolled in the Blue Choice HMO plan will receive new cards for 2017. The language on the back of the card is changing.
- Video visits are a new benefit option for 2017. Beginning Jan. 1 you will be able to do a virtual visit. Please review the information on video visits contained in this guide.

Flexible Spending Accounts (FSA)

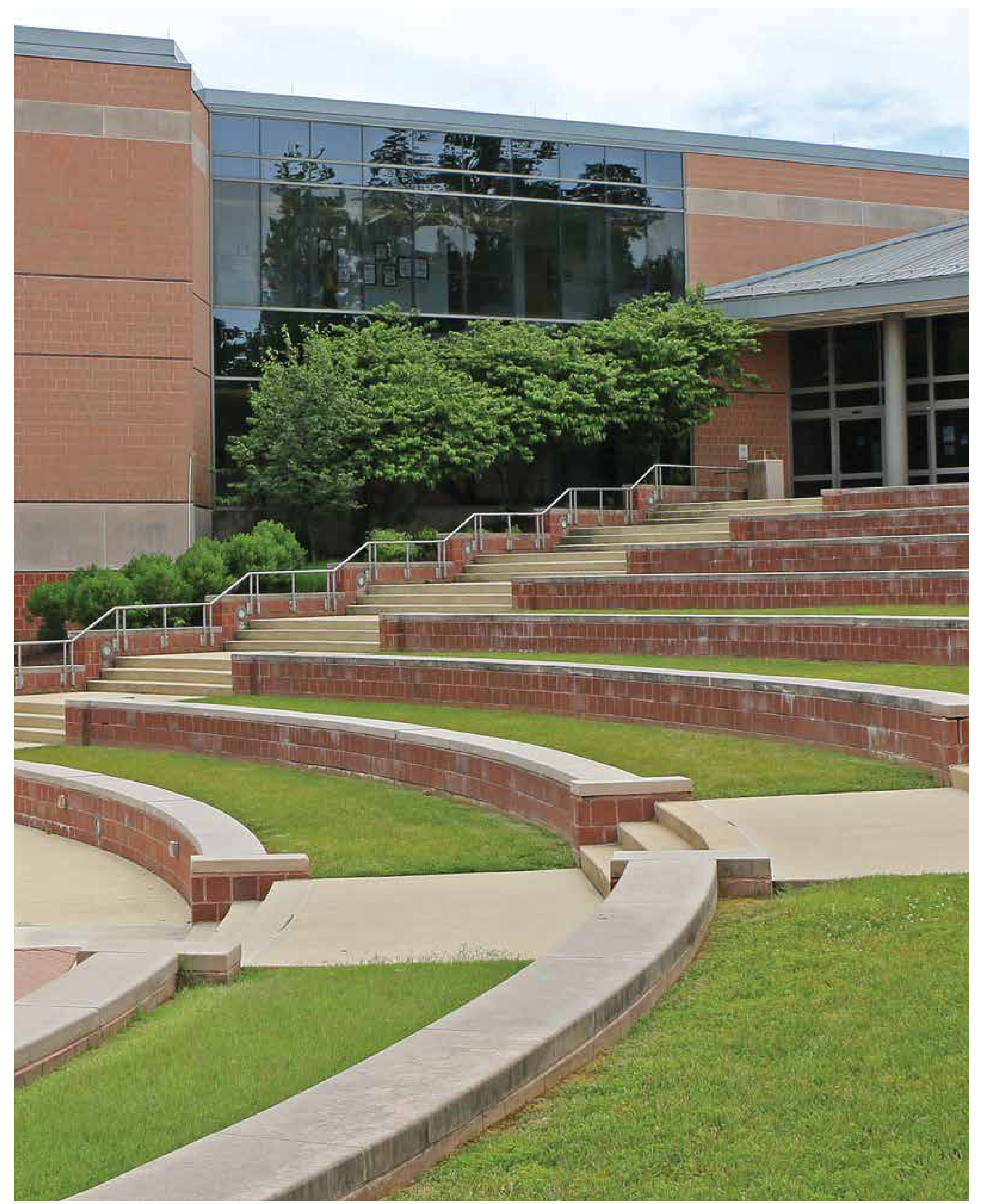
Both the medical and dependent care FSA plans will continue to offer a 2½-month grace period following the end of the plan year. With the 2½-month grace period, FSA participants who have dollars remaining in their FSA plan on Dec. 31, 2017, have until March 15, 2018, to incur eligible expenses for reimbursements.

Caremark Prescription Drug Compound Core Drug Strategy

In a cost-containing effort, the Compound Core Drug Strategy will be implemented effective Jan. 1, 2017. Requests for compound drugs will require a Prior Authorization (PA) on single ingredients over $300. The information will be reviewed through the PA process with CVS/Caremark and they will advise if the cost of the drug should be paid. The PA request must be sent to CVS/Caremark directly listing any ingredient over $300. All PAs must list the diagnosis code, estimated treatment plan and the length of time you will need to take the drug. Requests must be faxed directly to CVS/Caremark at 888-836-0730.

Formulary List

The formulary list is updated quarterly. Visit www.caremark.com/druglist to view the medications to be excluded from CVS/Caremark effective Jan. 1, 2017. Members who elect to continue to receive an excluded medication will be charged full price. For assistance in identifying prescription alternatives, visit www.caremark.com/druglist or call Caremark member services at 866-409-8521.



Did You Know…

Medical Deductibles

All three of the college's medical plans have a deductible. A deductible is the money you pay for health care services before your health insurance plan begins to pay. Traditionally this is for services above and beyond routine care. A good rule of thumb is if you pay an office visit copay, generally there will be no deductible – though there might be, if the services you receive are beyond a routine preventive examination.

Examples of expenses subject to a deductible (this list is not all-inclusive; refer to plan documents or call your health insurance provider for specific questions) include:

- Inpatient facility and professional services.
- Outpatient facility and professional services.
- Home health care.
- Hospice.
- Skilled nursing care.
- Durable medical equipment.
- External prosthetic devices.
- Lab and X-ray – inpatient and outpatient facilities.
- Maternity – delivery and facility charges.
- Men's family planning – inpatient and outpatient facilities/professional charges.
- Infertility – inpatient and outpatient facilities/ professional charges.
- Mental health and substance abuse – inpatient and outpatient facilities/ professional charges.

Getting Married or Expecting a Newborn?

Outside of the annual open enrollment period, all benefits changes must be made within 31 days of the qualifying event. For example, in the case of a newborn or new spouse, you must contact Human Resources within 31 days of the birth or marriage. Refer to the Making Midyear Changes section of this booklet for details.

CIGNA DHMO Dental

The Cigna DHMO dental plan has a national network of participating dentists. With the DHMO plan, you choose a network general dentist to manage your dental care needs. If you need specialty care, your network general dentist will provide you with a referral. (Remember, out-of-network benefits are not available with the DHMO plan). You also can check our directory at www.Cigna.com or call 800-Cigna24 for a complete listing of DHMO dental offices in your area.
Check to make sure your dentist is accepting new DHMO patients.

Away From Home Care

The Away From Home Care program allows BlueChoice Open Access HMO members and their dependents to receive care when they are away from home for at least 90 days. The care can be provided by an affiliate Blue Cross and Blue Shield HMO outside of the CareFirst BlueChoice service area. Your copay and benefits will be those of the affiliated HMO in the area you are vising. You will be treated as though you are actually a member of the affiliated plan. If there are no participating affiliated HMOs in the area, the program will not be available to you. For information, call the CareFirst BlueChoice member services number on your BlueChoice ID care and ask to be transferred to the Away From Home Care coordinator.

Your Benefit Options At-a-Glance

This chart can help you make your enrollment decisions quickly –
just glance at the brief descriptions here, then turn to the pages indicated for more information.

TYPE OF BENEFIT		YOUR BENEFIT OPTIONS FOR 2017	PAGE
Medical Care (includes Caremark Prescription Drug coverage)	CareFirst BlueChoice Triple Option Open Access	Offers three levels of coverage depending on the provider you visit, along with the freedom to see any provider you wish. Annual deductible and copayment/coinsurance vary by coverage level. Choose in-network providers for lower out-of-pocket cost.	14
	CareFirst EPO	All care must be provided by in-network providers. The EPO network includes providers nationwide. Referrals are not necessary for visits with network specialists.	26
	CareFirst BlueChoice HMO Open Access	Members select a BlueChoice HMO network Primary Care Physician (PCP) selection based in Maryland, D.C. or Northern Virginia. Care received outside the network is not covered. Referrals are not necessary for visits with network specialists.	36
Dental Care	CIGNA Dental HMO (DHMO)	Plan payments are based on a schedule of copays for dental service. All care must be coordinated by a CIGNA DHMO Network Dentist. No benefits are paid for out-of-network care. CIGNA DHMO is a national network – contact CIGNA for a list of participating DHMO dentists.	48
	CIGNA Dental PPO (Indemnity)	Plan pays a percentage of most dental services and supplies. $1,000 annual benefit maximum plus separate $1,000 orthodontia benefit. Participants may use CIGNA PPO network or non-network dentists. Use network dentists for the lowest out-of-pocket costs.	50
Vision Care	VSP Vision	Plan pays set amount toward annual eye exams, eyeglasses or contact lenses. Use VSP providers for the lowest out-of-pocket cost.	52
Flexible Spending Accounts	Health Care FSA	Set aside up to $2,550 to pay for eligible health care expenses with tax-free dollars. New enrollment required annually for FSA.	54
	Dependent Care FSA	Set aside up to $5,000 ($2,500 if married, filing separately) to pay for eligible dependent day care and elder care expenses with tax-free dollars. The age limit for dependent children is 13. New enrollment required annually for FSA.	54
Life Insurance	Basic Life Insurance	Optional benefit pays your beneficiary two times your annual salary to a maximum of $350,000. College pays 75% / Employee pays 25%.	58
	Supplemental Life Insurance	Optional benefit where employees can elect additional life insurance coverage in $10,000 increments up to $500,000 or five times your Basic Annual Earnings, whichever is less. Enroll for up to $100,000 of coverage with no health information required.	59
	Spouse/Domestic Partner Life Insurance	Optional benefit where employees may elect coverage in $5,000 increments, up to a maximum benefit of the lesser of 100% of your total Basic and Supplemental life coverage amount or $50,000. Employee must participate in Supplemental Life in order to participate in this coverage. Enroll for $10,000 of coverage with no health information required.	59
	Dependent Life Insurance	Optional benefit where employee may elect $10,000 in coverage for each of their dependent children. Employee must participate in Supplemental Life in order to participate in this coverage. No health information required.	59
	AD&D Insurance	College-paid benefit is collectable by the beneficiary if the cause of death is due to an accident. Some exclusions apply. Fractional payments are made if the covered employee loses a bodily appendage or sight due to an accident.	59

Mobile Technology Resources

Own a smart phone or tablet computer?

If so, take advantage of these *free* mobile technology resources.

CVS Caremark

Mobile app for Android and iPhone that allows members to:

- Refill a prescription.
- Check order status.
- View prescription history.
- Check drug cost.
- Find a pharmacy.
- Contact CVS Caremark.
- View member ID card.

CareFirst Blue Choice

Mobile app for Android and iPhone that allows members to gain access to the following features:

- Online ID cards.
- Displays both sides of ID card.
- Online ID cards always are available, even when offline (App users only).
- Capability to email ID card image to provider (App users only).
- Find A Provider.
- Urgent Care.
- "One click" search for nearby urgent care and ER facilities, based on the member's current location (as determined by the device's GPS).
- Claims.
- Who's Covered (Basic Eligibility).
- What's Covered (Detailed Benefits) Facets Only.
- FirstHelp® nurse hotline.

CIGNA

The myCigna mobile app allows members to:

- Personalize, organize and store health information such as your dentist name, address and phone number.
- View member ID card.
- Review current and past claims.
- Bookmark and group claims for quick reference.
- Search Cigna's national network of dental professionals.
- Obtain cost estimates and quality of care ratings.

Anne Arundel Community College
Group Medical Insurance Premiums

CY 2017 Jan. 1, 2017-Dec. 31, 2017		Employee Per Pay Period Amount			
		Full Time Employee		Part Time Employee*	
	100% Monthly	12 Month	10 Month	12 Month	10 Month
CAREFIRST BLUE CHOICE TRIPLE OPTION OPEN ACCESS *(College Pays 75%, Employee Pays 25%)*					
Individual	734.62	91.83	110.19	183.66	220.39
Parent/Child	1297.58	162.20	194.64	324.40	389.27
Employee/Spouse	1556.29	194.54	233.44	389.07	466.89
Family	2021.03	252.63	303.16	505.26	606.31
CAREFIRST BLUE CHOICE HMO OPEN ACCESS *(College Pays 85%, Employee Pays 15%)*					
Individual	560.82	42.06	50.47	140.21	168.25
Parent/Child	1005.59	75.42	90.50	251.40	301.68
Employee/Spouse	1197.26	89.80	107.75	299.32	359.18
Family	1548.36	116.13	139.35	387.09	464.51
CAREFIRST EPO *(College Pays 85%, Employee Pays 15%)*					
Individual	613.84	46.04	55.25	153.46	184.15
Parent/Child	1107.85	83.09	99.71	276.96	332.36
Employee/Spouse	1314.83	98.61	118.34	328.71	394.45
Family	1697.41	127.31	152.77	424.35	509.22

*These rates apply to part-time employees hired after Feb. 15, 1994.
Rates for vested part-time employees equal two times the full time rate.

Anne Arundel Community College
Group Dental and Vision Insurance Premiums

CY 2017 Jan. 1, 2017-Dec. 31, 2017		EMPLOYEE PER PAY PERIOD AMOUNT			
		Full Time Employee		Part Time Employee*	
	Total Monthly Premium	12 Month	10 Month	12 Month	10 Month
CIGNA DENTAL CARE PLAN (DHMO) *College Pays 100%*					
Individual	18.80	0.00	0.00	4.70	5.64
Parent/Child	37.58	0.00	0.00	9.40	11.27
Employee/Spouse	47.75	0.00	0.00	11.94	14.33
Family	54.29	0.00	0.00	13.57	16.29
CIGNA PREFERRED PROVIDER ORGANIZATION DENTAL PLAN (INDEMNITY) *College Pays 100%*					
Individual	35.16	0.00	0.00	8.79	10.55
Parent/Child	62.37	0.00	0.00	15.59	18.71
Employee/Spouse	80.89	0.00	0.00	20.22	24.27
Family	89.90	0.00	0.00	22.48	26.97
CIGNA GROUP VISION PLAN (VSP) *College Pays 100%*					
Individual	2.44	0.00	0.00	0.61	0.73
Parent/Child	4.87	0.00	0.00	1.22	1.46
Employee/Spouse	6.22	0.00	0.00	1.56	1.87
Family	7.07	0.00	0.00	1.77	2.12
EMPLOYEES WHO DO NOT ELECT COVERAGE RECEIVE A STIPEND PER YEAR IN THE AMOUNT OF:					
*These rates apply to part-time employees hired after Feb. 15, 1994. Rates for vested part-time employees equal two times the full time rate.		Full Time Employees:		Part Time Employees:	
		Medical:	450.00	Medical:	225.00
		Dental:	96.00	Dental:	48.00
		Total:	546.00	Total:	273.00

