Benefits Reference Guide

For Medicare Eligible Retirees

Plan Year 2022
OPEN ENROLLMENT
October 1 – November 1, 2021

Anne Arundel County Public Library
Educate. Enrich. *Inspire*

TABLE *of Contents*

The Anne Arundel County Public Library provides a very generous benefits package toeligible Retirees. For more details about each plan, review the sections in this book, the summary plan documents on Eliza, or refer to the Contact Information for phone numbers and websites for each of the plans.

THIS BOOK IS NOT A CONTRACT

This book is a summary of general benefits available to Anne Arundel County Public Library eligible retirees, and reflects applicable Federal Health Reform Regulations as of August 2018. 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, 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. After you enroll, you will have access to a copy of the Benefit Guide for the health plan that you have selected. Please retain this information for your records. Benefits provided can be changed at any time without con- sent of the participants.

October 1, 2021

Dear Medicare Eligible Retiree:

Open Enrollment is your annual opportunity to review and make changes to your health insurance benefit plans, your insurance coverage level and/or your enrolled dependents. The Open Enrollment period for Plan Year 2022 is October 1 — November 1, 2021.

Rate Changes

The 2022 premiums reflect a minimal decrease for the Aetna Medicare Advantage Plan, and a minimal increase for the Dental HMO and Vision plans.

SilverScript Prescription Coverage

The Formulary and Pharmacy network may change at any time. You will receive notice from SilverScript when necessary. You have from October 1 until November 1 to make changes to your SilverScript coverage for next year. ** Please note: This prescription drug coverage is offered in conjunction with your medical coverage. If you choose a Medicare prescription drug plan other than SilverScript, you will lose your medical and prescription drug coverage provided by Anne Arundel County Public Library.

If you are not making any changes to your health benefits coverage, you do not have to do anything. We will continue your current benefits through December 31, 2022.

If you would like to make a change to your coverage for 2022, the enrollment form is available on our website, www.aacpl.net/retirees. You may also request that an enrollment form be mailed to you. These elections must be made before the Open Enrollment deadline on November 1, 2021. The elections you make during this group enrollment will remain in effect until December 31, 2022.

All required supporting documentation for changes that you make (i.e. birth certificates, adoption paperwork, marriage certificate, etc.) must be received by the Human Resources office by November 1, 2021. Documentation can be mailed to 5 Harry Truman Parkway, Annapolis, MD 21401 or sent via email to humanresources@aacpl.net.

Once Open Enrollment ends, benefit changes are only permitted within 31 days of a qualifying event. Qualifying events are outlined in the Retiree Guide under Instructions for Benefit Enrollments and Mid-year Changes.

Please call Human Resources at 410-222-7107 or email humanresources@aacpl.net with any questions.

Wishing you every continued happiness in your retirement.

Sincerely,

Koven Roundtree
Chief of Human Resources

VENDOR *Contact Information*

Your Medical Providers:

Aetna Medicare Advantage PPO ESA
1-888-267-2637
http://aacounty.aetnamedicare.com

Your Prescription Drug Providers:

Caremark Prescription Plan
1-866-409-8521
https://www.caremark.com

SilverScript Prescription Plan
1-800-706-9348
http://aacounty.silverscript.com

Your Dental Provider:

CIGNA Dental PPO or DMO
1-800-CIGNA-24 or 1-800-244-6224
https://mycigna.com

Your Vision Provider:

EyeMed
1-866-804-0982
https://www.EyeMed.com

Your Life Insurance Provider:

MetLife (Group Life Insurance)
1-800-638-6420

Human Resources
410-222-7107
FAX: 410-222-7188
Mailing address:
5 Harry S. Truman Parkway, Annapolis MD 21401
Email: humanresources@aacpl.net

BENEFITS *Fairs*

In - person Benefit Fairs will not be held this year.

Anne Arundel County Public Library

RETIREE *Rate Schedule*

Effective – 1/1/22 to 12/31/22

Retiree cost share of 20% for medical; 100% for dental; 100% for vision. This rate sheet reflects an employer retiree subsidy of 80%. For retirees who were not eligible for an early or normal retirement as of January 1, 2017, in accordance with Section 6-1-308(i) of the County Code, the employer subsidy rates vary and are based on years of service at the time of retirement. Please contact the Human Resources for specific subsidy rate information. Rates are on a monthly basis.

Retirees and/or your spouse must enroll in Medicare at age 65 (or when you first become eligible) to avoid Medicare's late-enrollment penalties and to receive the maximum coverage available.