Health Benefit Options

Summary of Benefits–Anne Arundel County

Benefits	BlueChoice Triple Option *Open Access* A product of CareFirst BlueCross BlueShield			BlueChoice HMO *Open Access* Member is required to select participating BlueChoice PCP. A product of CareFirst BlueCross BlueShield	CareFirst EPO In-network using the PPO national network
	LEVEL 1 Rendered by BlueChoice PCP* or Specialist	LEVEL 2 Preferred Providers (PPO Blue Card)	LEVEL 3 All other Providers		
COST SHARING LIFETIME LIMITS					
Calendar Year Deductible	$125 Individual/$250 Family	$250 Individual/$500 Family	$500 Individual/$1,000 Family	$100 Individual/$200 Family	$100 Individual/$200 Family
Coinsurance	95%/5%	85%/15%	70%/30%	100%	100%
Calendar Year Out-of-Pocket Max (OOPM)	$500/$1,000	$1,000/$2,000	$1,500/$3,000	$800/$1,600	$1,100 Individual/$3,600 Family per calendar year
Lifetime Maximum	Unlimited, except on fertility	Unlimited, except on fertility	Unlimited, except on fertility	Unlimited, except on fertility	Unlimited, except on fertility
Dependent Age Limit	To age 26	To age 26	To age 26	To age 26	To age 26
PROFESSIONAL SERVICES					
Primary Care Office Visit	In Full after $15 Copay	In Full after $25 Copay	70% AB after deductible	$15 Copay/visit	$15 copay/visit
Gynecology Office Visit	In Full after $35 Copay	In Full after $50 Copay	70% AB after deductible	$15 Copay/visit	$15 copay/visit
Specialist Office Visit	In Full after $35 Copay	In Full after $50 Copay	70% AB after deductible	$15 Copay/visit	$15 copay/visit
Physical/Speech/Occupational Therapy Office Visits	In Full after $35 Copay (100 days combined per calendar year)	In Full after $50 Copay (100 days combined per calendar year)	70% AB after deductible (100 days combined per calendar year)	$15 Copay/visit (50 day max/year/therapy)	$15 copay/visit (50 day max/year/therapy)
Diagnostic Test in Doctor Office/Independent Lab	Tests covered at 100% AB (Lab Corp)	Tests covered at 100% AB	Tests covered at 100% AB	100% AB (Lab Corp only)	100% AB after deductible
Annual Adult Physical/Well Woman Exam	No charge	No charge	70% AB after deductible	No charge	No charge
Well Child Visit/Immunization	No charge	No charge	70% AB after deductible	No charge	No charge
INPATIENT HOSPITAL CARE					
Room and Board	95% AB after deductible to OOPM	85% AB after deductible to OOPM	70% AB after deductible to OOPM	Deductible, then no charge	Deductible, then no charge
Physician/Surgical Services	95% AB after deductible to OOPM	85% AB after deductible to OOPM	70% AB after deductible to OOPM	Deductible, then no charge	Deductible, then no charge
OUTPATIENT HOSPITAL SERVICES					
Surgical/Anesthesia Services	95% AB after deductible to OOPM	85% AB after deductible to OOPM	70% AB after deductible to OOPM	$15 facility practitioner copay/$25 facility copay	$15 facility practitioner copay/$25 facility copay
MATERNITY					
Prenatal Care (Routine)	No charge	No charge	70% AB after deductible to OOPM	100% AB	Covered at 100% AB
Delivery	95% AB after deductible to OOPM	95% AB after deductible to OOPM	70% AB after deductible to OOPM	Deductible, then no charge	Deductible, then no charge
MEDICAL EMERGENCIES					
Accidental Injury (Emergency Room)	Covered at 100% AB after $75 Copay (waived if admitted)	Covered at 100% AB after $75 Copay (waived if admitted)	Covered at 100% AB after $75 Copay (waived if admitted)	100% AB after $75 copay (waived if admitted)	Covered at 100% AB after $75 Copay for Emergency Room (waived if admitted)
Sudden and Serious Illness (Urgent Care Center)	Covered at 100% AB after $35 Copay	Covered at 100% AB after $35 Copay	Covered at 100% AB after $35 Copay	100% AB after $35 copay	Covered at 100% AB after $35 Copay
Ambulance (if medically necessary: Ground and Air)	100% AB	Considered under Level 1. If benefits are not available under Level 1, benefits will be payable under the appropriate Level.	Considered under Level 1. If benefits are not available under Level 1, benefits will be payable under the appropriate Level.	100% AB	100% AB
Durable Medical Equipment	95% AB after deductible to OOPM	95% AB after deductible to OOPM	95% AB after deductible to OOPM	Deductible, then no charge	Deductible, then no charge
MENTAL HEALTH/SUBSTANCE ABUSE					
Inpatient (requires authorization from Magellan**)	Magellan's Network 95% AB after deductible to OOPM**	85% AB after deductible to OOPM**	70% AB after deductible to OOPM**	Deductible, then no charge**	Covered at 100% AB after deductible to OOPM**
Outpatient Office Visits	Subject to Federal Mandate** $15 copay/visit	Subject to Federal Mandate** $15 copay/visit	Subject to Federal Mandate** 70% AB after deductible to OOPM	Subject to Federal Mandate** $15 copay/visit	Subject to Federal Mandate** $15 copay/visit
Hearing Aids	Covered – up to 100% AB per hearing aid once every 36 months, adults and children	Covered – up to 100% AB per hearing aid once every 36 months, adults and children	Covered – up to 100% AB per hearing aid once every 36 months, adults and children	100% AB per hearing aid once every 36 months (minor children only)	100% AB per hearing aid once every 36 months (minor children only)
OUTPATIENT PRESCRIPTION DRUG BENEFIT (See your prescription Benefits At-A-Glance on the back of this brochure.)					

The above serves as a comparison only. Please consult each plan benefit guide for full details, particularly in regard to exclusions, limitations, and additional coverage. Benefits subject to the contracts between CareFirst BlueCross BlueShield and the Anne Arundel County entities.

**Care must be authorized or provided by a participating BlueChoice Primary Care Provider.*

***Benefits will be managed through Magellan Behavioral Health—Level III.
All inpatient psychiatric/alcoholism treatment requires preauthorization by Magellan Behavioral Health: (800) 245-7013.***

AB= Allowed Benefit OOPM= Out of pocket Maximum

How to Locate a Provider

CareFirst BlueChoice or BlueCard PPO Provider

1. Go to **www.carefirst.com**.

2. Click on *Find a Doctor*.

3. Select the radio button for *Name* and enter the provider name – Last, First.
Enter ZIP code and Distance and click *Search.*

4. Check the list of networks in which the provider participates.

A. Level 1 Providers = *BlueChoice Network.*
B. Level 2 Providers = *CareFirst Regional Provider Directory.*
C. Level 3 Providers = *Traditional/Indemnity Network.*

5. If you are outside of the CareFirst Service area, follow next steps to see if they are a BlueCard PPO provider.

A. Click on BlueCross BlueShield National Doctor and Hospital Finder.
B. Select BlueCard PPO/EPO under Choose Your Network.
C. Enter the Provider name and click Go.
D. If the provider is a match, then he or she is a BlueCard PPO Provider (Level 2).

CareFirst EPO Provider

1. Go to www.carefirst.com.

2. Go to Find a Doctor and click on Search Now.

3. Continue as a guest or member by logging into My Account.

4. Under "What type of care are you looking for?" select Medical or Mental Health

5. Key in a ZIP code or city and state.

A. The option is there also to increase the radius and select continue.

6. Select Blue Preferred (PPO) and then Blue Preferred again

7. From the next page you can search by the doctor's last name, specialty or facility, or choose the type of provider/facility you are looking for.

CareFirst Video Visit

See a doctor 24/7

When your primary care provider (PCP) isn't available, CareFirst Video Visit allows you to securely connect with a doctor* whenever and wherever you want on a smartphone, tablet or computer. Video Visits cost the same as your PCP sick office visit copay (up to a maximum of $60).

Get treatment for common health issues

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
- Respiratory infection

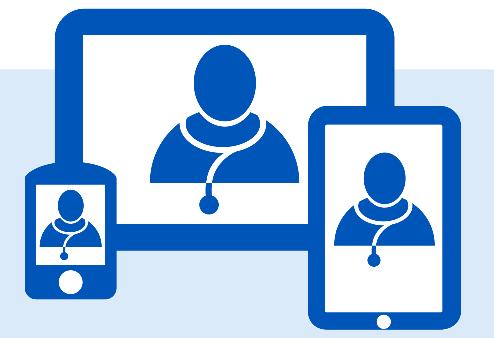
Video Visit doctors provide consultation, diagnosis and even prescriptions (when available and appropriate). They are all U.S. board-certified, licensed, credentialed and have profiles so you can see their education and practice experience.

When to use Video Visit

- Your doctor's office is closed
- You are on business travel or vacation
- You have children at home and can't bring them to the doctor's office
- You feel too sick to drive

Register today so you'll be ready when you want to visit. There are two easy ways:

1. Visit **www.carefirst.com/needcare** and click on any of the *Video Visit* links, or
2. Download the CareFirst Video Visit app from your favorite app store



CareFirst Video Visit. The doctor will see you now!

**The doctors accessed via this website are independent providers making their own medical determinations and are not employed by CareFirst. CareFirst does not direct the action of participating providers or provide medical advice.*

***In the case of a life-threatening emergency, you should always call 911 or your local emergency services. CareFirst Video Visit does not replace these services.*

SUM3420-1N (3/16)

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst MedPlus is the business name of First Care, Inc. CareFirst BlueCross BlueShield, First Care, Inc., and CareFirst BlueChoice, Inc., are independent licensees of the Blue Cross and Blue Shield Association. ® Registered trademark of the Blue Cross and Blue Shield Association. ®' Registered trademark of CareFirst of Maryland, Inc.

Anne Arundel County Government Triple Option Open Access Coverage Period: 01/01/2017 – 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Cost **Coverage for:** Individual | **Plan Type: POS**

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-800-628-8549.

Important Questions	Answers			Why this Matters:
	Option 1	Option 2	Option 3	
What is the overall deductible?	$125 Individual $250 Family	$250 Individual $500 Family	$500 Individual $1,000 Family	Option 1: You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 5 for how much you pay for covered services after you meet the **deductible**. Option 2: You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 5 for how much you pay for covered services after you meet the **deductible**. Option 3: You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 5 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No	No	No	Option 1: You don't have to meet deductibles for specific services, but see the chart starting on page 5 for other costs for services this plan covers. Option 2: You don't have to meet deductibles for specific services, but see the chart starting on page 5 for other costs for services this plan covers. Option 3: You don't have to meet deductibles for specific services, but see the chart starting on page 5 for other costs for services this plan covers.

Questions: If you are a member please call the number on your ID card or by logging into My Account. Otherwise, please call 1-800-628-8549. If you aren't clear about any of the underlined terms used in this form, see the Glossary at www.carefirst.com/sbcg.
CareFirst SBC ID: SBC20160816AnneArundelCountyGovernmentPOSN012017

Important Questions	Option 1	Option 2	Option 3	Why this Matters:
Is there an out–of–pocket limit on my expenses?	$500 Individual $1,000 Family	$1,000 Individual $2,000 Family	$1,500 Individual $3,000 Family	Option 1: The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. Option 2: The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. Option 3: The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges (unless balanced billing is prohibited), and health care this plan doesn't cover	Premiums, balance-billed charges (unless balanced billing is prohibited), and health care this plan doesn't cover	Premiums, balance-billed charges (unless balanced billing is prohibited), and health care this plan doesn't cover	Option 1 :Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. Option 2: Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. Option 3: Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No	No	No	Option 1 :The chart starting on page 5 describes any limits on what the plan will pay for *specific* covered services, such as office visits. Option 2: The chart starting on page 5 describes any limits on what the plan will pay for *specific* covered services, such as office visits. Option 3: The chart starting on page 5 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. Please visit www.carefirst.com or call 1-800-628-8549 for a listing of In-network providers.	Yes. Please visit www.carefirst.com or call 1-800-628-8549 for a listing of Preferred providers.	No	Option 1: If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 5 for how this plan pays different kinds of **providers**. Option 2: If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 5 for how this plan pays different kinds of **providers**. Option 3 : If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 5 for how this plan pays different kinds of **providers**.

Do I need a referral to see a specialist?	No but you must use a provider within the Blue Choice network	No but you must use a provider within the Blue Preferred network	No	Option 1: You can see the specialist you choose without permission from this plan. Option 2: You can see the specialist you choose without permission from this plan. Option 3: You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Yes	Yes	Option 1: Some of the services this plan doesn't cover are listed on page 10. See your policy or plan document for additional information about excluded services. Option 2: Some of the services this plan doesn't cover are listed on page 10. See your policy or plan document for additional information about excluded services. Option 3: Some of the services this plan doesn't cover are listed on page 10. See your policy or plan document for additional information about excluded services.

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- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Option 1	Option 2	Option 3	
		Participating Provider	Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay	$25 copay	30% coinsurance subject to deductible	For treatment at an Outpatient Hospital Facility, an additional charge may apply
	Specialist visit	$35 copay	$50 copay	30% coinsurance subject to deductible	For treatment at an Outpatient Hospital Facility, an additional charge may apply
	Other practitioner office visit	$35 copay for Chiropractor and Acupuncture Services	$50 copay for Chiropractor and Acupuncture Services	30% coinsurance subject to deductible for Chiropractor and Acupuncture Services	For treatment at an Outpatient Hospital Facility, an additional charge may apply
	Retail Health Clinic	$15 copay	$25 copay	30% coinsurance subject to deductible	For treatment at an Outpatient Hospital Facility, an additional charge may apply
	Preventive care/screening/immunization	No member liability	No member liability	30% coinsurance subject to deductible	Some services may have limitations or exclusions based on your contract
If you have a test	Diagnostic test (x-ray, blood work)	Facility: 5% coinsurance subject to deductible Office: No member liability	Facility: Deductible; 5% coinsurance Office: No member liability	Facility: 5% coinsurance subject to deductible Office: No copay, coinsurance or deductible	Option 1 In-Network Lab Test benefits apply only to tests performed at LabCorp. For services provided at an Outpatient Hospital Facility, a higher charge may apply
	Imaging (CT/PET scans, MRIs)	5% coinsurance subject to deductible	Facility: Deductible; 5% coinsurance Office: No member liability	Facility: 5% coinsurance subject to deductible Office: No copay, coinsurance or deductible	For services provided at an Outpatient Hospital Facility, a higher charge may apply

Common Medical Event	Services You May Need	Your cost if you use a Option 1 Participating Provider	Option 2 Participating Provider	Option 3 Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition	Generic drugs	Not covered	Not covered	Not covered	Prescription plan administered by Caremark
	Preferred brand drugs	Not covered	Not covered	Not covered	Prescription plan administered by Caremark
More information about **prescription drug coverage** is available at www.caremark.com	Non-preferred brand drugs	Not covered	Not covered	Not covered	Prescription plan administered by Caremark
	Specialty drugs	Not covered	Not covered	Not covered	Specialty drugs are only provided by Caremark Speciality Drug Services 1-800-237-2767
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Non-Hospital: 5% coinsurance subject to deductible Hospital: 5% coinsurance subject to deductible	Non-Hospital: 15% coinsurance subject to deductible Hospital: 15% coinsurance subject to deductible	Non-Hospital: 30% coinsurance subject to deductible Hospital: 30% coinsurance subject to deductible	——none——
	Physician/surgeon fees	Non-Hospital: $15 copay/PCP $35 copay/Specialist Hospital: $15 copay/PCP $35 copay/Specialist	Non-Hospital: $50 copay Hospital: $50 copay	Non-Hospital: 30% coinsurance subject to deductible Hospital: 30% coinsurance subject to deductible	——none——
If you need immediate medical attention	Emergency room services	$75 copay	$75 copay	$75 copay	Copay waived if admitted Limited to Emergency Services or unexpected, urgently required services; Additional professional charges may apply
	Emergency medical transportation	No member liability	No member liability	No copay, coinsurance or deductible	Prior authorization is required for air ambulance services, except for Medically Necessary air ambulance services in an emergency
	Urgent care	$35 copay	$35 copay	$35 copay	Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	5% coinsurance subject to deductible	15% coinsurance subject to deductible	30% coinsurance subject to deductible	Prior authorization is required
	Physician/surgeon fee	5% coinsurance subject to deductible	15% coinsurance subject to deductible	30% coinsurance subject to deductible	——none——

Common Medical Event	Services You May Need	Your cost if you use a Option 1 Participating Provider	Option 2 Participating Provider	Option 3 Non-Participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Office Visits: $15 copay	Office Visits: $15 copay	Office Visits: 30% coinsurance subject to deductible	For treatment at an Outpatient Hospital Facility, an additional professional charge may apply
	Mental/Behavioral health inpatient services	5% coinsurance subject to deductible	15% coinsurance subject to deductible	30% coinsurance subject to deductible	Prior authorization is required; Additional professional charges may apply Requires authorization from Magellan 1-800-245-7013
	Substance use disorder outpatient services	Office Visits: $15 copay	Office Visits: $15 copay	Office Visits: 30% coinsurance subject to deductible	For treatment at an Outpatient Hospital Facility, an additional professional charge may apply
	Substance use disorder inpatient services	5% coinsurance subject to deductible	15% coinsurance subject to deductible	30% coinsurance subject to deductible	Prior authorization is required; Additional professional charges may apply Requires authorization from Magellan 1-800-245-7013
If you are pregnant	Prenatal and postnatal care	No member liability	No member liability	30% coinsurance subject to deductible	For routine pre/postnatal office visits only. For non-routine obstetrical care or complications of pregnancy, cost sharing may apply.
	Delivery and all inpatient services	5% coinsurance subject to deductible	5% coinsurance subject to deductible	30% coinsurance subject to deductible	Additional professional charges may apply

Common Medical Event	Services You May Need	Your cost if you use a Option 1 Participating Provider	Option 2 Participating Provider	Option 3 Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	5% coinsurance subject to deductible	Deductible; 5% coinsurance	5% coinsurance subject to deductible	Option 2 and 3: 90 days of unlimited visits per Benefit Period
	Rehabilitation services	Facility: 5% coinsurance subject to deductible Office: $35 copay	Facility: 5% coinsurance subject to deductible Office: $50 copay	30% coinsurance subject to deductible	For treatment at an Outpatient Hospital Facility, an additional charge may apply Rehabilitation Services includes Physical, Speech and Occupational Therapies Option 1: Limited to 100 combined visits per benefit period Option 2 and 3: Limited to 100 combined visits per benefit period
	Habilitation services	Facility: 5% coinsurance subject to deductible Office: $35 copay	Facility: 5% coinsurance subject to deductible Office: $50 copay	30% coinsurance subject to deductible	Prior authorization is required after the first visit Limited to members under age 19
	Skilled nursing care	5% coinsurance subject to deductible	15% coinsurance subject to deductible	30% coinsurance subject to deductible	Option 2 and 3: Limited to 120 days per Benefit Period
	Durable medical equipment	5% coinsurance subject to deductible	Deductible; 5% coinsurance	Deductible; 5% coinsurance	———none———
	Hospice service	Inpatient care: 5% coinsurance subject to deductible Outpatient care: 5% coinsurance subject to deductible	Inpatient care: Deductible; 5% coinsurance Outpatient care: Deductible; 5% coinsurance	Inpatient care: Deductible; 5% coinsurance Outpatient care: Deductible; 5% coinsurance	———none———
If your child needs dental or eye care	Eye exam	Not covered	Not covered	Not covered	Routine vision services are not provided by Blue Choice Triple Option Open Access. Vision services are available with separate enrollment in the VSP Vision plan.
	Glasses	Not covered	Not covered	Not covered	Routine vision services are not provided by Blue Choice Triple Option Open Access. Vision services are available with separate enrollment in the VSP Vision plan.
	Dental check-up	Not covered	Not covered	Not covered	Routine Dental services are not provided by Blue Choice HMO. Dental services are available with separate enrollment in the Cigna PPO Dental Plan or the Cigna DHMO Dental Plan.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care
- Long-term care
- Routine eye care
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (Children & Adults)
- Infertility treatment
- Most coverage provided outside the United States. See www.carefirst.com
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

Your Rights to Continue Coverage:

**** Individual health insurance–**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-800-628-8549.You may also contact your state insurance department at

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

OR

**** Group health coverage–**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-628-8549. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: www.carefirst.com or 1-800-628-8549. You may also contact state consumer Assistance Program

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

For group health coverage subject to ERISA you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-258-6518

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-258-6518

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-258-6518

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-258-6518

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,910
- **Patient pays** $630

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$250
Co-pays	$10
Co-insurance	$220
Limits or exclusions	$150
Total	**$630**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,660
- **Patient pays** $740

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$250
Copays	$350
Coinsurance	$60
Limits or exclusions	$80
Total	**$740**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Anne Arundel County Government EPO

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2017 – 12/31/2017
Coverage for: Individual | **Plan Type: EPO**

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-800-628-8549.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$100 Individual $200 Family Co-pays do not apply to the deductible	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	$1,100 Individual $3,600 Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges (unless balanced billing is prohibited), and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. Please visit www.carefirst.com or call 1-800-628-8549 for a listing of Preferred providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No but you must use a provider within the PPO network	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about **excluded services**.

Questions: If you are a member please call the number on your ID card or by logging into My Account. Otherwise, please call 1-800-628-8549. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**.
CareFirst SBC ID: SBC20160816AnneArundelCountyGovernmentEPON012017

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
RIf you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay	Not covered	For treatment at an Outpatient Hospital Facility, an additional charge may apply
	Specialist visit	$15 copay	Not covered	For treatment at an Outpatient Hospital Facility, an additional charge may apply
	Other practitioner office visit	$15 copay for Chiropractic and Acupuncture Services	Not covered	For treatment at an Outpatient Hospital Facility, an additional charge may apply Acupuncture Services are limited to12 days per benefit period
	Retail Health Clinic	$15 copay	Not covered	
	Preventive care/screening/immunization	No member liability	Not covered	Some services may have limitations or exclusions based on your contract
If you have a test	Diagnostic test (x-ray, blood work)	Lab Tests (Non-Hospital): Deductible;0% coinsurance Hospital: Deductible; 0% coinsurance	Lab Tests (Non-Hospital): Not covered	——————none——————
	Imaging (CT/PET scans, MRIs)	Non-Hospital: Deductible;0% coinsurance	Non-Hospital: Not covered	For services provided at an Outpatient Hospital Facility, a higher charge may apply
If you need drugs to treat your illness or condition	Generic drugs	Not covered	Not covered	Prescription plan administered by Caremark
	Preferred brand drugs	Not covered	Not covered	Prescription plan administered by Caremark
	Non-preferred brand drugs	Not covered	Not covered	Prescription plan administered by Caremark

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
More information about **prescription drug coverage** is available at www.caremark.com	Specialty drugs	Not covered	Not covered	Specialty drugs are only provided by Caremark Specialty Drug Services 1-800-237-2767
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$25 copay	Not covered	——none——
	Physician/surgeon fees	$15 copay	Not covered	——none——
If you need immediate medical attention	Emergency room services	$75 copay	$75 copay	Copay waived if admitted Limited to Emergency Services or unexpected, urgently required services; Additional professional charges may apply
	Emergency medical transportation	No member liability	Not covered	Prior authorization is required for air ambulance services, except for Medically Necessary air ambulance services in an emergency
	Urgent care	$35 copay	$35 copay	Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible;0% coinsurance	Not covered	Prior authorization is required
	Physician/surgeon fee	Deductible;0% coinsurance	Not covered	——none——

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Office Visits: $15 copay	Office Visits: Not covered	For treatment at an Outpatient Hospital Facility, an additional professional charge may apply
	Mental/Behavioral health inpatient services	Deductible;0% coinsurance	Not covered	Prior authorization is required; Additional professional charges may apply Requires pre-authorization from Magellan 1-800-245-7013
	Substance use disorder outpatient services	Office Visits: $15 copay	Office Visits: Not covered	For treatment at an Outpatient Hospital Facility, an additional professional charge may apply
	Substance use disorder inpatient services	Deductible;0% coinsurance	Not covered	Prior authorization is required; Additional professional charges may apply Requires pre-authorization from Magellan 1-800-245-7013
If you are pregnant	Prenatal and postnatal care	No member liability	Not covered	For routine pre/postnatal office visits only. For non-routine obstetrical care or complications of pregnancy, cost sharing may apply.
	Delivery and all inpatient services	Deductible;0% coinsurance	Not covered	Additional professional charges may apply

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	Deductible; 0% coinsurance	Not covered	——none——
	Rehabilitation services	Facility: $25 copay Office: $15 copay	Not covered	For treatment at an Outpatient Hospital Facility, an additional charge may apply Rehabilitation Services includes Physical, Speech and Occupational Therapies Limited to 50 visits per condition per Benefit Period
	Habilitation services	Facility: $25 copay Office: $15 copay	Not covered	For treatment at an Outpatient Hospital Facility, an additional charge may apply Prior authorization required after the first visit Limited to Members under age 19
	Skilled nursing care	Deductible; 0% coinsurance	Not covered	Limited to 120 days per benefit period
	Durable medical equipment	Deductible; 0% coinsurance	Not covered	——none——
	Hospice service	Inpatient care: Deductible; 0% coinsurance Outpatient care: Deductible; 0% coinsurance	Not covered	——none——
If your child needs dental or eye care	Eye exam	Not covered	Not covered	Routine vision services are not provided by Blue Choice HMO. Vision services are available with separate enrollment in the VSP Vision Plan.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
	Glasses	Not covered	Not covered	Routine vision services are not provided by Blue Choice HMO. Vision services are available with separate enrollment in the VSP Vision Plan.
	Dental check-up	Not covered	Not covered	Routine Dental services are not provided by Blue Choice HMO. Dental services are available with separate enrollment in the Cigna PPO Dental Plan or the Cigna DHMO Dental Plan.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care
- Hearing aids (except children 18 & under)
- Long-term care
- Routine eye care
- Routine foot care
- Weight loss programs

Other Covered Services

(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Private-duty nursing
- Most coverage provided outside the United States. See www.carefirst.com
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage:

**** Individual health insurance–**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-800-628-8549. You may also contact your state insurance department at

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

OR

**** Group health coverage–**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-628-8549. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: www.carefirst.com or 1-800-628-8549. You may also contact state consumer Assistance Program

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

For group health coverage subject to ERISA you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-258-6518

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-258-6518

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-258-6518

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-258-6518

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $7,370
- **Patient pays:** $170

Sample care costs:	
Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:	
Deductibles	$20
Copays	$0
Coinsurance	$0
Limits or exclusions	$150
Total	**$170**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $4,870
- **Patient pays:** $530

Sample care costs:	
Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:	
Deductibles	$100
Copays	$350
Coinsurance	$0
Limits or exclusions	$80
Total	**$530**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.

The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Anne Arundel County Government Blue Choice Open Access

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2017 – 12/31/2017
Coverage for: Individual | **Plan Type: HMO**

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-800-628-8549.

Important Questions	Answers	Why this Matters:
What is the overall **deductible**?	$100 Individual $200 Family Co-pays do not apply to the deductible	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other **deductibles** for specific services?	No	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an **out–of–pocket limit** on my expenses?	$800 Individual $1,600 Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the **out–of–pocket limit**?	Premiums, balance-billed charges (unless balanced billing is prohibited), and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a **network** of **providers**?	Yes. Please visit www.carefirst.com or call 1-800-628-8549 for a listing of In-network providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a **specialist**?	No but you must use a provider within the Blue Choice network	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about **excluded services**.

Questions: If you are a member please call the number on your ID card or by logging into My Account. Otherwise, please call 1-800-628-8549. If you aren't clear about any of the underlined terms used in this form, see the Glossary at www.carefirst.com/sbcg.
CareFirst SBC ID: SBC20160816AnneArundelCountyGovernmentHMON012017

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care **provider's** office or clinic	Primary care visit to treat an injury or illness	$15 copay	Not covered	For treatment at an Outpatient Hospital Facility, an additional charge may apply
	Specialist visit	$15 copay	Not covered	For treatment at an Outpatient Hospital Facility, an additional charge may apply
	Other practitioner office visit	$15 copay for Chiropractic Services	Not covered	For treatment at an Outpatient Hospital Facility, an additional charge may apply
	Retail Health Clinic	$15 copay	Not covered	
	Preventive care/screening/immunization	No member liability	Not covered	Some services may have limitations or exclusions based on your contract
If you have a test	Diagnostic test (x-ray, blood work)	Lab Tests (Non-Hospital): No member liability X-Ray (Non-Hospital): No member liability	Lab Tests (Non-Hospital): Not covered X-Ray (Non-Hospital): Not covered	In-Network Lab Test benefits apply only to tests performed at LabCorp. For services provided at an Outpatient Hospital Facility, a higher charge may apply
	Imaging (CT/PET scans, MRIs)	Non-Hospital: No member liability	Non-Hospital: Not covered	For services provided at an Outpatient Hospital Facility, a higher charge may apply
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	Not covered	Not covered	Prescription plan administered by Caremark
	Preferred brand drugs	Not covered	Not covered	Prescription plan administered by Caremark
	Non-preferred brand drugs	Not covered	Not covered	Prescription plan administered by Caremark
	Specialty drugs	Not covered	Not covered	Specialty drugs are only provided by Caremark Specialty Drug Services 1-800-237-2767

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Non-Hospital: $25 copay Hospital: $25 copay	Non-Hospital: Not covered Hospital: Not covered	——none——
	Physician/surgeon fees	Non-Hospital: $15 copay Hospital: $15 copay	Non-Hospital: Not covered Hospital: Not covered	——none——
If you need immediate medical attention	Emergency room services	$75 copay	$75 copay	Copay waived if admitted Limited to Emergency Services or unexpected, urgently required services; Additional professional charges may apply
	Emergency medical transportation	No member liability	Not covered	Prior authorization is required for air ambulance services, except for Medically Necessary air ambulance services in an emergency
	Urgent care	$35 copay	$75 copay	Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible;0% coinsurance	Not covered	Prior authorization is required
	Physician/surgeon fee	Deductible;0% coinsurance	Not covered	——none——

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Office Visits: $15 copay	Office Visits: Not covered	For treatment at an Outpatient Hospital Facility, an additional professional charge may apply
	Mental/Behavioral health inpatient services	Deductible;0% coinsurance	Not covered	Prior authorization is required; Additional professional charges may apply Requires pre-authorization from Magellan 1-800-245-7013
	Substance use disorder outpatient services	Office Visits: $15 copay	Office Visits: Not covered	For treatment at an Outpatient Hospital Facility, an additional professional charge may apply
	Substance use disorder inpatient services	Deductible;0% coinsurance	Not covered	Prior authorization is required; Additional professional charges may apply Requires pre-authorization from Magellan 1-800-245-7013
If you are pregnant	Prenatal and postnatal care	No member liability	Not covered	For routine pre/postnatal office visits only. For non-routine obstetrical care or complications of pregnancy, cost sharing may apply.
	Delivery and all inpatient services	Deductible;0% coinsurance	Not covered	Additional professional charges may apply

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	Deductible; 0% coinsurance	Not covered	———none———
	Rehabilitation services	Facility: $25 copay Office: $15 copay	Not covered	For treatment at an Outpatient Hospital Facility, an additional charge may apply Rehabilitation Services includes Physical, Speech and Occupational Therapies Limited to 50 visits per condition per Benefit Period
	Habilitation services	Facility: $25 copay Office: $15 copay	Not covered	For treatment at an Outpatient Hospital Facility, an additional charge may apply Prior authorization required after the first visit Limited to Members under age 19
	Skilled nursing care	Deductible; 0% coinsurance	Not covered	———none———
	Durable medical equipment	Deductible; 0% coinsurance	Not covered	———none———
	Hospice service	Inpatient care: Deductible; 0% coinsurance Outpatient care: Deductible; 0% coinsurance	Inpatient care: Not covered Outpatient care: Not covered	———none———
If your child needs dental or eye care	Eye exam	Not covered	Not covered	Routine vision services are not provided by Blue Choice HMO. Vision services are available with separate enrollment in the VSP Vision Plan.
	Glasses	Not covered	Not covered	Routine vision services are not provided by Blue Choice HMO. Vision services are available with separate enrollment in the VSP Vision Plan.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
	Dental check-up	Not covered	Not covered	Routine Dental services are not provided by Blue Choice HMO. Dental services are available with separate enrollment in the Cigna PPO Dental Plan or the Cigna DHMO Dental Plan.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care
- Hearing aids (except children 18 & under)
- Long-term care
- Most coverage provided outside the United States. See www.carefirst.com
- Non-emergency care when traveling outside the U.S.
- Routine eye care
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Private-duty nursing

Your Rights to Continue Coverage:

**** Individual health insurance–**

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For group health coverage subject to ERISA you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

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See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $7,370
- **Patient pays:** $170

Sample care costs:

Sample care costs	
Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Patient pays	
Deductibles	$20
Copays	$0
Coinsurance	$0
Limits or exclusions	$150
Total	**$170**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $4,870
- **Patient pays:** $530

Sample care costs:

Sample care costs	
Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Patient pays	
Deductibles	$100
Copays	$350
Coinsurance	$0
Limits or exclusions	$80
Total	**$530**

CareFirst SBC ID: SBC20160816AnneArundelCountyGovernmentHMON012017

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.

The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-800-628-8549. If you aren't clear about any of the underlined terms used in this form, see the Glossary at **www.carefirst.com/sbcg**. CareFirst's role is limited to the provision of administrative services only and that CareFirst assumes no financial responsibility for claims arising from these described benefits
CareFirst SBC ID: SBC20160816AnneArundelCountyGovernmentHMON012017

CVS Caremark
Prescription Benefit Program

The Anne Arundel Community College prescription plan is managed by CVS Caremark. A brief summary of the prescription benefit plan is listed below and on the pages following. For additional plan details, contact CVS Caremark at 1-866-409-8521 or www.caremark.com or the Human Resources office.

	CarePlus Retail Pharmacy 2666 Riva Road, Annapolis, MD	Network Retail	CVS/pharmacy	Mail Services Pharmacy
When to Use Your Benefit:	For immediate and maintenance medication needs	For immediate and maintenance medication needs	For immediate and maintenance medication needs	For maintenance medication needs
Where:	2666 Riva Road, Suite 110 Annapolis, MD 21401 Phone: 410-573-1635 Fax: 410-573-5012 Hours of Operation: 8:00am to 5:00pm, Mon to Friday	The CVS Caremark Retail Program includes more than 64,000 participating pharmacies nationwide, including independent pharmacies and chain pharmacies. To locate a CVS Caremark participating retail network pharmacy in your area, simply click on "Find a Local Pharmacy" at www.caremark.com.	You have the convenience of getting your long-term medications at one of our 6,900 CVS/pharmacy locations for your mail service copay. You also have the convenience of getting your prescriptions at your local CVS/pharmacy. To locate a CVS/pharmacy in your area, simply click on "Find a Local Pharmacy" at www.caremark.com.	Simply mail your original prescription and the mail service order form to CVS Caremark. Your medications will be sent directly to your home, office, or a location of your choice.
Copay up to a 30-Day Supply:	• $5 for each generic medication • $22 for each brand-name medication on the drug list • $32 for each brand-name medication not on the drug list	• $5 for each generic medication • $25 for each brand-name medication on the drug list • $35 for each brand-name medication not on the drug list	• $5 for each generic medication • $25 for each brand-name medication on the drug list • $35 for each brand-name medication not on the drug list	Up to a 90-day supply: • $10 for each generic medication • $50 for each brand-name medication on the drug list • $70 for each brand-name medication not on the drug list
Refill Limits:	None	One initial fill plus one refill on maintenance medicines up to a 30-day supply.	One initial fill plus one refill on maintenance medicines up to a 30-day supply. No refill limits for maintenance medications with a 31-90 day supply.	
Copay up to a 90-Day Supply:	• $10 for each generic medication • $50 for each brand-name medication on the drug list • $70 for each brand-name medication not on the drug list	Not available	• $10 for each generic medication • $50 for each brand-name medication on the drug list • $70 for each brand-name medication not on the drug list	
Web Services:	Register at Caremark.com to access tools that can help you save money and manage your prescriptions. To register, have your Prescription Card ready.			
Customer Care:	Visit Caremark.com or call toll-free at 1-866-409-8521.			