Plan & Coverage Level	Total Cost	County Cost	Retiree Cost
Aetna Medicare Advantage			
Retiree	523.39	418.71	104.68
Retiree and Spouse	1046.78	837.42	209.36

CIGNA Dental Plans and EyeMed Vision Plan (Retirees Pay 100% of Cost for CIGNA Dental and EyeMed Vision)				
	Dental *HMO*	Dental PPO (CORE Plan)	Dental PPO (Buy Up Plan)	Vision
Individual	$19.15	$34.37	$53.13	$4.71
Retiree and Child	$38.30	$60.96	$94.26	$9.40
Retiree and Spouse	$48.65	$79.06	$122.23	$12.01
Family	$55.32	$87.86	$135.85	$13.64

Non-Medicare Plans	Total Cost	County Cost	Retiree Cost
Aetna Select HMO – EPO Open Access			
Retiree	$684.68	$547.74	$136.94
Retiree and Child	$1,235.71	$988.57	$247.14
Retiree and Spouse	$1,466.57	$1,173.26	$293.31
Family	$1,893.31	$1,514.65	$378.66
Aetna Open Choice PPO			
Retiree	875.39	700.31	175.08
Retiree and Child	1546.22	1236.98	309.24
Retiree and Spouse	1854.49	1483.59	370.90
Family	2408.29	1926.63	481.66

BENEFITS *Overview*

Medical Plan for Medicare Eligible Retirees

Retirees who are eligible for Medicare Parts A & B and Library health insurance may elect coverage through the Aetna Medicare Advantage PPO Plan with ESA (Extended Service Area). The Aetna Medicare Advantage plan is the only medical insurance option for retirees who are eligible for Medicare and dependents of retirees who are eligible for Medicare.

Library retirees and the dependents of retirees who are eligible for Medicare must enroll in both Medicare Parts A & B as soon as they are eligible (due to age or disability). If you are retired, or a dependent of a retiree and receiving Social Security Disability, you may be eligible to enroll in Medicare Part A&B even though you are under age 65. Refer to the Medicare & You section of this booklet for additional information. Please note that your legal name with Social Security (on your Medicare ID card) must match the name we put in our benefits system.

Dental and Vision Plan Options for Medicare Eligible Retirees

We offer 3 dental options with Cigna. We have the Cigna Dental HMO plan, the Cigna Dental PPO (Core) plan and the Cigna Dental PPO (Buy-up) plan. We offer one vision plan with EyeMed. Refer to the dental and vision plan descriptions in this booklet for plan highlights.

Prescription Drug Coverage for Medicare Eligible Retirees

Medicare eligible retirees enrolled in the Aetna Medicare Advantage PPO plan will be covered by the SilverScript prescription plan. Refer to the SilverScript plan description in this booklet for additional information.

Coverage for Dependents of Medicare Eligible Retirees

Eligible dependents are defined in the benefits eligibility section of this booklet. **Dependents may not be enrolled unless the retiree is also enrolled.**

In split family cases where the retiree and/or their dependent is eligible for Medicare and the other members are not, the person that is Medicare eligible will be enrolled in the Aetna Medicare Advantage plan and SilverScript Prescription Drug Plan and the other members will be enrolled in one of the two Aetna plans with Caremark as their prescription drug coverage.

Paying for Retiree Insurance Premiums

Premiums will be deducted from your monthly retirement annuity. If your retirement annuity is not large enough to cover any or all of your monthly plan premiums, you are responsible for paying your premiums directly to the Library. The Library will send you a quarterly bill that you can use to send in your payments. The premium payment for each quarter is due within 30 days of the bill date. Payment deadlines are strictly enforced. Coverage will be suspended if payment is not received by the due date. If payment is not received within the 30 day grace period, you will be dis-enrolled from the plans for which payments were not received and you will not be permitted to re-enroll until the next Open Enrollment period.

Voluntary Coverage Cancellation

Retirees who cancel their medical, dental or vision insurance through Anne Arundel County Public Library will be permitted to re-enroll during any Open Enrollment period or within 31 days of a qualifying event. Coverage for dependents of retirees will end when a retiree cancels their own insurance or are cancelled due to enrolling in another Medicare Medical Plan or Medicare Part D prescription drug plan, or when a dependent child reaches age 26.

MEDICARE *& You*

Frequently Asked Questions about Medicare

What is Medicare?

Medicare is health insurance for people age 65 or older, people under age 65 with certain disabilities, and people of any age with End-Stage Renal Disease.

What are the various parts of Medicare?

Medicare Part A	coverage for Hospital services & Skilled Nursing Care
Medicare Part B	coverage for Doctor and Outpatient services
Medicare Part C	a health care option, offered by a private insurer, that combines Part A & Part B coverage; sometimes referred to as Medicare Advantage
Medicare Part D	prescription drug coverage

When do I sign up for Medicare Parts A & B?

Contact the Social Security Administration at **1-800-772-1213** or visit **www.medicare.gov** to determine when you are eligible to enroll in Medicare. Spouses and dependents of retirees must enroll in Medicare as soon as they are eligible. Late enrollment penalties may apply if you do not enroll when you are first eligible.

Initial Enrollment period	Begins 3 months before your 65th birthday and ends 3 months after your 65th birthday.
General Enrollment period	Occurs annually between January 1 – March 31st. Late penalties may apply.
Special Enrollment period	Individuals who are currently working and enrolled in an employer sponsored health plan have a limited window to apply for Medicare A & B during the Special Enrollment period.

If I delay receiving Social Security payments, should I delay enrolling in Medicare?

No, the Library requires that you enroll in Medicare as soon as you are eligible. You can enroll in Medicare even if you are not receiving your Social Security benefit.

What happens if I am retired and decline Medicare Part B coverage even though I am eligible for it?

To be eligible for the Aetna Medicare Advantage PPO Plan, you must have Medicare Part A and Part B. If you are not enrolled in Medicare Part A & B, you will not have medical or prescription coverage through AACPL. Your dependents will also lose coverage through the Library medical and prescription plans.

What about Medicare fees and Penalties?

There is a monthly premium for Medicare Part B coverage. There are also penalties for individuals who do not enroll in Medicare timely. Other Medicare fees may apply based on your individual case. For additional details, contact the Social Security Administration at **1-800-772-1213** or visit **www.medicare.gov**.

ANNE ARUNDEL COUNTY PUBLIC LIBRARY, MARYLAND
Aetna Medicare℠ Plan (PPO)
Medicare (S01) ESA PPO Plan

Benefits and Premiums are effective January 1, 2022 through December 31, 2022

SUMMARY OF BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

Primary Care Physician (PCP): You have the option to choose a PCP. When we know who your doctor is, we can better support your care.

Referrals: Your plan doesn't require a referral from a PCP to see a specialist. Keep in mind, some providers may require a recommendation or treatment plan from your doctor in order to see you.

Prior Authorizations: Your doctor will work with us to get approval before you receive certain services. Benefits that may require a prior authorization are listed with an asterisk (*) in the benefits grid.

PLAN FEATURES	Network & out-of-network providers.
Monthly Premium	Please contact your former employer/union/trust for more information on your plan premium.
Annual Deductible	$0
This is the amount you have to pay out of pocket before the plan will pay its share for your covered Medicare Part A and B services.	
Annual Maximum Out-of-Pocket Amount	
Annual maximum out-of-pocket limit amount includes any deductible, copayment or coinsurance that you pay.	$2,000
It will apply to all medical expenses except Hearing Aid Reimbursement that may be available on your plan.	
HOSPITAL CARE*	**This is what you pay for network & out-of-network providers.**
Inpatient Hospital Care	$0 per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	
Observation Care	Your cost share for Observation Care is based upon the services you receive.
Outpatient Services & Surgery	$65
Ambulatory Surgery Center	$65

PHYSICIAN SERVICES	This is what you pay for network & out-of-network providers.
Primary Care Physician Visits	$10
Includes services of an internist, general physician, family practitioner for routine care as well as diagnosis and treatment of an illness or injury and in-office surgery.	
Physician Specialist Visits	$20
PREVENTIVE CARE	**This is what you pay for network & out-of-network providers.**
Medicare-covered Preventive Services	$0

- Abdominal aortic aneurysm screenings
- Alcohol misuse screenings and counseling
- Annual Well Visit - One exam every 12 months.
- Breast exams
- Breast cancer screening: mammogram - one baseline mammogram for members age 35-39; and one annual mammogram for members age 40 & over.
- Cardiovascular behavior therapy
- Cardiovascular disease screenings
- Cervical and vaginal cancer screenings (Pap) - one routine GYN visit and pap smear every 24 months. All asymptomatic female patients aged 30-65 years.
- Depression screenings
- Diabetes screenings
- HBV infection screening
- Hepatitis C screening tests
- HIV screenings - annually for patients younger than 15 and adults older than 65 at increased risk for HIV infection
- Lung cancer screenings and counseling - Aged 55–77
- Nutrition therapy services
- Obesity behavior therapy
- Pelvic Exams - one routine GYN visit and pap smear every 24 months. All asymptomatic female patients aged 30-65 years.
- Prolonged Preventive Services - prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service

• Prostate cancer screenings (PSA) - for all male patients aged 50 and older (coverage begins the day after 50th birthday)	
• Sexually transmitted infections screenings and counseling	
• Tobacco use cessation counseling	
• Welcome to Medicare preventive visit	
• Bone mass measurements	$0
• Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) - For all members aged 50 to 85 years	$0
• Medicare Diabetes Prevention Program - 12 months of core session for program eligible members with an indication of pre-diabetes.	$0
Immunizations	$0
• Flu	
• Hepatitis B	
• Pneumococcal	
Additional Medicare Preventive Services	$0
• Barium enema - one exam every 12 months.	
• Diabetes self-management training (DSMT)	
• Digital rectal exam (DRE)	
• EKG following welcome exam	
• Glaucoma screening	
EMERGENCY AND URGENT MEDICAL CARE	**This is what you pay for network & out-of-network providers.**
Emergency Care; Worldwide (waived if admitted)	$50
Urgently Needed Care; Worldwide	$35