Note:

1. A maintenance medication is taken regularly for chronic conditions or long-term therapy. A few examples include medications for managing high blood pressure, diabetes, or high cholesterol.
2. Copayments, copay or coinsurance means the amount a plan participant is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan.
3. When a generic is available, but the pharmacy dispenses the brand-name medication for any reason, you will pay the difference between the brand-name medication and the generic plus the brand copayment. A brand penalty appeal form is available on the HR Intranet/Forms.

Important Things to Know about the **Caremark Prescription Plan**

Prescriptions filled at the retail pharmacy have a Day Supply Limit and Refill Limit

Prescriptions written for up to a 30-day supply of a new, non-maintenance medication may be filled twice at any retail pharmacy (that's one initial fill plus one refill). After the second retail fill on medications, you must use the Caremark Mail Service or a CVS retail pharmacy and request a 90-day supply.

Maintenance Choice Program

Maintenance Choice offers you choice and savings when it comes to filling long-term* prescriptions. You have two ways to save

Option 1

CVS Caremark Mail Service Pharmacy:

- Enjoy convenient home delivery.
- Receive a 90 day supply.
- Receive your medications in private, tamper-resistant and (when needed) temperature controlled packaging.
- Talk to a pharmacist by phone.

Plus, you can easily order refills and manage your prescriptions anytime at www.caremark.com

Option 2

CVS/Pharmacy:

- Pick up your medication at a time that is convenient for you.
- Receive a 90-day supply for the same mail order copayment.
- Enjoy same-day prescription availability.
- Talk with a pharmacist face-to-face.

**A long-term medication is taken regularly for chronic conditions or long-term therapy. A few examples include medications for managing high blood pressure, asthma or high cholesterol.*

Mandatory Generic Requirement

When a generic drug is available, but the pharmacy dispenses the brand name drug for any reason, you will pay the difference between the brand name drug and the generic, plus the brand copayment. Members with a medical necessity for a brand name medication may request an appeal by having their physician complete an appeal form and provide supporting documentation.

Primary/Preferred Drugs

Preferred drugs are those medications that CVS Caremark has on its primary/preferred drug list. This list may change at any time, and is published on the Caremark website in January, April, July and October. The CVS Caremark pharmacists evaluate the medications approved by the Food and Drug Administration (FDA) before adding it to the primary/preferred drug list. Each drug is reviewed for safety, side effects, efficacy (how well the drug works), ease of dosage and cost. The drugs that are judged the best overall are selected as the primary/preferred drugs. Your out-of-pocket costs will be less if you choose primary/preferred drugs.

Drugs with Quantity Limits

Some drugs have limits on the quantities that are covered. Drugs may have these limits due to warnings from the Food and Drug Administration (FDA), serious or toxic effects, or a high potential for misuse or abuse. Some drugs with quantity limits include, *but are not limited to:*

- Viagra.
- Sedatives.
- Hypnotics (e.g., sleeping pills).

When you go to the pharmacy for a prescription drug with a quantity limitation, your copay will cover only the quantity allowed by the plan. You will pay the full cost of any additional quantities.

Drug Exclusions

Some drugs and medications are excluded from coverage, including, but not limited to:

- Weight-loss drugs.
- Vitamins and minerals (except for prescription prenatal).
- Drugs that are labeled by the FDA as "less than effective."
- Cosmetic products (not including acne medication).

The excluded drug list can change at any time. You can check to see if a particular drug is covered by visiting www.caremark.com. Members with a medical necessity for a newly excluded drug can submit an appeal to Caremark along with supporting documentation from their physician.

Specialty Pharmacies for Highly Specialized Drugs

Many new drugs being approved by the FDA are for chronic or serious diseases and are highly specialized. CVS Caremark provides a specialty pharmacy that helps members who need these specialty drugs. These drugs include some anti-cancer medication, growth hormones, infertility drugs, and drugs for multiple sclerosis. The specialty pharmacy has nurses, pharmacists and other health care professionals who can answer questions you may have regarding specialty drugs and schedule delivery of these drugs to your home.

To find out more about all the benefits CVS Caremark Specialty Pharmacy Services has to offer, including express delivery, follow-up care calls, expert counseling and more, contact **CaremarkConnect at 800-237-2767**.

Dental Options

CIGNA Dental DHMO

CIGNA Dental Care is a dental plan that cares about your health and well-being. You and your covered family members have convenient access to dental care through the CIGNA DHMO nationwide network of quality dentists. CIGNA Dental Care covers most preventive and restorative procedures. Orthodontic care (even for adults) is covered, too! And, there are no claim forms to file. See your dental DHMO benefits schedule for more information.

Follow these easy steps to use your **CIGNA Dental Care (DHMO)** plan:

Select a DHMO Network Dentist and Inform CIGNA of your Selected Dentist

- **VISIT US ONLINE –** Register on **www.myCIGNA.com**, a secure online tool that makes it easier and faster for you to gain access to your personalized dental benefits information including your patient charge schedule, replacement ID cards, provider look-up and much more.
- **CALL US –** Our dedicated team of trained service professionals are ready to assist you with any questions about your coverage, they also can help you find a network general dentist near you. For toll-free customer service nationwide, call the number on your ID card or **800-CIGNA24**.
- **NOTE:** Each covered family member can choose his or her own general dentist - near home, work or school. A dental ID card will be mailed to you after you have informed CIGNA which network dentist you've selected.
- You can change your dental office at any time by visiting myCIGNA.com, using our automated Quick Transfer option or simply by calling customer service at **800-CIGNA24**. The change will become effective the first of the following month.

Visit your Network Dentist

- Review the CIGNA DHMO Plan Patient Charge Schedule (PCS) and other plan materials. The PCS lists all of the services your dental plan covers and your financial responsibility for any dental treatment you receive.
- Coverage for most preventative services is covered and provided at low or no charge.
- You are responsible for paying the provider at the time of services as shown on your PCS.
- If you seek covered services from a dentist who does not participate in the CIGNA DHMO network, your benefits may be significantly reduced or may not apply at all.

CIGNA Dental DHMO
Benefit Summary

FEATURE	BENEFIT COVERAGE *(In Network Services Only)*
Annual Deductible	None
Annual Maximum	None
Preventive and diagnostic services, including exams, X-rays, cleanings, sealants, fluoride treatments, other preventive care services	You pay $0, refer to CIGNA DHMO Patient Charge Schedule (K1-09)* for age and frequency limits
Restorative services, including restoration of teeth, space maintainers, extraction of teeth, endodontic (root canal) services, periodontal services (including surgical and nonsurgical services), oral surgery	You pay according to the CIGNA DHMO Patient Charge Schedule (K1-09)*
Major restorative services, including crowns, inlays, onlays, bridges, dentures, denture repair	You pay according to the CIGNA DHMO Patient Charge Schedule (K1-09)*
Orthodontia (for adults and children), including evaluation	You pay according to the CIGNA DHMO Patient Charge Schedule (K1-09)*

**The CIGNA DHMO schedule is available on the AACC intranet and in the Human Resources office. Review the CIGNA DHMO Schedule of Benefits for the fee schedule amounts associated with each type of dental service.*
Services not listed on the CIGNA DHMO Schedule of Benefits are not covered.

Your dental plan covers services that can help you maintain a healthy mouth and treat or manage dental conditions. But no plan covers everything. Here are some examples of services not covered:

- Services provided by a non-network dentist without prior approval from Cigna Dental (except emergencies).
- Replacement of fixed or removable bridges, dentures and orthodontic retainers that are lost, stolen or damaged due to patient abuse, misuse or neglect.
- Cosmetic dentistry unless specifically listed on your patient charge schedule.
- Dental implant surgery or services associated with placement, repair removal, or restoration of a dental implant.

This is not a complete list. For a complete list of services not covered, refer to **K1-09 Patient Charge Schedule** or call **800-244-6224** if you have questions or need more information.

CIGNA Dental PPO

The **CIGNA Dental PPO (DPPO)** plan balances choice and savings, giving you more reasons to smile! You and your covered family members have convenient access to the dental care you need through our nationwide network of dentists. There is a $1,000 maximum benefit per person per calendar year (in or out of network) and a separate $1,000 lifetime maximum benefit for orthodontia for children under age 19.

CIGNA wants you to get the most out of your dental care dollars. CIGNA DPPO network providers agree to accept discounts when treating CIGNA Dental members and cannot charge more than their contracted fees. Non-network dentists are not obligated to charge discounted fees, which can raise your out-of pocket costs.

Referrals are not needed for specialty care. You can visit a specialist (or any dentist) whether in or out of the CIGNA DPPO network at any time for care. Remember: you can save by choosing an in-network provider.

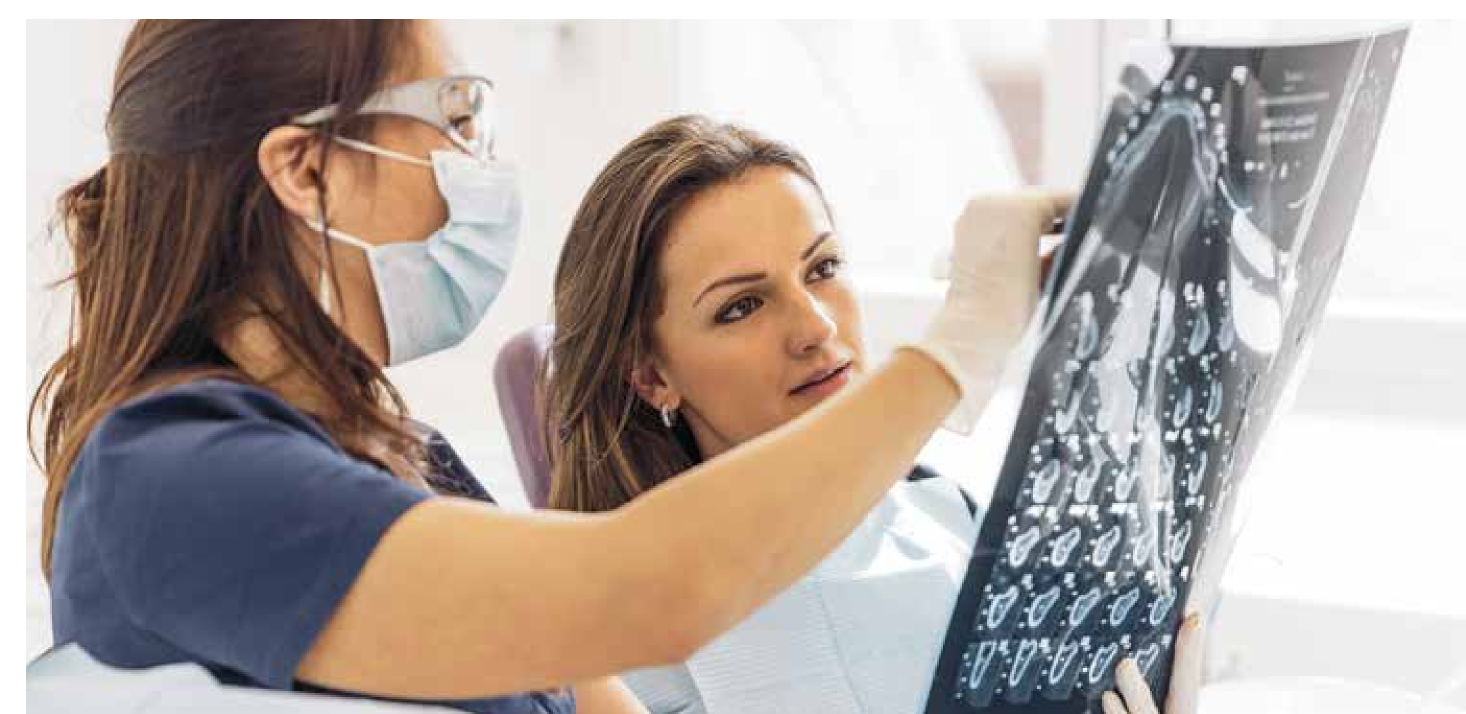
Estimate and Plan your Dental Care Costs

You can find out what treatment costs will be by asking your dentist for a predetermination of benefits or log on to myCIGNA.com to access the Dental Treatment Cost Estimator. This user-friendly, comprehensive Web-based tool on myCIGNA.com allows you to get dental estimates based on your specific plan design with Anne Arundel Community College and is adjusted by geographic location.

Contacting CIGNA

VISIT US ONLINE – Register on **www.myCIGNA.com**, a secure on-line tool th1t makes it easier and faster for you to gain access to your personalized dental benefits information, replacement ID cards, provider look-up and much more.

CALL US – Our dedicated team of trained service professionals are ready to assist you with any questions about your coverage. They also can help you find a network general dentist near you. For toll-free customer service nationwide, call the number on your ID card or **800-CIGNA24**.



CIGNA Dental PPO Benefit Summary

	IN-NETWORK		OUT-OF-NETWORK	
Calendar Year Maximum (Class I, II and III expenses)	$1,000		$1,000	
Annual Deductible Individual Family	$10 per person $25 per person		$10 per person $25 per person	
Reimbursement Levels	Based on Reduced Contracted Fees		Maximum reimbursable charge	
	Plan Pays	**You Pay**	**Plan Pays**	**You Pay****
Class I – Preventive and Diagnostic Care Oral Exams Routine Cleanings Full Mouth, Bitewing, Panoramic X-rays Flouride Application Sealants: Per tooth Space Maintainers: Non-orthodontic Emergency Care to Relieve Pain	100% No deductible	No Charge	100% No deductible	No Charge
Class II – Basic Restorative Care Fillings Root Canal Therapy Osseous Surgery Periodontal Scaling & Root Planning Denture Adjustments & Repairs Oral Surgery – Simple Extractions Oral Surgery – all except simple extractions Anesthetics Surgical Extractions of Impacted Teeth Repairs to Bridges, Crowns & Inlays	100%*	0%*	100%*	0%*
Class III – Major Restorative Care Crowns, Bridges, Dentures Inlays and Onlays Prosthesis over implant	80%*	20%*	80%*	20%*
Class IV – Orthodontia Lifetime Maximum	50%* $1,000 Dependent Children to Age 19	50%*	50%* $1,000 Dependent Children to Age 19	50%*

Notes:

1. All deductibles, plan maximums and service specific maximums (dollar and occurrence) cross accumulate between in and out of network.
2. Pretreatment review is available on a voluntary basis when extensive dental work in excess of $200 is proposed.
3. *Subject to annual deductible.
4. **In addition to the amount you pay as indicated in this column, if the out-of-network provider charges a total that is higher than the 90th percentile of reasonable and customary allowances, the provider generally also will bill you for that additional amount.

Vision Care

VSP WELLVISION PLAN

The VSP vision plan does not issue member ID cards, but members can print one by registering at **www.vsp.com**. VSP members can use a VSP network provider or an out of network (nonparticipating) provider. If you use a nonparticipating provider, you will be responsible for submitting a claim form to VSP. If you use a VSP provider, the provider can confirm your enrollment directly with VSP and apply any VSP benefits or discounts at time of service.

When you obtain services from a VSP doctor, you get the most value from your VSP benefit. And with the largest network of highly qualified private practice doctors, it's easy to find a doctor near your home or work. To verify your doctor is a VSP doctor or to locate a VSP doctor:

- Visit **www.vsp.com**.
- Call Member Services at **800-877-7195**.

Using your VSP benefit is simple.
No member ID cards, no claim forms, no hassles.