DIAGNOSTIC PROCEDURES*	This is what you pay for network & out-of-network providers.
Diagnostic Radiology MRI and CT scans	$20
Lab Services	$10
Diagnostic testing & procedures	$10
Outpatient X-rays	$10
HEARING SERVICES	**This is what you pay for network & out-of-network providers.**
Routine Hearing Screening One exam every 12 months.	$0
Medicare Covered Hearing Examination	$20
Hearing Aid Reimbursement Applies to in or out of network	$3,000 once every 12 months
DENTAL SERVICES	**This is what you pay for network & out-of-network providers.**
Medicare Covered Dental* Non-routine care covered by Medicare.	$10
VISION SERVICES	**This is what you pay for network & out-of-network providers.**
Routine Eye Exams One annual exam every 12 months.	$0
Diabetic Eye Exams	$0

MENTAL HEALTH SERVICES*	This is what you pay for network & out-of-network providers.
Inpatient Mental Health Care	$0 per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	
Outpatient Mental Health Care	$10
Individual visit	
Inpatient Substance Abuse	$0 per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	
Outpatient Substance Abuse	$10
Individual visit	
SKILLED NURSING SERVICES*	**This is what you pay for network & out-of-network providers.**
Skilled Nursing Facility (SNF) Care	$0 per day, days 1-100
Limited to 100 days per Medicare Benefit Period.	
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	
A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.	
PHYSICAL THERAPY SERVICES*	**This is what you pay for network & out-of-network providers.**
Outpatient Rehabilitation Services	$0
(Speech, physical, and occupational therapy)	
AMBULANCE SERVICES	**This is what you pay for network & out-of-network providers.**
Ambulance Services	$0
Prior authorization rules may apply for non-emergency transportation services received in-network. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of non-emergency transportation services when provided by an out-of-network provider.	
TRANSPORTATION SERVICES	**This is what you pay for network & out-of-network providers.**
Transportation (non-emergency)	24 trips with 60 miles allowed per trip

MEDICARE PART B PRESCRIPTION DRUGS*	This is what you pay for network & out-of-network providers.
Medicare Part B Prescription Drugs	$0
ADDITIONAL PROGRAMS AND SERVICES	**This is what you pay for network & out-of-network providers.**
Allergy Shots	$0
Allergy Testing	$20
Blood	All components of blood are covered beginning with the first pint.
Cardiac Rehabilitation Services	$20
Chiropractic Services* Medicare covered benefits only.	$20
Diabetic Supplies* Includes supplies to monitor your blood glucose.	$0
Durable Medical Equipment/ Prosthetic Devices*	4%
Home Health Agency Care*	$0
Hospice Care	Covered by Original Medicare at a Medicare certified hospice.
Outpatient Dialysis Treatments*	$20
Podiatry Services Medicare covered benefits only.	$20
Pulmonary Rehabilitation Services	$20
Radiation Therapy*	$20

ADDITIONAL PROGRAMS (NOT COVERED BY ORIGINAL MEDICARE)	This is what you pay for network & out-of-network providers.
Fitness Benefit	SilverSneakers
Meals	Covered up to 14 meals following an inpatient stay.
Resources For Living®	Covered
For help locating resources for every day needs.	
Teladoc™	$10
Telemedicine services with a Teladoc™ provider. State mandates may apply.	
Telehealth	Covered
Telemedicine Services. Member cost share will apply based on services rendered.	
Telehealth PCP	$10
Telehealth Specialist	$20
Telehealth Other Health care Providers	$20
Telehealth Individual Mental Health	$10
Telehealth Group Mental Health	$10
Telehealth Individual Psychiatric Services	$10
Telehealth Group Psychiatric Services	$10
Telehealth Urgent care	$35
Wigs*	$0

ADDITIONAL SERVICES (NOT COVERED BY ORIGINAL MEDICARE)	This is what you pay for network & out-of-network providers.
Acupuncture	$0
unlimited. In lieu of anesthesia and chronic pain.	
Routine Physical Exams	$0
One exam per calendar year	

Benefits that may require a prior authorization are listed with an asterisk (*) in the benefits grid.

Medical Disclaimers

For more information about Aetna plans, go to www.AetnaRetireePlans.com or call Member

Services at toll-free at 1-888-267-2637 (TTY: 711). Hours are 8 a.m. to 9 p.m. EST, Monday through Friday.

The provider network may change at any time. You will receive notice when necessary.

Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.

In case of emergency, you should call 911 or the local emergency hotline. Or you should go directly to an emergency care facility.