TO ACCESS YOUR BENEFITS, SIMPLY:

- Make an appointment with a VSP doctor.
- Tell the doctor you are a VSP member when making the appointment.
- Provide the doctor with the **covered member's ID number.**

Your **VSP WellVision** Coverage at a Glance

Benefit	Frequency	Co-Payment	Allowance from a VSP Doctor	Out-of-Network Reimbursement
Eyecare Wellness – Regular exams are essential for protecting your visual wellness.				
Exam Your plan provides a 20% discount* off the VSP doctor's fee for an exam, plus an allowance.	12 months**	None	Allowance of $40	Up to $40 allowance
Prescription Eyeware – You may choose between glasses or contacts. Remember if you choose contacts, you will not be eligible to receive glasses (lenses and a frame) in the same service period.				
Lenses Your plan provides a 20% discount* off the VSP doctor's fees for prescription lenses (when a complete pair of glasses is purchased) plus a schedule of allowances. You are responsible for any amount that exceeds the allowance.	12 months**	None	Single Vision - $48 allowance Lined Bifocal - $90 allowance Lined Trifocal - $90 allowance	Single Vision - $48 allowance Lined Bifocal - $90 allowance Lined Trifocal - $90 allowance
Frame Your plan provides a 20% discount* off the VSP doctor's fees for prescription frames (when a complete pair of glasses is purchased) plus an allowance. You are responsible for any amount that exceeds the allowance.	12 months**	None	Up to $29.50 allowance	Up to $29.50 allowance
OR				
Contact Lenses (in lieu of frames and lenses) Your plan provides a 15% discount* off the cost of your contact lens exam from a VSP doctor (discount does not apply to eyeware plus an allowance). You are responsible for any amount that exceeds the allowance.	12 months**	None	Allowance of $75	Up to $75 allowance

*VSP doctors are not required to extend a discount if they have not provided an eye exam to the patient within the last 12 months.
**Based on last date of service.

Value Added Discounts
Laser Vision Care – VSP has contracted with many of the nation's finest surgery facilities and doctors, offering you a discount off PRK and LASIK surgeries, available through contracted laser centers. Visit VSP's website at www.vsp.com to learn more about the exciting program.
Contact Lenses – VSP also offers valuable savings on annual supplies of certain brand of contacts. You can receive these VSP Member Preferred Prices, even if you use your coverage for glasses, when you purchase your contact lenses from the same VSP doctor who provided your eye exam within the previous 12 months. Visit www.vsp.com or ask your doctor for details.

Flexible Spending Accounts (FSA)

Flexible Spending Accounts allow you to set aside dollars from your salary, before paying taxes, to pay for certain out-of-pocket heath and/or dependent care expenses. Tax savings result because you do not have to pay income or FICA taxes on the amount withheld from your paycheck or the reimbursement amount. You do not have to participate in a Anne Arundel Community College-sponsored health plan to participate in a Flexible Spending Account.

You must enroll each year if you want to participate in a Health Care or Dependent Care FSA, even if you are currently contributing to a reimbursement account.

Health Care Spending Account

You may set aside $240 to $2,550 annually in a Health Care Spending Account to pay for qualified medical, prescription drug copayments and certain over-the-counter (OTC) medications, dental and vision care expenses. The health care expenses may be for you, your spouse or your eligible dependents. It is no longer necessary that a FSA dependent qualify as a "tax dependent" for purposes of income taxes in order for the employee to claim reimbursements. By signing the FSA claim form you certify the eligibility of your dependent. The Health Care FSA allows the reimbursement of medical expenses of an employee's child up to age 26.

The Health Care FSA is used for tax-deductible health care expenses not paid by insurance. Whether an expense is eligible for reimbursement under the Health Care FSA is determined under IRS rules. For information on whether an expense is eligible visit the ADP FSA website at **www.myspendingaccount.adp.com**. A prescription is required for over-the-counter drugs in order to process a claim reimbursement under a flexible spending account.

Dependent Care Spending Account

The Dependent Care Account helps you pay the cost of day care and/or elder care for one or more "Qualifying Individuals" so you (or your spouse, if married) can work.

A "Qualifying Individual" is:

- Your child (including a stepchild), brother, sister, stepbrother or stepsister (or a descendent of any of those, such as your grandchild or your niece or nephew) who is under the age of 13, who has the same principal residence as you for at least half of the tax year and who does not provide at least half of his or her own support for the current calendar year.
- Your spouse (for the purposes of federal law) who is physically or mentally incapable of taking care of himself or herself and who has the same principal residence as you for at least half of the tax year.
- Any person who qualifies as your dependent for tax purposes (using the same definition of dependent for tax purposes that applies to medical benefits under the Benefits Eligibility section of this guide, except that the special rule for children of divorced or separated does not apply) who is physically or mentally incapable of taking care of himself or herself and who has the same principal residence as you for at least half of the tax year.

NOTE: If you are single or married and filing a joint tax return, you may contribute up to $5,000 each calendar year. If you are married and filing a separate tax return, you may contribute up to $2,500 per year. However, your total contributions for the year cannot exceed the lesser of your earned income or, if you are married, your spouse's earned income. For purposes of this limit, if your spouse is either a full-time student or is incapable of self-care, your spouse will be deemed to have earned income for each month that he or she is a full-time student or incapacitated. The amount of deemed earnings will be $250/month, if you provide care for one Qualifying Individual, or $500/month, if you provide care for more than one Qualifying Individual. The Dependent Care FSA is used for dependent care expenses that allow you (or you and your spouse, if married) to work or look for work, or that allow your spouse to attend school full-time. Expenses incurred for services outside your household maybe reimbursed only if incurred for the care of (i) a Qualifying Individual who is a qualifying child under 13 years of age, or (ii) another qualifying individual who regularly spends at least eight hours each day in your household. In addition, if the services are provided by a Dependent Care Center, the center must comply with applicable laws and regulations of a state or local government. A "Dependent Care Center" is any facility services for any of the individuals.

Under the Internal Revenue Code, you also may reduce your taxes by taking a depending care tax credit. However, any amounts which you exclude from income under the Dependent Care FSA will reduce, dollar for dollar, the tax credit available.

Consult your tax advisor to determine whether the FSA or the tax credit gives the greater tax advantage for you.

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

Helpful Information for Submitting FSA Claims

Use the FSA supporting documentation forms to help expedite your claim. There are three supporting documentation forms:

1. **Proof of Medical Claim Form –** use this form to obtain and/or submit supporting documentation for a medical, dental or vision expense.
2. **Prescription for OTC Medicines and Drugs Form –** use this form to submit a prescription for over-the-counter medicines and drugs, such as pain relievers, cold and flu remedies or antihistamines.
3. **Orthodontia Documentation –** use this form to submit your contract for orthodontia expenses.

Receiving Your Reimbursement

ADP FSA processes reimbursement claims weekly for those healthcare expenses not already paid through the FSA debit card and for dependant care expenses. There is a $20 minimum reimbursement amount. If your claim is for less than $20, your reimbursement will be held until you file additional claims. You may be reimbursed from the Health Care FSA at any time throughout the year for expenses up to the annual amount you elected to contribute. For the Dependent Care FSA, however, you may only be reimbursed up to your current balance. If you file a reimbursement request for more than your Dependent Care FSA current balance, it will be held until additional contributions have been added to your account. In addition, day care expenses are not reimbursed until the end of the time period incurred. For example, expenses for summer camp from June 1-15 would not be reimbursed until after June 15. Sign up for the direct deposit for faster access to your FSA reimbursement dollars. Visit the ADP FSA website at www.myspendingaccount.adp.com to authorize direct deposit for FSA funds.

Current participants will not receive a new card. Your card is valid for three years.

FSA Deadlines

There are two types of deadlines to be aware of with the FSA program: a deadline to incur claims and a deadline to submit claims.

All FSA claims must be submitted to ADP FSA by the next March 31 following the end of the plan year. For the 2017 plan year, all FSA claims must be submitted by March 31, 2018.

There is a 2½ month "grace period" following the end of the plan year in which you can continue to incur expenses for that plan year for both the Health Care and Dependent Care FSA. So, you actually have until March 15, 2018, to incur eligible expenses for reimbursement.

Because of the FSA tax advantages, the IRS places strict limits on them, including a "Use-it-or-Lose-it" rule that means that if you have unused dollars in your account and you have not incurred eligible expense by the end of the year or by the end of the grace period that follows the plan year, you cannot roll the leftover amount over to the next plan year, and unused dollars cannot be paid out to you. So plan carefully when deciding how much you want to contribute to the FSA.

Special FSA Distributions for Reservists

The Heroes Earning Assistance and Tax Relief Tax Act of 2008 (HEART ACT) permits qualified reservist distributions of unused amounts in health flexiblespending account to reservist ordered or called to active duty for at least 180 days or on an indefinite basis. Contact Human Resources for additional information.

Resigning or Retiring in 2017?

If you retire or end college employment during the plan year, only expenses incurred while you were still an active employee will be considered for reimbursement (except if you are eligible and elect to continue Health Care FSA coverage under COBRA).

ADP Health Care Account Debit Card

Important Facts You Need to Know

What is the Health Care Flexible Spending Account (FSA) Debit Card?

The FSA Debit Card is a convenient tool that can help you maximize your FSA benefit. Just like your bank debit card is linked to your checking or savings account, your FSA card is linked directly to your FSA account. Taking advantage of the card benefit can help you:

- Avoid out-of-pocket expenditures.
- Receive immediate reimbursement for eligible expenses.
- Reduce paperwork.
- Simplify managing your FSA account (be sure to monitor your account regularly on the ADP FSA website).

Where do I get my FSA Debit Card?

If you enroll in a health-based FSA plan with your employer, you will automatically receive the FSA Debit Card. Your card will be mailed to the address on your payroll file, usually your home address. Even though you'll have a debit card, you can still file paper claims, if you choose.

NOTE: FSA Debit Cards are not available for use with Dependent Care FSA Plans.

How do I use my FSA Debit Card?

Using your FSA Debit Card is as easy as using your bank ATM or credit card. Just swipe your card, take your receipt and go! However, because the card is linked to your FSA funds, the IRS has placed restrictions on its use:

- Your card can only be used at authorized merchants or providers where FSA products and services are sold.
- You only can purchase items and services recognized by the IRS as FSA-eligible. So, you always should be sure to save your detailed purchase receipts when using your card.

Select "credit" when swiping your card at the payment terminal. Even though your card functions as a debit card, selecting "credit" generates the correct type of electronic transaction. Remember, there is no PIN associated with your card.

When using your card at a medical provider (doctor, dentist, hospital, vision center, etc.), be sure you only use the card for your portion of the charges and not any charges that are covered by your insurance.

Even if your card swipe is approved at the time of purchase, you may still need to verify that the purchase was an eligible expense, so you must save your itemized receipt. (See the next page for more information on verifying purchase eligibility).

When you're purchasing eligible items along with other items, always pay for the eligible items with your FSA Debit Card first, then use a different form of payment for all other items.

Where can I use my FSA Debit Card?

In the rare case that our card is denied at the checkout counter, even though you have sufficient funds in your account, there's no need to worry ... it can be a little embarrassing, but it most likely means:

- The card doesn't recognize the merchant's information or the product code(s) for the item(s) you're purchasing.
- You've failed to verify a previous purchase and your card has been temporarily suspended (see the reverse side for information on verifying purchases).

Most qualified health care providers (doctors, dentists, hospitals, vision centers, etc.) are eligible to accept the card based on the type of services they provide. Additionally, many retail merchants and pharmacies across the country can accept the card because they use specialized technology that allows them to determine which, if any, of the items in your purchase are eligible under a Health Care FSA plan.

For comprehensive lists of eligible expenses and retailers who accept the FSA Debit Card, visit the ADP FSA website at www.myspendingaccount.adp.com. First-time users will need to register their online account to gain access.

Verifying the Eligibility of Your Card Purchases

Why do I have to verify the eligibility of my FSA Debit Card purchases?

The IRS has set strict rules on the types of items that can be purchased with FSA funds. ADP makes every attempt, through all available technology and sources, to automatically verify that your purchase is eligible. Sometimes, however, those attempts are unsuccessful and we will ask that you provide a detailed receipt to show that your purchase is eligible under the IRS rules. This is why you must save all of your itemized receipts for card purchases. If a receipt is required for your purchase, you will be notified by email (if you have an email address on file with ADP) or by U.S. mail.

How will I know if a receipt is needed for my FSA Debit Card purchase?

If you need to submit a receipt, you will receive notifications either by email or by U.S. mail. Each notification type will state clearly that it is a receipt request. It will advise you of the action you need to take and will show you the specific transaction(s) for which receipts are required. Receipt requests sent via email will reflect a single transaction while requests sent as a hard copy letter may list multiple transactions in a single letter. Receipt requests are typically generated within 24 to 72 hours after the purchase is made.

How do I respond to receipt requests and what if I don't respond?

Responding to a receipt request is simple, yet very important ... just gather your itemized receipt(s) for the indicated purchase(s), complete a Substantiation Form, print and sign your form and then fax the form and receipt(s) to ADP. You can locate Substantiation Forms on the ADP FSA website at **www.myspendingaccount.adp.com**. The easiest and most secure way to complete your receipt request is by using the online forms completion tool available on the Flex Forms tab in the ADP FSA website. If you prefer to complete a form by hand, you can find manual forms under the Tools and Forms tab. First-time users to the site will need to register their online account.

Failure to respond to a receipt request will place an overpayment on your account and your card will be temporarily deactivated ... that means card swipes will be denied until you resolve the overpayment.

How do I resolve an overpayment?

An overpayment will be placed on your account if you have not responded to a receipt request (to show proof of an eligible item) or if you submitted the receipt(s) but the purchase, or some part of it, was deemed ineligible under IRS regulations. Resolving an overpayment is a simple process:

1. Make new purchases for eligible items and pay for those items "out-of-pocket."
2. Submit a paper claim with the receipts for the new eligible items you've purchased.
3. The amount of these new claims will be applied against the overpayment amount until it is cleared.
4. If your new claims exceed the overpayment amount, you will receive a reimbursement for the excess amount.
5. Once the overpayment amount is cleared, your card will automatically be reactivated and will be ready for use.

IMPORTANT: You may not offset overpayment amounts with receipts from previously approved card purchases.

Group Life Insurance

Basic Term Life Insurance

AACC offers Basic Term Life insurance coverage in the amount of two times your base annual earnings up to a maximum benefit of $350,000. Employees pay 25 percent of the cost and the college pays 75 percent. Rates for basic term life are:

Salary	Life Insurance Face Value	Employee 12 Mo.	Cost 10 Mo.
$12,000	$24,000	$0.38	$0.46
$13,000	$26,000	$0.42	$0.50
$14,000	$28,000	$0.45	$0.54
$15,000	$30,000	$0.48	$0.58
$16,000	$32,000	$0.51	$0.61
$17,000	$34,000	$0.54	$0.65
$18,000	$36,000	$0.58	$0.69
$19,000	$38,000	$0.61	$0.73
$20,000	$40,000	$0.64	$0.77
$21,000	$42,000	$0.67	$0.81
$22,000	$44,000	$0.70	$0.84
$23,000	$46,000	$0.74	$0.88
$24,000	$48,000	$0.77	$0.92
$25,000	$50,000	$0.80	$0.96
$26,000	$52,000	$0.83	$1.00
$27,000	$54,000	$0.86	$1.04
$28,000	$56,000	$0.90	$1.08
$29,000	$58,000	$0.93	$1.11
$30,000	$60,000	$0.96	$1.15
$31,000	$62,000	$0.99	$1.19
$32,000	$64,000	$1.02	$1.23
$33,000	$66,000	$1.06	$1.27
$34,000	$68,000	$1.09	$1.31
$35,000	$70,000	$1.12	$1.34
$36,000	$72,000	$1.15	$1.38
$37,000	$74,000	$1.18	$1.42
$38,000	$76,000	$1.22	$1.46
$39,000	$78,000	$1.25	$1.50
$40,000	$80,000	$1.28	$1.54
$41,000	$82,000	$1.31	$1.57
$42,000	$84,000	$1.34	$1.61
$43,000	$86,000	$1.38	$1.65
$44,000	$88,000	$1.41	$1.69
$45,000	$90,000	$1.44	$1.73
$46,000	$92,000	$1.47	$1.77
$47,000	$94,000	$1.50	$1.80
$48,000	$96,000	$1.54	$1.84
$49,000	$98,000	$1.57	$1.88
$50,000	$100,000	$1.60	$1.92
$51,000	$102,000	$1.63	$1.96
$52,000	$104,000	$1.66	$2.00
$53,000	$106,000	$1.70	$2.04
$54,000	$108,000	$1.73	$2.07
$55,000	$110,000	$1.76	$2.11
$56,000	$112,000	$1.79	$2.15
$57,000	$114,000	$1.82	$2.19
$58,000	$116,000	$1.86	$2.23

Salary	Life Insurance Face Value	Employee 12 Mo.	Cost 10 Mo.
$59,000	$118,000	$1.89	$2.27
$60,000	$120,000	$1.92	$2.30
$61,000	$122,000	$1.95	$2.34
$62,000	$124,000	$1.98	$2.38
$63,000	$126,000	$2.02	$2.42
$64,000	$128,000	$2.05	$2.46
$65,000	$130,000	$2.08	$2.50
$66,000	$132,000	$2.11	$2.53
$67,000	$134,000	$2.14	$2.57
$68,000	$136,000	$2.18	$2.61
$69,000	$138,000	$2.21	$2.65
$70,000	$140,000	$2.24	$2.69
$71,000	$142,000	$2.27	$2.73
$72,000	$144,000	$2.30	$2.76
$73,000	$146,000	$2.34	$2.80
$74,000	$148,000	$2.37	$2.84
$75,000	$150,000	$2.40	$2.88
$76,000	$152,000	$2.43	$2.92
$77,000	$154,000	$2.46	$2.96
$78,000	$156,000	$2.50	$3.00
$79,000	$158,000	$2.53	$3.03
$80,000	$160,000	$2.56	$3.07
$81,000	$162,000	$2.59	$3.11
$82,000	$164,000	$2.62	$3.15
$83,000	$166,000	$2.66	$3.19
$84,000	$168,000	$2.69	$3.23
$85,000	$170,000	$2.72	$3.26
$86,000	$172,000	$2.75	$3.30
$87,000	$174,000	$2.78	$3.34
$88,000	$176,000	$2.82	$3.38
$89,000	$178,000	$2.85	$3.42
$90,000	$180,000	$2.88	$3.46
$91,000	$182,000	$2.91	$3.49
$92,000	$184,000	$2.94	$3.53
$93,000	$186,000	$2.98	$3.57
$94,000	$188,000	$3.01	$3.61
$95,000	$190,000	$3.04	$3.65
$96,000	$192,000	$3.07	$3.69
$97,000	$194,000	$3.10	$3.72
$98,000	$196,000	$3.14	$3.76
$99,000	$198,000	$3.17	$3.80
$100,000	$200,000	$3.20	$3.84

Supplemental Term Life Insurance Coverage Options

For you	$10,000 increments up to a maximum benefit of the lesser of 5 times your total basic annual earnings or $500,000
For Your Spouse/Domestic	$5,000 increments, up to a maximum benefit of the lesser of 100 percent of your total Basic and Supplemental Life coverage amount or $50,000
For Your Dependent Children*	Under 6 months: $500 6 months and older: $10,000

**Child(ren)'s Eligibility: Dependent children ages from 15 days to 19 years old, or 23 years old if a child is a full-time student, are eligible for coverage. In TX, regardless of student status, child(ren) are covered until age 25.*

Monthly Costs for Supplemental Term Life Insurance

You have the option to purchase Supplemental Term Life Insurance. Calendar year 2016 monthly rates are listed below as well as those for your spouse/domestic partner (based on your age and the amount of coverage you want). Rates to cover your child(ren) also are shown. Please note that your rate will increase if you are moving into the next age bracket for the supplemental life insurance coverage only. These rates remain the same as our current rates for calendar year 2015.