The complete list of services can be found in the Evidence of Coverage (EOC). You can request a copy of the EOC by contacting Member Services at 1-888-267-2637 (TTY: 711). Hours are 8 a.m. to 9 p.m. EST, Monday through Friday.

The following is a partial list of what isn't covered or limits to coverage under this plan:

- Services that are not medically necessary unless the service is covered by Original Medicare or otherwise noted in your Evidence of Coverage
- Plastic or cosmetic surgery unless it is covered by Original Medicare
- Custodial care
- Experimental procedures or treatments that Original Medicare doesn't cover
- Outpatient prescription drugs unless covered under Original Medicare Part B

You may pay more for out-of-network services. Prior approval from Aetna is required for some network services. For services from a non-network provider, prior approval from Aetna is recommended. Providers must be licensed and eligible to receive payment under the federal Medicare program and willing to accept the plan.

Out-of-network/non-contracted providers are under no obligation to treat Aetna members, except in emergency situations. Please call our Customer Service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Aetna will pay any non contracted provider (that is eligible for Medicare payment and is willing to accept the Aetna Medicare Plan) the same as they would receive under Original Medicare for Medicare covered services under the plan.

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Plan Disclaimers

Aetna Medicare is a HMO, PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal.

Plans are offered by Aetna Health Inc., Aetna Health of California Inc., and/or Aetna Life Insurance Company (Aetna).

If there is a difference between this document and the Evidence of Coverage (EOC), the EOC is considered correct.

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

You can read the *Medicare & You 2022* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (http://www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-888-267-2637 (TTY: 711). Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-267-2637 (TTY: 711). Traditional Chinese: 注意：如果您使用中文，您可以免費獲得語言援助服務。請致電 1-888-267-2637 (TTY: 711).

You can also visit our website at http://www.aetnaretireeplans.com. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug List).

*****This is the end of this plan benefit summary*****

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Safe, comfortable transportation to your medical appointments

We don't want you to worry about how you'll get to your medical appointments. Instead, we want you to focus on what matters, like your health and treatment plans. That's why Aetna offers optional, non-emergency transportation that gets you there and back.

If you need to reserve a ride, call **1-855-814-1699 (TTY: 711)**, Monday – Friday, 8 a.m. to 8 p.m. all time zones. You can also reserve a ride or get more details at **www.access2care.net**.

These rides are included with your plan **at no extra cost**.

You can check your Evidence of Coverage or call the number above for information on trip and mileage allowances. Rides are provided through Access2Care℠. If you need a ride to and from the doctor, you'll use two trips.

Here are some examples* of how members may use the benefit

- Diane's son can take her to an appointment with her cardiologist, but he has to pick up his kids later and can't make the return trip. Diane uses one trip of her transportation benefit to get home from the doctor.
- John's neighbor Mary usually takes him to check-ups with his primary care doctor, but she's busy on one appointment day. John needs a ride both to and from the doctor, so he uses two trips.

* These are illustrative examples only, not actual member experiences.

Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premium and/or co-payments/co-insurance may change on January 1 of each year. See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage.

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medicare solutions

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SILVERSCRIPT *Prescription Drug Plan*

Annual Deductible	N/A			
Initial Coverage Level	The plan pays its share of the cost of your drugs and you pay your share of the cost. You stay in this stage until your payments for the year plus the plan's payments total $4,430.			
Prescription Benefit	**Network Retail** (up to 30-day supply)	**Network Retail** (up to 90-day supply)	**Network Mail Service** (up to 90-day supply)	**Network Retail** (up to 90-day supply)
Generic Drugs	$5.00	$10.00	$10.00	$25.00
Preferred Brand Drugs	$25.00	$50.00	$50.00	$65.00
Non Preferred Brand Drugs	$35.00	$70.00	$70.00	$85.00
Tier 4 Drugs *(90-day supplies are not available for Drugs over $670)*	$35.00	N/A	N/A	N/A
Coverage Gap	The plan offers coverage through the Coverage Gap.			
Generic Drugs	$5.00	$10.00	$10.00	$25.00
Preferred Brand Drugs	$25.00	$50.00	$50.00	$65.00
Non Preferred Brand Drugs	$35.00	$70.00	$70.00	$85.00
Tier 4 Drugs *(90-day supplies are not available for Drugs over $670)*	$35.00	N/A	N/A	N/A
Catastrophic Coverage	You qualify for Catastrophic Coverage once your true out-of-pocket (also known as TrOOP) costs reach $7,050 for the year. During Catastrophic Coverage you will pay no more than: the greater of 5% coinsurance or $3.95 for generics (or drugs treated as generic) and $9.85 for all other drugs. The 5% co-insurance amount will not exceed the copay amounts listed in the Initial Coverage Level section above.			
Generics *(including brand drugs treated as generic)*	$3.95 or 5%; The 5% co-insurance amount will not exceed the copay amounts listed in the Initial Coverage Level section above.			
All other drugs	$9.85 or 5%; The 5% co-insurance amount will not exceed the copay amounts listed in the Initial Coverage Level section above.			
Out-of-Network	Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from SilverScript (Employer PDP) for its share of the costs. Please refer to your Evidence of Coverage for more information.			