Employee Age	Your Monthly Cost Per $1,000 of Coverage	Spouse/Domestic Partner Monthly Cost Per $1,000 of Coverage
Under 25	$0.040	$0.045
25 - 20	$0.040	$0.045
30 - 34	$0.052	$0.054
35 - 39	$0.066	$0.060
40 - 44	$0.092	$0.084
45 - 49	$0.140	$0.130
50 - 54	$0.223	$0.235
55 - 59	$0.365	$0.383
60 - 64	$0.551	$0.690
65 - 69	$1.043	$1.201
70 +	$1.970	$1.895
Cost for your Child(ren)†	$0.160	

† Covers all eligible children.

Use the table below to calculate your premium based on the amount of life insurance you will need.
Example: $100,000 Supplemental Life Coverage

1. Enter the rate from the table (example age 36)	$0.066	$
2. Enter the amount of insurance in thousands of dollars (Example: for $100,000 of coverage enter $100)	100	
3. Monthly premium (1) x (2)	$6.60	$
Repeat the three easy steps above to determine the cost for each coverage selected.		

Group Life Insurance Features

This insurance offering from AACC and MetLife comes with a variety of added features that can provide assistance to you and your family members today and during a difficult time.

Accelerated Benefits Option[1]

For access to funds during a difficult time.

You can receive up to 80 percent of your Basic and Supplemental Term Life insurance proceeds to a maximum of $680,000 in the event that you become terminally ill and are diagnosed with less than 12 months to live. This can go a long way toward helping your family meet medical and other related expenses at this difficult time. The Accelerated Benefit Option also is available to spouses/domestic partners insured under Dependent Life insurance plans. This option is not available for dependent child coverage.

Conversion

For protection after your coverage terminates.

You can generally convert your Group Term Life insurance benefits to an Individual Whole Life insurance policy if your coverage terminates in whole or in part due to your retirement, termination of employment, or, a change in your employee class. Conversion is available on all Group Life insurance coverages. Please note that conversion is not available on AD&D coverage. If you experience an event that makes you eligible to convert your coverage, you can speak with a MetLife representative by calling: 1-877-275-6387.

Waiver of Premiums for Total Disability (Continued Protection)

Offering continued coverage when you need it most.

If you become Totally Disabled, you may qualify to continue certain insurance. You also may be eligible for waiver of your Basic and Supplemental Term Life and Personal Accidental Death and Dismemberment insurance premium until you reach age 65, die or recover from your disability, whichever is sooner, should you become unable to work due to a Total Disability.

Total Disability or Totally Disabled means you are unable to do your job and any other job for which you are fit by education, training or experience, due to injury or sickness. The Total Disability must begin before age 60, and your waiver will begin after you have satisfied a six-month waiting period. The Waiver of Premium will end when you turn age 65, die or recover. Please note this benefit is available after you have participated in the Supplemental Term Life Plan for one year and it is only available to you. This one-year requirement applies to new participants in the plan.

Portability

So you can keep your coverage even if you leave AACC.

Should you leave Anne Arundel Community College for any reason, and your Basic and Supplemental and Dependent Term Life insurance under this plan terminates, you will have an opportunity to continue group term coverage ("portability") under a different policy, subject to plan design and state availability. Rates will be based on the experience of the ported group and MetLife will bill you directly. Rates may be higher than your current rates. To take advantage of this feature, you must have coverage of at least $10,000 up to a maximum of $2,000,000.

Portability also is available on coverage you've selected for your spouse/domestic partner and dependent child(ren). The maximum amount of coverage for spouses/domestic partners is $250,000; the maximum amount of dependent child coverage is $25,000. Increases, decreases and maximums are subject to state availability.

Generally, there is no minimum time for you to be covered by the plan before you can take advantage of the portability feature. Please note that if you experience an event that makes you eligible for portable coverage, please a MetLife representative at 888-252-3607 or contact Human Resources for more information.

Will Preparation Service[2]

To help ensure your decisions are carried out.

Like life insurance, a carefully prepared will (simple, complex or living) along with a power of attorney are important. With a will, you can define your most important decisions such as who will care for your children or inherit your property.

Living Will:

- Ensures your wishes are carried out, and protects your loved ones from making these very difficult and personal medical decisions by themselves.
- Also called an "advanced directive," it is a document authorized by statutes in all states. A person appoints someone as his/her proxy or representative to make decisions on maintaining extraordinary life-support if the person should become incapacitated so that he or she is unable to communicate his or her wishes

Power of Attorney:

- Allows you to plan ahead by designating someone you know and trust to act on your behalf in the event of unexpected occurrences or if you become incapacitated. It is a written document that grants an individual the power to act on the grantor's behalf.

By enrolling in Supplemental Term Life coverage, you will have access to Hyatt Legal Plans' network of 12,000 participating attorneys. When you enroll in this plan, you may take advantage of face-to-face access to a participating plan attorney to prepare or update a will, living will or powers of attorney.* When you use a participating plan attorney there will be no charge for the services. Contact Hyatt Legal Plans at 800-821-6400, 8 a.m. to 7 p.m. Monday through Friday, Eastern time. The college's group number is 148497.

** You also have the flexibility of using an attorney who is not participating in the Hyatt Legal Plans' network and being reimbursed for covered services according to a set fee schedule. In that case you will be responsible for any attorney's fees that exceed the reimbursed amount.*

MetLife Estate Resolution Services – ERS[3]

Personal service and compassion to help your beneficiaries and others manage your estate during their time of need.

MetLife Estate Resolution Services is a valuable service offered under the plan. When your estate representative uses a participating Hyatt Legal plan attorney there will be no charge for the services. A Hyatt Legal Plan attorney will consult face-to-face with your beneficiaries or by telephone regarding the probate process for your estate. The attorney also will handle the probate of your estate for your executor or administrator. This can help alleviate the financial and administrative burden upon your loved ones in their time of need.

Delivering The Promise®

For support when beneficiaries need it most.

Delivering The Promise® is a service designed to provide beneficiaries with the support and assistance they need during an especially difficult time. Services include assistance filing life insurance claims and consultation to help with the financial details and questions that arise upon the loss of a loved one.

Funeral Planning Guide

Provides beneficiaries a resource that outlines your final wishes.

It highlights details of pertinent information including: how to plan for funeral costs, the death claim process, personal funeral preferences and more.

Total Control Account®[7]

For immediate access to death proceeds.

The Total Control Account® settlement option provides your loved ones with a safe and convenient way to manage the proceeds of a life or accident policy for claim payments of $5,000 or more, backed by the financial strength and claims paying ability of Metropolitan Life Insurance Company. They'll have the convenience of immediate access to any or all of their proceeds, through an interest bearing account with unlimited draft-writing privileges. The Total Control Account gives beneficiaries time to decide what to do with their proceeds, which can be very helpful to them during a difficult time.

What's Not Covered?

Like most insurance plans, this plan has exclusions. Supplemental and Dependent Life Insurance do not provide payment of benefits for death caused by suicide within the first two years (one year in North Dakota or Colorado) of the effective date of the certificate, or payment of increased benefits for death caused by suicide within two years (one year in North Dakota or Colorado) of an increase in coverage.

Please note that a reduction schedule may apply. Please see your employer or certificate for specific details.

Accidental Death & Dismemberment Coverage Options (AD&D)

All employees enrolled in the Basic Life Insurance coverage will automatically be enrolled in Accidental Death and Dismemberment coverage at no cost to the employee. This is a benefit 100 percent paid by the college. This valuable coverage is available to you even if you already have accident insurance. It provides benefits beyond your disability or life insurance for losses due to covered accidents – while commuting, traveling by public or private

transportation and during business trips. MetLife's AD&D insurance pays you benefits if you suffer a covered accident that results in paralysis or the loss of a limb, speech, hearing or sight, or brain damage or coma. If you suffer a covered fatal accident, benefits will be paid to your beneficiary.

Covered Losses

This AD&D insurance pays benefits for covered losses that are the result of an accidental injury or loss of life. The full amount of AD&D coverage you select is called the "Full Amount" and is equal to the benefit payable for the loss of life. Benefits for other losses are payable as a predetermined percentage of the Full Amount, and will be listed in your coverage in a Table of Covered Losses. Such losses include loss of limbs, sight, speech and hearing, various forms of paralysis, brain damage and coma. The maximum amount payable for all Covered Losses sustained in any one accident is capped at 100 percent of the Full Amount.

Standard Additional Benefits Include

Some of the standard additional benefits included in your coverage that may increase the amounts payable to you and/or defray additional expenses that result from accidental injury or loss of life are:

- Air Bag Benefit.
- Seat Belt Benefit.
- Common Carrier Benefit.

What Is Not Covered?

Accidental Death and Dismemberment insurance does not include payment for any loss which is caused by or contributed to by physical or mental illness, diagnosis of or treatment of the illness; an infection, unless caused by an external wound accidentally sustained; suicide or attempted suicide; injuring oneself on purpose; the voluntary intake or use by any means of any drug, medication or sedative, unless taken as prescribed by a doctor or an over-the-counter drug taken as directed; voluntary intake of alcohol in combination with any drug, medication or sedative; war, whether declared or undeclared, or act of war, insurrection, rebellion or riot; committing or trying to commit a felony; any poison, fumes or gas, voluntarily taken, administered or absorbed; service in the armed forces of any country or international authority, except the United States National Guard; operating, learning to operate, or serving as a member of a crew of an aircraft; while in any aircraft for the purpose of descent from such aircraft while in flight (except for self preservation); or operating a vehicle or device while intoxicated as defined by the laws of the jurisdiction in which the accident occurs.

How to apply

The following actions can be taken during Open Enrollment:

- Enrolling for the first time in the Basic Life Insurance coverage, which is two times your annual salary*.
- Enrolling for the first time in the Employee Supplemental Life Insurance coverage of $10,000 increments up to $500,000 or five times your Basic Annual Earnings, whichever is less*.
- Increasing the amount of Employee Supplemental Life Insurance coverage you currently have*.
- Enrolling for the first time in the Spouse/Same-sex Domestic Partner Life Insurance coverage of $5,000 increments, up to maximum benefit of the lesser of 100% of your total Basic and Supplemental Life coverage amount of $50,000*.
- Enrolling for the first time in dependent child coverage.
- Increasing the amount of Spouse/Same-sex Domestic Partner Life Insurance coverage you currently have*.

** Coverage will either be approved by MetLife based upon its underwriting rules and your answers or you will be asked to submit a Statement of Health to complete your application for coverage. All applications are subject to review and approval by Metropolitan Life Insurance Company based upon its underwriting rules.*

No action is required if you wish your current life insurance coverage(s) to remain the same.
If you would like to make a change, please contact Human Resources for the enrollment/change form or visit the HR intranet site/Open Enrollment for the form.

Who Can Be A Designated Beneficiary?

You can select any beneficiary(ies) other than your employer, and you may change your beneficiary(ies) at any time. You also can designate more than one beneficiary.

About Your Coverage Effective Date

You must be Actively at Work on the date your coverage becomes effective. Your coverage must be in effect for your spouse/domestic partner's and eligible children's coverage to take effect. In addition, your spouse/domestic partner and eligible child(ren) must not be home or hospital confined or receiving or applying to receive disability benefits from any source when their coverage becomes effective.

If Actively at Work requirements are met, coverage will become effective on the date following the receipt of your completed application for all requests that do not require additional medical information. A request for your amount that requires additional medical information and is not approved by the date listed above will not be effective until the later of the date that notice is received that MetLife has approved the coverage or increase if you meet Actively at Work requirements on that date, or the date that Actively at Work requirements are met after MetLife has approved the coverage or increase. The coverage for your spouse/domestic partner and eligible child(ren) will take effect on the date they are no longer confined, receiving or applying for disability benefits from any source or hospitalized.

Pursuant to IRS Circular 230, MetLife is providing you with the following notification: The information contained in this document is not intended to (and cannot) be used by anyone to avoid IRS penalties. This document supports the promotion and marketing of insurance products. You should seek advice based on your particular circumstances from an independent tax advisor.

[1]The Accelerated Benefits Option is subject to state availability and regulation. The accelerated life insurance benefits offered under your certificate are intended to qualify for favorable federal tax treatment. If the accelerated benefits qualify for favorable tax treatment, the benefits will be excludable from your income and not subject to federal taxation.
This information was written as a supplement to the marketing of life insurance products. Tax laws relating to accelerated benefits are complex and limitations may apply. You are advised to consult with and rely on an independent tax advisor about your own particular circumstances.
Receipt of accelerated benefits may affect your eligibility, or that of your spouse or your family, for public assistance programs such as medical assistance (Medicaid), Temporary Assistance to Needy Families (TANF), Supplementary Social Security Income (SSI) and drug assistance programs. You are advised to consult with social service agencies concerning the effect that receipt of accelerated benefits will have on public assistance eligibility for you, your spouse or your family.

[2] Will Preparation Services are offered by Hyatt Legal Plans, Inc., Cleveland, Ohio. In certain states, Will Preparation services are provided through insurance coverage underwritten by Metropolitan Property and Casualty Insurance Company and Affiliates, Warwick, Rhode Island. For New York cases, the Will Preparation service is an expanded offering that includes office consultations and telephone advice for certain other legal matters beyond Will Preparation. Tax Planning and preparation of Living Trusts are not covered by the Will Preparation service.

[3]Estate Resolution Services are offered by Hyatt Legal Plans, Inc., Cleveland, Ohio. In certain states, Estate Resolution Services are provided through insurance coverage underwritten by Metropolitan Property and Casualty Insurance Company and Affiliates, Warwick, Rhode Island. The following are not covered by the Estate Resolution Service: Matters in which there is a conflict of interest between the executor, administrator, any beneficiary or heir and the estate; any disputes with the Policyholder, Employer, Plan Attorneys, MetLife and/or any of its affiliates; any disputes involving statutory benefits; Will contests or litigation outside Probate Court; Appeals; Court costs, filing fees, recording fees, transcripts, witness fees, expenses to a third party, judgments or fines; and frivolous or
unethical matters.

[5] Investment advisory services offered by MetLife Securities, Inc., 200 Park Ave., New York, NY 10166.

[7] Subject to state law, and/or group policyholder direction, the Total Control Account is provided for all Life and AD&D benefits of $5,000 or more. The TCA is not insured by the Federal Deposit Insurance Corporation or any government agency. The assets backing the TCA are maintained in MetLife's general account and are subject to MetLife's creditors. MetLife bears the investment risk of the assets backing the TCA, and expects to earn income sufficient to pay interest to TCA Accountholders and to provide a profit on the operation of the TCAs. Guarantees are subject to the financial strength and claims paying ability of MetLife.

This summary provides an overview of your plan's benefits. These benefits are subject to the terms and conditions of the contract between MetLife and Anne Arundel Community College and are subject to each state's laws and availability.
Specific details regarding these provisions can be found in the booklet certificate.