Frequently Asked Questions about the Silverscript Prescription Plan

❶ What is the SilverScript Prescription Plan for Medicare eligible Anne Arundel County retirees?

The SilverScript plan is a Medicare Part D prescription drug plan, with additional benefits for the "Donut Hole" Coverage Gap and the "Catastrophic Coverage Level." SilverScript, an affiliate of CVS Caremark, is an approved Medicare Part D Prescription Drug Plan provider.

❷ Who is eligible for the SilverScript Prescription Plan?

- Anne Arundel County retirees who are eligible for Medicare due to age or disability and enrolled in the Aetna medical plan.
- Dependents of Anne Arundel County retirees who are eligible for Medicare due to age or disability (the AA County retiree must also be enrolled in a County sponsored health plan).

❸ What prescription drug coverage will be available for non-Medicare-eligible dependents with a Medicare eligible family member?

Non-Medicare-eligible participants will be enrolled in the Caremark prescription plan.

❹ Is the reimbursement for out-of-network pharmacies the same as in-network pharmacies?

Members who use an out-of-network pharmacy must file a paper claim directly with SilverScript. The Silverscript network includes over 68,000 participating pharmacies including national, regional chain and grocery store pharmacies such as CVS, Walmart, Target, Rite-Aid, Giant & Safeway, plus many independent community-based pharmacies.

❺ What should I know about 90-day prescription supplies?

- There is a higher copay for 90-day prescriptions not filled at CVS pharmacy or through the Caremark Mail Service pharmacy.
- 90-day prescriptions are not available for Tier 4 Drugs over $670. (These prescriptions must be filled in 30-day supplies.)

❻ How will Part D vs. Part B medications be covered going forward?

Some medications may require additional authorization; however, the drug will continue to be covered once the authorization is completed.

❼ If I decide to opt out of the SilverScript plan, can I retain medical coverage?

No, if you choose to decline the SilverScript coverage, you will not be eligible for coverage in an AA County sponsored medical insurance plan.

❽ Can I reenroll in the plan after opting out of the SilverScript plan?

You can reenroll during the next Anne Arundel County Open Enrollment period.

❾ What happens when a member reaches age 65 – what is the process and who should they call?

Enroll in Medicare as soon as you're eligible. In general, you can apply for Medicare beginning 3 months before you reach age 65. The AA County Benefits Team will send a letter with additional information about Aetna Medicare Advantage PPO and SilverScript to you about 90 days before you reach age 65.

❿ I have a PO Box, but not a street address; can I use my PO Box address?

CMS (Medicare) requires that we have a street address on every member.

Note: Members may still have a PO Box for their mailing address.

⓫ Where can I find the formulary for the SilverScript plan?

An abridged formulary (containing commonly dispensed medications) will be mailed to you by mid-December. The complete unabridged formulary is available at **http://aacounty.silverscript.com**.

⓬ What is the Income-Related Monthly Adjustment Amount (or IRMAA)?

If your modified adjusted gross income is above a certin amount, you may pay a Part D income-related monthly adjustment amount (Part D-IRMAA). Medicare uses the modified adjusted gross income reported on your IRS tax return from 2 years ago (the most recent tax return information provided to Social Security by the IRS). You'll pay the Part D-IRMAA amount in adition to your monthly plan premium, and this extra amount is paid directly to capital Madicare, not to your plan. Social Security will contact you if you have to pay Part D-IRMAA, based on your income. The amount you pay can change each year. If you have to pay a higher amount for your Part D premium and you disagree (for example, if your income goes down) use this form **https://www.ssa.gov/forms/ssa-44.pdf**. If Social Security notifies you about paying a higher amount for your Part D coverage, you're required by law to pay the Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA). If you don't pay the Part D-IRMAA, you'll lose your Part D coverage which means that you lose coverage under SilverScript.

⓭ Who should I contact if I have additional questions?

Contact SilverScript Customer Care at 1-800-706-9348 or visit **http://aacounty.silverscript.com**

CIGNA *Dental PPO (Core and Buy Up Options)*

The CIGNA Dental PPO (DPPO) plans balance 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 for the Dental PPO (Core) plan. This is for in or out of network. There is a $2,000 maximum benefit per person per calendar year for the Dental PPO (Buy Up) plan in network and a $1,500 maximum benefit for out of network.

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 money 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 logging 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 County and is adjusted by geographic location.

Contacting CIGNA

Visit us online – Register on www.myCIGNA.com, a secure on-line tool that 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 can also help you find a network general dentist near you. For toll-free customer service nationwide, call the number on your ID card or 1-800-CIGNA24.

Cigna Dental Benefit Summary
Anne Arundel County Government Core
Plan Renewal Date: 01/01/2022

Administered by: Cigna Health and Life Insurance Company

This material is for informational purposes only and is designed to highlight some of the benefits available under this plan. Consult the plan documents to determine specific terms of coverage relating to your plan. Terms include covered procedures, applicable waiting periods, exclusions and limitations. **Your DPPO plan allows you to see any licensed dentist, but using an in-network dentist may minimize your out-of-pocket expenses.**

Cigna Dental PPO				
Network Options	*In-Network:* **Total Cigna DPPO Network**		*Non-Network:* **See Non-Network Reimbursement**	
Reimbursement Levels	Based on Contracted Fees		Maximum Reimbursable Charge	
Calendar Year Benefits Maximum Applies to: Class I, II & III expenses	$1,000		$1,000	
Calendar Year Deductible Individual Family	$10 $25		$10 $25	
Benefit Highlights	*Plan Pays*	*You Pay*	*Plan Pays*	*You Pay*
Class I: Diagnostic & Preventive Oral Evaluations Prophylaxis: routine cleanings X-rays: routine X-rays: non-routine Fluoride 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 Restorative: fillings Endodontics: minor and major Periodontics: minor and major Oral Surgery: minor and major Anesthesia: general and IV sedation Repairs: bridges, crowns and inlays Repairs: dentures Denture Relines, Rebases and Adjustments	100% After Deductible	0% After Deductible	100% After Deductible	0% After Deductible
Class III: Major Restorative Inlays and Onlays Prosthesis Over Implant Crowns: prefabricated stainless steel / resin Crowns: permanent cast and porcelain Bridges and Dentures	80% After Deductible	20% After Deductible	80% After Deductible	20% After Deductible
Class IV: Orthodontia Coverage for Dependent Children to age 26 Lifetime Benefits Maximum: $1,000	50% After Deductible	50% After Deductible	50% After Deductible	50% After Deductible
Benefit Plan Provisions:				
In-Network Reimbursement	For services provided by a Cigna Dental PPO network dentist, Cigna Dental will reimburse the dentist according to a Fee Schedule or Discount Schedule.			
Non-Network Reimbursement	For services provided by a non-network dentist, Cigna Dental will reimburse according to the Maximum Reimbursable Charge. The MRC is calculated at the 90th percentile of all provider submitted amounts in the geographic area. The dentist may balance bill up to their usual fees.			
Cross Accumulation	All deductibles, plan maximums, and service specific maximums cross accumulate between in and out of network. Benefit frequency limitations are based on the date of service and cross accumulate between in and out of network.			
Calendar Year Benefits Maximum	The plan will only pay for covered charges up to the yearly Benefits Maximum, when applicable. Benefit-specific Maximums may also apply.			
Calendar Year Deductible	This is the amount you must pay before the plan begins to pay for covered charges, when applicable. Benefit-specific deductibles may also apply.			

Carryover Provision	Dental Expenses incurred and applied toward the Individual or Family Deductible during the last 3 months of the calendar year will be applied toward the next year's Deductible.
Pretreatment Review	Pretreatment review is available on a voluntary basis when dental work in excess of $200 is proposed.
Alternate Benefit Provision	When more than one covered Dental Service could provide suitable treatmen t based on common dental standards, Cigna will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.
*Oral Health Integration Program**	The program offers enhanced dental coverage for customers with the following: cardiovascular conditions, cerebrovascular conditions (stroke), diabetes, maternity, chronic kidney disease (CKD), organ transplants, head and neck cancer radiation, rheumatoid arthritis, Sjogren's syndrome, lupus, Parkinson's disease, amyotrophic lateral sclerosis (ALS), Huntington's disease, and opioid misuse and addiction. There is no additional charge for the program. Those who qualify can receive reimbursement of their coinsurance for eligible dental services. Eligible customers can also receive guidance on behavioral issues related to oral health. Reimbursements under this program are not subject to the annual deductible, but will be applied to the plan annual maximum. For more information on how to enroll in this program and a complete list of terms and eligible conditions, go to www.mycigna.com or call customer service 24/7 at 1-800-Cigna24.
Timely Filing	Out of network claims submitted to Cigna after 365 days from date of service will be denied.
Benefit Limitations:	
Missing Tooth Limitation	Teeth missing prior to coverage effective date are not covered for 24 months.
Oral Evaluations/Exams	2 per calendar year.
X-rays (routine)	Bitewings: 2 per calendar year.
X-rays (non-routine)	Complete series of radiographic images and panoramic radiographic images: Limited to a combined total of 1 per 36 months.
Diagnostic Casts	Payable only in conjunction with orthodontic workup.
Cleanings	2 per calendar year, including periodontal maintenance procedures following active therapy.
Fluoride Application	1 per calendar year for children under age 19.
Sealants (per tooth)	Limited to posterior tooth. 1 treatment per tooth every 36 months for children under age 14.
Space Maintainers	Limited to non-orthodontic treatment for children under age 19.
Inlays, Crowns, Bridges, Dentures and Partials	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.
Denture and Bridge Repairs	Reviewed if more than once.
Denture Relines, Rebases and Adjustment s	Covered if more than 6 months after installation.
Prosthesis Over Implant	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.