Life and AD&D coverages are provided under a group insurance policy (Policy Form GPNP99) issued to AACC by MetLife. Life and AD&D coverages under AACC's plan terminates when your employment ceases when your Life and AD&D contributions cease, or upon termination of the group contract. Dependent Life coverage will terminate when a dependent no longer qualifies as a dependent. Should your life insurance coverage terminate for reasons other than nonpayment of premium, you may convert it to a MetLife individual permanent policy without providing medical evidence of insurability.

An additional benefit provided by your employer through its partnership with Business Health Services.

What is the EAP?

Your Employee Assistance Program (EAP) provides you and your household members with free, confidential assistance to help with personal or professional problems that may interfere with work or family responsibilities. Services are available 24-hours a day, 7-days a week via a toll-free nationwide number. You and your household members can receive up to **4 face-to-face counseling sessions** (which include assessment, follow-up and referral services) per person, per problem episode, per year.

Program Cost

The Program is a free benefit provided and paid for by your employer. If additional help is needed, your health insurance plan may cover a portion of the costs.

Confidentiality

Business Health Services adheres to federal and state privacy laws and holds client information in the strictest of confidence. Information about a client's problem cannot be released without the written permission of that individual.

How Does It Work?

A Care Coordinator will confidentially assess the problem, assist with any emergencies and connect you to the appropriate resources. The Care Coordinator then becomes your personal point of contact and will keep in touch to ensure you are satisfied with all services provided.

Problems Addressed

Relationships
Spouse, Kids, Boss, Co-worker, Customers, Friends

Life Challenges
Stress, Conflict, Financial, Legal, Parenting, Illness

Life Changes
Marriage, Divorce, Birth, Death, Promotion, Retirement

Risks
Depression, Anxiety, Burnout, Anger, Alcohol, Drug Abuse

Online Resources

Your online resource library, contains over 500,000 resources to help improve your overall wellbeing. Browse through a variety of resources including articles, videos, health assessment tools, quizzes, and interactive tools. Access your password-protected online resource library and interactive website at:

www.bhsonline.com | username: AAC

Contact Your EAP

Help is just a phone call away. Simply call Business Health Services' toll-free number:

800.327.2251

Childcare Services

Balancing work and family life is increasingly difficult. Fortunately, the EAP can help make this part of life easier. BHS will provide up-to-date, carefully screened, national resources and referrals for a range of childcare needs including:

- Family Daycare & Group Homes
- Nurseries & Preschools
- Before & After School Programs
- Summer Camps
- Adoption & Special Needs
- Emergency & Back-Up Care
- Nanny & Au Pair Services

Eldercare Services

Americans are living longer. Needless to say, the needs of the elderly are increasing as well. Finding the right care for an aging loved one is very important, but isn't always easy. BHS provides up-to-date, national resources and referrals for a range of eldercare needs including:

- In-Home Care: Medical & Nursing Rehabilitation Services
- Home-Based Services: Nutrition, Meals on Wheels, Cleaning & Repair
- Inpatient Services: Nursing Homes, Intermediate Care Facilities, Respite Care, & Assisted Living Facilities
- Housing: Retirement Communities, Subsidized Housing
- Older Adult Services: Support/ Advocacy Groups, Volunteer Opportunities & Adult Day Care
- Transportation Services

Legal Services

Through BHS, you and your household members can access qualified attorneys to discuss legal matters. An unlimited number of telephonic legal consultations are available to you and each member of your household per problem episode, per year. Should further legal consultation be necessary, you will be connected to a local, pre-screened and appropriately credentialed attorney at a discounted rate. Legal matters commonly addressed under the program include:

- Domestic & Family Matters
- Landlord & Tenant Disputes
- Business Matters
- Motor Vehicle Violations
- IRS Matters
- Real Estate Concerns
- Criminal Charges

Financial Services

In need of financial services? The EAP provides unlimited telephonic financial counseling, information and education to you and your household members per problem, per year. Should you or your household member need further financial advice, you will be connected to a local advisor and/ or community resource at a discounted rate. Typical financial matters include:

- Debt Management & Consolidation
- College Funding
- Tax Planning & Preparation
- Retirement Funding
- Credit Counseling
- Budgeting

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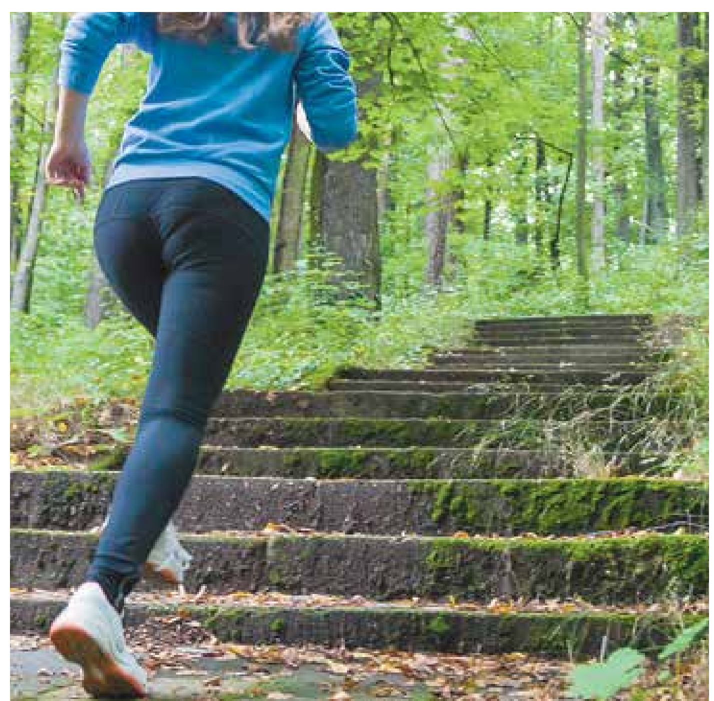
Wellness Tips and Information to Encourage a Year of Living Healthy



January – Depression Awareness

Depression is more than feeling sad – it is sadness, and losing interest in the things you enjoy. It's fatigue, aches and pains, and insomnia or excessive sleeping. It is irritability and hopelessness.

It is also a medical illness, not a sign of weakness. And it is treatable. If you feel you might be depressed, seek help now.

February – Schedule your Medical Exam!

Regular checkups can find problems before they start! They also can find concerns early, when chances for treatment and full recovery are better.

By getting the right health services, screenings and treatments, you are taking steps to help you live a longer, healthier life!

March – Start with a Healthy Breakfast

You have gone the whole night without eating – start your day with a healthy meal to provide energy and nutrients for your morning. This will help you avoid snacking until lunch and prevents the midmorning slump.

For a quick breakfast try scrambled eggs on a whole wheat English muffin with a piece of fruit. Too busy to make that – grab a breakfast bar that provides protein, carbohydrates and energy!

April – Financial Health

It is tax season – what a great time to think about your finances. According to an Employee Benefit Research survey quoted in **www.usatoday.com** more than half of active workers and a third of retirees are managing debt and are unable to focus on saving. There are some simple steps to take to manage your finances. You should assess your personal financial situation (debts and income), use calculators and online planning tools to create a road map focusing on saving, and implement that plan.

May – Allergies

One in five Americans has allergy/asthma symptoms! And 55 percent of Americans test positive to one or more allergens! Hay fever causes 4 million lost workdays each year (data from **www.webmd.com**).

Allergies are very common and easily treated. If you have persistent symptoms like itchy/watery eyes, sneezing, itchy/runny nose see your doctor to be evaluated for allergies. If you do have allergies, avoid your triggers!

June – Exercise

It's a lot easier to sit on the couch than it is to exercise – so here are five good reasons to get off the couch!

- It will keep you healthier. Give your heart a good workout – it's your most important muscle.
- It will help you lose weight (or maintain a healthy weight).
- You will feel better. Honestly. Once you start moving, even if you initially don't want to, you will have more energy.
- Exercise helps you sleep better.
- It can be fun. Grown-ups call it working out, kids call is playing. What would you rather do? Find something you love to do and get out there and do it!

July – Sun Safety

Overexposure to the sun causes many of the changes attributed to aging, like wrinkles, sagging, age spots and cancer. Luckily it is easy to protect yourself from the sun.

Try to avoid the sun between 10 a.m. and 2 p.m. when it is directly overhead. Uses sunscreen of at least 30 SPF and reapply often. Wear a hat and sunglasses. Make sure you check your skin for any changes and report them to your doctor.

August – Heart Health

Heart disease is the leading cause of death in America. The Mayo clinic offers these six tips to start doing now to keep your heart healthy into the future.

- Don't smoke or use tobacco.
- Exercise for 30 minutes most days of the week (remember that can be broken into smaller 10 minute segments).
- Eat a healthy diet with whole grains, low fat dairy, limit saturated fat and incorporate fish.
- Maintain a healthy weight.
- Get six-eight hours of sleep a night.
- Get regular checkups and know your numbers (blood pressure, cholesterol, etc).

September – Farmer's Market

Farmers markets are the perfect place to buy a variety of fresh fruits, vegetables, meats, dairy and other produce directly from farmers. Why should you buy at a farmers market? You can eat seasonally – the produce changes with the seasons. The food there is fresher – most grocery store produce travels more than 1,000 miles to get to your store. And the food tastes better.

Try something new, like kale or beets. If you don't know how to prepare them, ask the farm (or whoever sells you the produce) – he will be able to provide many ideas!

October – Portion Control

Don't be misled by portion distortion! The portion sizes served in America are often enough to feed two people – and are usually consumed by one. A great resource is **www.choosemyplate.gov** for detailing what amount you should be eating. Rather than the 16-ounce T-bone, a serving of meat should be 4 ounces – about the size of a deck of cards. Another example is bagels – 20 years ago they were half the size and 210 fewer calories than they are today.

Start small – serve your meals on smaller plates. Get a scale and measuring cups so you know exactly what that cup of pasta, or a serving of fruit looks like. Little changes will add up to big changes in your health and weight.

November – Smoking Cessation

Smoking is the leading cause of preventable death in America. If you needed more reasons to quit today, the American Lung Association has many good reasons. Quit smoking today and your body will start repairing itself – quit for your health. If a pack of cigarettes costs $5 and you smoke a pack a day – that is $1,825 every year – quit to save money. More and more locations are banning smoking making it inconvenient to smoke – quit to avoid the aggravation. Your house, clothes and air smell like cigarettes – quit to smell better.

If you are ready to quit, there are many free resources to help you through CareFirst, CIGNA, Anne Arundel County Health Department and **MDQuit.org**.

December – Stress Management

While stress is a good thing to spark action (the original fight or flight reflex), constant stress leads to many physical problems like racing heart, headaches, back aches, stiff neck and/or tight shoulders, upset stomach. Chronic stress can lead to very real physical problems.

Recognize that you are stressed and take time to RELAX. Take care of yourself by deep breathing, taking a warm bath, meditating or going on a walk. The important thing is to take a break from the thing causing you stress.

Resources are available:

CareFirst – www.carefirst.com

Cigna – www.cigna.com

Employee Assistance Program – www.bhsonline.com (password AAC) or 1-800-237-2251

Anne Arundel County Health Department – www.AAHealth.org

Benefits Eligibility

Who is Eligible for Benefits

Individuals eligible for benefits include:

- Full- or part-time (working 50 percent or more of the work week) permanent Anne Arundel Community College (AACC) employees are eligible for all benefits in this guide.

Eligible dependents include:

- Your legal spouse, as recognized in Maryland (not including common law spouses).
- Your child, including stepchild, adopted child or biological child, is eligible until the end of the month in which the child turns 26.
- Your dependent child of any age who is physically/mentally incapable of self-support (as specified through IRS guidelines) and whose disability began before age 26 and while the child was covered under the plan. Guardianship ends with the courts at age 18 and so does your coverage for the child unless you adopt them.
- Your dependent grandchild for whom you are the legal guardian.

Note: It is your responsibility to notify the Human Resources office each time you have a change in your eligible dependents and to notify the Human Resources office within 31 days of qualifying events such as marriage, a newborn's birth or loss of other insurance coverage.

Dependent Documentation

Dependent documentation is required with new employee benefit enrollments. Documentation also is required for dependents added to your plan during open enrollment and following a midyear qualifying event. Dependent documentation includes copies of your marriage certificate, dependent's birth certificates and dependent's Social Security cards. Birth registration notices are not accepted as proof of birth. Refer to the Making Midyear Changes section for information on dependent documentation.

Dependent Type and Documentation Needed

Spouse

- Copy of official state marriage certificate dated and signed by the appropriate state or county official.
- A copy of your spouse's Social Security card.
- A copy of Medicare card if your spouse is enrolled in Medicare.

Child

- Copy of child's official state birth certificate, dated and signed by the appropriate state. Note: Maryland Birth Registration Notices are not accepted as dependent documentation.
- For stepchildren, provide a copy of the child's official state birth certificate and a copy of your official state marriage certificate.
- For adopted children, provide a copy of the court order placing the child pending final adoption or a copy of the final adoption decree signed by a judge.
- For court appointed of grandchildren guardianships of 12 months or longer, provide a copy of court documents signed by a judge. Note: temporary custody and guardianships under 12 months are not eligible for college insurance enrollment.
- A copy of the child's Social Security card.
- A copy of Medicare card if the child is enrolled in Medicare.

Enrolling During Open Enrollment and Throughout the Year

Anne Arundel Community College's benefits fall into two different enrollment categories. Most benefits are limited-enrollment, allowing you to enroll only as a new hire, during the annual open enrollment period, or if you qualify to make a midyear change in coverage that is permitted under the plan (and under IRS rules).

Other benefits, such as voluntary benefits, allow you to enroll at any time during the year subject to any administrative procedures that may be imposed by the plan or insurance carrier. You may not change your elections midyear for limited-enrollment benefits except under conditions as described in the Making Midyear Changes section below.

Making Midyear Changes

If you wish to make a midyear change to your benefit elections, you must contact the AACC HR team within 31 days after the qualifying event and provide a benefits election form with supporting documentation. Your request must be consistent with the qualifying event. Proof of other coverage is required for midyear requests to cancel your coverage or your dependent coverage.

Examples of Qualifying Status Change Events:

- Change in dependents due to birth, adoption, marriage, divorce, death or reaching the maximum age limit for the plan.
- Involuntary loss of other medical insurance coverage for yourself or your dependents.
- You or your dependent child's enrollment in or loss or SCHIP, Medicaid, Medicare or Medical Assistance coverage.
- Employee moving out of the Blue Choice HMO serving area.
- Significant midyear change in cost or plan coverage in the AACC sponsored plans.

Coverage Level for Employees

Four coverage level options are available: Individual, Parent and Child, Employee and Spouse, or Family.

Duplicate Coverage

A husband and wife who both are active AACC employees and/or retirees may not have duplicate coverage under any plan by covering each other under separate enrollments. Also, children of two employees and/or retirees may not be covered twice under both parent's plans. This rule includes life insurance, medical, dental and vision coverage. It is your responsibility to make sure you or your dependents do not have duplicate college coverage. Duplicate benefits will not be paid, however, in the event benefits are paid, you will be responsible for reimbursing the college.

Special Enrollment Periods for Employees and Dependents

If you decline enrollment in the plan's health coverage options for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the plan's health coverage features if you or your dependents lose eligibility for that other coverage (or if an employer stops contributing toward your or your dependent's other coverage). However, you must request enrollment within 31 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

You (or your dependent) will be treated as losing eligibility for other coverage if the coverage is no longer available because you (or your dependent) have reached a lifetime limit for all benefits under that coverage. In that case, you must request enrollment within 31 days of the date that a claim is denied, in whole or in part, because of reaching that lifetime limit, or, if the other coverage is COBRA continuation coverage, within 31 days after a claim that would exceed the lifetime limit is incurred.

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

To request special enrollment or obtain more information, contact HR at **410-777-2425**.

Instructions for Benefits Enrollments and Midyear Changes

Event	Action Required	Enrollment Deadline	Coverage Effective Date
Open Enrollment Change & FSA Enrollment for 2017	1. Complete the Benefits Election Form 2. Send all required dependent documentation to the HR Office before the enrollment deadline.	Nov. 11, 2016	January 1, 2017
New Employee	1. Complete the Benefits Election Form 2. Send all required dependent documentation to the HR Office before the enrollment deadline.	31 days after Hire date	Coverage is effective on the 1st of the following month after date of hire.
Marriage	1. Complete the Benefits Election Form 2. Send all required dependent documentation to the HR Office before the enrollment deadline.	31 days after marriage	1st of the month following the marriage
Newborn	1. Complete the Benefits Election Form. Newborns will be temporarily enrolled for 30 days pending receipt of official birth certificate and social security card.	31 days after birth	Child's date of birth
Retirement	1. Complete the Benefits Election Form 2. Send all required dependent documentation to the HR Office before the enrollment deadline.	31 days after retirement date	Retirement Date
Moving out of HMO Service Area	Provide new address information to the HR Office	31 days after move	1st of month after move
Loss of Coverage Elsewhere	1. Complete the Benefits Election Form 2. Send a Certificate of Prior Coverage or employer letter listing the insurance end date, and all required dependent documentation to the HR Office before the enrollment deadline.	31 days after coverage end date	1st of month after coverage end date
Cancel Dependent Coverage Mid-Year	1. Complete the Benefits Election Form 2. Send proof of other coverage for the dependent such as letter from their employer or copy of insurance card to the HR Office.	N/A	1st of month following notice of change to the HR office. Retroactive adjustments are not allowed.
Divorce	1. Complete the Benefits Election Form 2. Send a copy of your divorce decree signed by a judge or court official to the HR Office.	31 days following divorce	Coverage for an ex-spouse ends at the end of the month of the divorce. Employees will be responsible for insurance claims incurred by ex-spouses who are not removed from the insurance plan within 31 days after the divorce.

Required Legal Notices for 2017

Notice: Health Information Privacy

For purposes of the health benefits offered under the plan, the plan uses and discloses health information about you and any covered dependents only as needed to administer the plan. To protect the privacy of health information, access to your health information is limited to such purposes. The health plan options offered under the plan will comply with the applicable health information privacy requirements of federal Regulations issued by the Department of Health and Human Services. The plan's privacy policies are described in more detail in the Notice of Health Information Privacy Practices or Privacy Notice available on the Human Resources Benefits intranet site. Contact the Human Resources office if you have questions about the plan's privacy policies.

Notice: The Women's Health and Cancer Rights Act of 1998 (WHCRA)

The Women's Health and Cancer Rights Act of 1998 (WHCRA) is a federal law that provides protection to patients who choose to have breast reconstruction in connection with a mastectomy. As required by the WHCRA, this plan provides coverage for:

- All stages of reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and physical complication of all stages of mastectomy, including lymphedema.

Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter.

NOTICE: The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA)

The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) affects the amount of time you and your newborn child are covered for a hospital stay following childbirth. In general, group health plans and health insurance issuers that are subject to NMHPA may NOT restrict benefits for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by Cesarean section. If you deliver in the hospital, the 48- or 96-hour period starts at the time of delivery. If you deliver outside the hospital and you are later admitted to the hospital in connection with childbirth, the period begins at the time of admission.

Although the NMHPA prohibits group health plans and health insurance issuers from restricting the length of a hospital stay in connection with childbirth, the plan or health insurance issuer does not have to cover the full 48 or 96 hours in all cases. If the attending provider, in consultation with the mother, determines that either the mother or the newborn child can be discharged before the 48- or 96-hour period, the group health plan and health insurance issuers do not have to continue covering the stay for whichever one of them is ready for discharge.

IMPORTANT: In order to have your newborn added to a policy, you must enroll the newborn through Human Resources within 31 days of birth.

NOTICE:
Nonassignment of Benefits

No participant or beneficiary may transfer, assign or pledge any plan benefits.

NOTICE:
Benefits Appeal Process

The college's benefit vendors are committed to processing claims in accordance with their contracts. If you have questions regarding how a claim was processed, first contact the plan's member services department. If the matter is not resolved by contacting member services, call Human Resources at 410-777-2425. The next step is to submit an appeal for review by an independent party. Your appeal request should include details about the claim including the date of service, physician or facility where the service was received, patient's name, membership ID number and why you believe the claim was improperly processed. Refer to the member handbook for deadlines for submitting an appeal.

Address your appeal to:

CVS Caremark
Prescription Claim Appeals MC109
P.O. Box 52084
Phoenix, AZ 85072-2084
Fax: 866-443-1172

CareFirst BlueChoice
Central Appeals and Analysis Unit
P.O. Box 14114
Lexington, KY 40512-4114

NOTICE:
Medicaid and the Children's Health Insurance Program (CHIP)

Free or Low-Cost Health Coverage to Children and Families

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from Anne Arundel Community College, your state may have a premium assistance program that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents already are enrolled in Medicaid or CHIP and you live in a state listed below, you can contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your state Medicaid or CHIP office or 877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 866-444-EBSA **(3272).**

Eligibility for State Assistance

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2016. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562

KANSAS - Medicaid	NEVADA - Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KENTUCKY - Medicaid	**NEW HAMPSHIRE - Medicaid**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA - Medicaid	**NEW JERSEY - Medicaid and CHIP**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE - Medicaid	**NEW YORK - Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS - Medicaid and CHIP	**NORTH CAROLINA - Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA - Medicaid	**NORTH DAKOTA - Medicaid**
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI - Medicaid	**OKLAHOMA - Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA - Medicaid	**OREGON - Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
NEBRASKA - Medicaid	**PENNSYLVANIA - Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462

RHODE ISLAND - Medicaid	VIRGINIA - Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH CAROLINA - Medicaid	**WASHINGTON - Medicaid**
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
SOUTH DAKOTA - Medicaid	**WEST VIRGINIA - Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
TEXAS - Medicaid	**WISCONSIN - Medicaid and CHIP**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
UTAH - Medicaid and CHIP	**WYOMING - Medicaid**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VERMONT- Medicaid	
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	

To see if any other states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2016)

Creditable Coverage Notice

Important Notice from Anne Arundel Community College About Your Prescription Drug Coverage and Medicare

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 Community College (AACC) 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. If you are considering joining, 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- 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 also may offer more coverage for a higher monthly premium.
- Anne Arundel Community College has determined that the prescription drug coverage offered by the Caremark Prescription Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from Oct. 15 to Dec. 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you also will be eligible for a two month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current AACC coverage will be affected. If you elect Part D coverage, coverage under Anne Arundel Community College's plan will end for you and all covered dependents.

Prescription Benefits with AACC's Caremark Plan:

Prescriptions obtained at Retail Pharmacy:

$5 copay for generic medications

$25 copay for preferred brand name medications

$35 copay for non-preferred brand name medications

Prescriptions obtained thru Caremark mail-order service (maintenance medications can be ordered through mailorder after first two retail fills) or obtained at a CVS pharmacy:

$10 copay for generic medications

$50 copay for preferred brand name medications

$70 copay for non-preferred brand name medications

If you decide to join a Medicare drug plan and drop your current AACC coverage, be aware that you and your dependents will be able to get this coverage back at the next open enrollment period.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

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

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1 percent of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium consistently may be at least 19 percent higher than the Medicare 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 office for information.

NOTE: You'll get this notice each year. You also will get it before the next period you can join a Medicare drug plan, and if this coverage through AACC changes. You also may request a copy of this notice at any time.

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, therefore, whether or not you are required to pay a higher premium (a penalty).

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 and You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You also may 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 and You" handbook for their telephone number) for personalized help.
- Call 800-MEDICARE (800-633-4227). TTY users should call 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

800-772-1213 (TTY 800-325-0778).

NAME OF ENTITY/SENDER:
Anne Arundel Community College

CONTACT – POSITION/OFFICE:
Human Resources, Attn: Benefits

ADDRESS:
101 College Parkway, Arnold, MD 21012

PHONE NUMBER:
410-777-2425

New Health Insurance Marketplace Coverage Options and Your Health Coverage

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

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact _
. Anne Arundel Community College, Human Resources, 410-777-2425, humanresources@aacc.edu

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

\

3. Employer name	4. Employer Identification Number (EIN)
Anne Arundel Community College	52-0905706
5. Employer address	6. Employer phone number
101 College Parkway	410-777-2425

7. City	8. State	9. ZIP code
Arnold	MD	21012

10. Who can we contact about employee health coverage at this job?
AACC Human Resources

11. Phone number (if different from above)	12. Email address
	Humanresourcces@aacc.edu

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

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☑ Some employees. Eligible employees are:
    Full-time or part-time permanent budgeted AACC employees (working 50 percent% or more of the work week).
- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are:
    Your legal spouse (not including common law spouse); your biological child, adopted child or stepchild is eligible until the end of month he/she turns 26; your disabled dependent child who is incapable of self-support (as specified by IRS guidelines whose disability began before age 26 and while the child was covered under the plan); your dependent child for whom you are the legal guardian.
  - ☐ We do not offer coverage.

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

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

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

Glossary of Health Coverage and Medical Terms

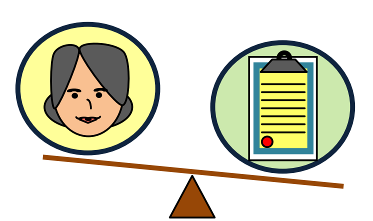
- This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- **Bold blue** text indicates a term defined in this Glossary.
- See page 4 for an example showing how **deductibles**, **co-insurance** and **out-of-pocket limits** work together in a real life situation.

Allowed Amount
Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your **provider** charges more than the allowed amount, you may have to pay the difference. (See **Balance Billing**.)

Appeal
A request for your health insurer or **plan** to review a decision or a **grievance** again.

Balance Billing
When a **provider** bills you for the difference between the provider's charge and the **allowed amount**. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A **preferred provider** may ***not*** balance bill you for covered services.

Co-insurance
Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the **allowed amount** for the service. You pay co-insurance ***plus*** any **deductibles** you owe. For example, if the **health insurance** or **plan's** allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

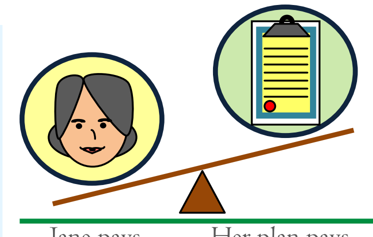


(See page 4 for a detailed example.)

Complications of Pregnancy
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Co-payment
A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible
The amount you owe for health care services your **health insurance** or **plan** covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.



(See page 4 for a detailed example.)

Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care **provider** for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition
An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation
Ambulance services for an **emergency medical condition**.

Emergency Room Care
Emergency services you get in an emergency room.

Emergency Services
Evaluation of an **emergency medical condition** and treatment to keep the condition from getting worse.

Excluded Services
Health care services that your **health insurance** or **plan** doesn't pay for or cover.

Grievance
A complaint that you communicate to your health insurer or **plan**.

Habilitation Services
Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance
A contract that requires your health insurer to pay some or all of your health care costs in exchange for a **premium**.

Home Health Care
Health care services a person receives at home.

Hospice Services
Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care
Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance
The percent (for example, 20%) you pay of the **allowed amount** for covered health care services to **providers** who contract with your **health insurance** or **plan**. In-network co-insurance usually costs you less than **out-of-network co-insurance.**

In-network Co-payment
A fixed amount (for example, $15) you pay for covered health care services to **providers** who contract with your **health insurance** or **plan**. In-network co-payments usually are less than **out-of-network co-payments.**

Medically Necessary
Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

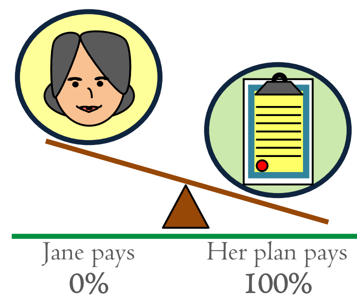
Network
The facilities, **providers** and suppliers your health insurer or **plan** has contracted with to provide health care services.

Non-Preferred Provider
A **provider** who doesn't have a contract with your health insurer or **plan** to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your **health insurance** or plan, or if your health insurance or plan has a "tiered" **network** and you must pay extra to see some providers.

Out-of-network Co-insurance
The percent (for example, 40%) you pay of the **allowed amount** for covered health care services to providers who do ***not*** contract with your **health insurance** or **plan**. Out-of-network co-insurance usually costs you more than **in-network co-insurance**.

Out-of-network Co-payment
A fixed amount (for example, $30) you pay for covered health care services from providers who do ***not*** contract with your **health insurance** or **plan**. Out-of-network co-payments usually are more than **in-network co-payments**.

Out-of-Pocket Limit
The most you pay during a policy period (usually a year) before your **health insurance** or **plan** begins to pay 100% of the **allowed amount**. This limit never includes your **premium**, **balance-billed** charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your **co-payments**, **deductibles**, **co-insurance** payments, out-of-network payments or other expenses toward this limit.



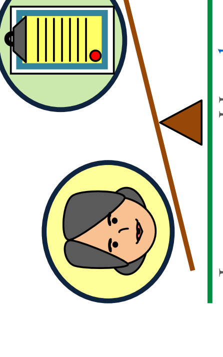
(See page 4 for a detailed example.)

Physician Services
Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

How You and Your Insurer Share Costs - Example

Jane's Plan Deductible: $1,500 **Co-insurance:** 20% **Out-of-Pocket Limit:** $5,000

January 1st Beginning of Coverage Period



Jane hasn't reached her $1,500 deductible yet

Her plan doesn't pay any of the costs.
Office visit costs: $125
Jane pays: $125
Her plan pays: $0

more costs

Jane pays 20% | Her plan pays 80%

Jane reaches her $1,500 deductible, co-insurance begins

Jane has seen a doctor several times and paid $1,500 in total. Her plan pays some of the costs for her next visit.
Office visit costs: $75
Jane pays: 20% of $75 = $15
Her plan pays: 80% of $75 = $60

more costs

Jane pays 0% | Her plan pays 100%

Jane reaches her $5,000 out-of-pocket limit

Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.
Office visit costs: $200
Jane pays: $0
Her plan pays: $200

December 31st End of Coverage Period

Plan
A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization
A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider
A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium
The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

Prescription Drug Coverage
Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs
Drugs and medications that by law require a prescription.

Primary Care Physician
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services
Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care
Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist
A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Notes

PLEASE TEAR OUT AND RETURN TO HUMAN RESOURCES, LUDL 106 BY FRIDAY, NOV. 11, 2016.

BENEFIT AUTHORIZATION FORM
FOR THE EMPLOYEES OF

ANNE ARUNDEL COMMUNITY COLLEGE

Datatel ID:______________________ Department: ______________

Name: ______________________ Work Phone: ______________

Address:____

City:______________________ State:__________ Zip: ________

If you want to continue your current benefit elections for Medical, Dental and Vision coverage and your current levels of coverage, please sign the bottom of this form and return it to the Office of Human Resources, LUDL 106, no later than November 11, 2016. Your signature below certifies that you want to continue programs for Medical, Dental and Vision coverage that are currently in place through the next plan year of January 1, 2017 to December 31, 2017. In addition, you are certifying that you understand that these elections will continue in force and cannot change unless you have a lifestyle change as designated by the IRS Code Section 125.

If you want to have a Health Care and/or Dependent Care Flexible Spending Account (FSA) for the next plan year of January 1, 2017 to December 31, 2017, you must fill out a new Election Form. Your current FSA contributions will not continue unless you fill out a new Election Form.

Election Forms can be obtained from the Office of Human Resources or at one of the scheduled on-campus open election meetings. Examples of elections include level of coverage (employee/spouse, family, etc.), participation in a Flexible Spending Account, Medical, Dental or Vision benefits, opt-out or other insurance information.

To comply with the Benefit Program guidelines, members of all healthcare plans will have thirty days (30) to make all lifestyle changes to their coverage. This includes adding a spouse or the birth of a baby, even if the member **currently** has family coverage. If lifestyle changes are not made within 30 days of the qualifying event, the member will have to wait until the next plan year's group open election period. Lifestyle changes shall be effective on the 1st of the month following the change if the Election Form is received in the Office of Human Resources between the 1st and the 15th of the month. Election Forms received in the Office of Human Resources between the 16th and the end of the month shall be effective on the first day of the second month following the change date.

If you do not sign and submit this form to the Office of Human Resources or complete a new Election Form by November 11, 2016, you will NOT have any Medical, Dental or Vision benefits during the next plan year beginning January 1, 2017.

Employee Signature: ______________________________ Date: ____________

Authorized Employer Signature:__________________________ Date: ____________

CareFirst BlueCross BlueShield is an independent licensee of the Blue Cross and Blue Shield Association

FGE5099-1N (9/16)

Contact Information

CAREFIRST BLUECHOICE
TRIPLE OPTION OPEN ACCESS PLAN
BLUECHOICE HMO OPEN ACCESS PLAN
CAREFIRST EPO PLAN
800-628-8549
410-268-6488 (Annapolis office)
www.carefirst.com
Email address: **AACG@carefirst.com;**
CareFirst will reply within 48 hours.
First help 24 hour Health Care Advice Line
800-535-9700

CIGNA DENTAL PPO OR DMO
800-CIGNA-24
800-244-6224
www.cigna.com

CAREMARK PRESCRIPTION PLAN
866-409-8521
www.caremark.com

CAREPLUS PHARMACY
2666 Riva Road Annapolis, Md.
410-573-1635

FLEXIBLE SPENDING ACCOUNTS
800-654-6695
FSA Claim Fax: **866-392-4090**
www.myspendingaccount.adp.com

HUMAN RESOURCES OFFICE
410-777-2425
FAX: 410-777-2014
Mail Stop: LUDL 106
Email Address: **humanresources@aacc.edu**

MAGELLAN MENTAL HEALTH
(CAREFIRST MEMBERS ONLY)
800-245-7013

METLIFE
Life Insurance: **866-492-6983**

VSP VISION PLAN
800-877-7195
FAX: **916-858-4985**
www.vsp.com