Benefit Exclusions:

Covered Expenses will not include, and no payment will be made for the following:

- Procedures and services not included in the list of covered dental expenses;
- Diagnostic: cone beam imaging;
- Preventive Services: instruction for plaque control, oral hygiene and diet;
- Restorative: veneers of porcelain, ceramic, resin, or acrylic materials on crowns or pontics on or replacing the upper and or lower first, second and/or third molars;
- Periodontics: bite registrations; splinting;
- Prosthodontic: precision or semi-precision attachments;
- Implants: implants or implant related services;
- Procedures, appliances or restorations, except full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of dysfunction of the temporomandibular joint (TMJ), stabilize periodontally involved teeth or restore occlusion;
- Athletic mouth guards;
- Services performed primarily for cosmetic reasons;
- Personalization or decoration of any dental device or dental work;
- Replacement of an appliance per benefit guidelines;
- Services that are deemed to be medical in nature;

- Services and supplies received from a hospital;
- Drugs: prescription drugs;
- Charges in excess of the Maximum Reimbursable Charge.

This document provides a summary only. It is not a contract. If there are any differences between this summary and the offici al plan documents, the terms of the official plan documents will prevail.

Product availability may vary by location and plan type and is subject to change. All group dental insurance policies and dental benefit plans contain exclusions and limitations. For costs and details of coverage, review your plan documents or contact a Cigna representative.

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Cigna Dental Benefit Summary
Anne Arundel County Government Buy Up
Plan Renewal Date: 01/01/2022

Administered by: Cigna Health and Life Insurance Company

This material is for informational purposes only and is designed to highlight some of the benefits available under this plan. Consult the plan documents to determine specific terms of coverage relating to your plan. Terms include covered procedures, applicable waiting periods, exclusions and limitations. **Your DPPO plan allows you to see any licensed dentist, but using an in-network dentist may minimize your out-of-pocket expenses.**

Cigna Dental PPO				
Network Options	*In-Network:* **Total Cigna DPPO Network**		*Non-Network:* **See Non-Network Reimbursement**	
Reimbursement Levels	Based on Contracted Fees		Maximum Reimbursable Charge	
Calendar Year Benefits Maximum Applies to: Class I, II & III expenses	$2,000		$1,500	
Calendar Year Deductible Individual Family	$25 $50		$50 $100	
Benefit Highlights	*Plan Pays*	*You Pay*	*Plan Pays*	*You Pay*
Class I: Diagnostic & Preventive Oral Evaluations Prophylaxis: routine cleanings X-rays: routine X-rays: non-routine Fluoride Application Sealants: per tooth Space Maintainers: non-orthodontic Emergency Care to Relieve Pain	100% No Deductible	No Charge	90% No Deductible	10% No Deductible
Class II: Basic Restorative Restorative: fillings Endodontics: minor and major Periodontics: minor and major Oral Surgery: minor and major Anesthesia: general and IV sedation Repairs: bridges, crowns and inlays Repairs: dentures Denture Relines, Rebases and Adjustments	100% After Deductible	0% After Deductible	90% After Deductible	10% After Deductible
Class III: Major Restorative Inlays and Onlays Prosthesis Over Implant Crowns: prefabricated stainless steel / resin Crowns: permanent cast and porcelain Bridges and Dentures	80% After Deductible	20% After Deductible	70% After Deductible	30% After Deductible
Class IV: Orthodontia Coverage for Dependent Children to age 26 Lifetime Benefits Maximum: In-Network: $2,000 Out-of-Network: $1,500	50% After Deductible	50% After Deductible	50% After Deductible	50% After Deductible
Benefit Plan Provisions:				
In-Network Reimbursement	For services provided by a Cigna Dental PPO network dentist, Cigna Dental will reimburse the dentist according to a Fee Schedule or Discount Schedule.			
Non-Network Reimbursement	For services provided by a non-network dentist, Cigna Dental will reimburse according to the Maximum Reimbursable Charge. The MRC is calculated at the 90th percentile of all provider submitted amounts in the geographic area. The dentist may balance bill up to their usual fees.			
Cross Accumulation	All deductibles, plan maximums, and service specific maximums cross accumulate between in and out of network. Benefit frequency limitations are based on the date of service and cross accumulate between in and out of network.			
Calendar Year Benefits Maximum	The plan will only pay for covered charges up to the yearly Benefits Maximum, when applicable. Benefit-specific Maximums may also apply.			

Calendar Year Deductible	This is the amount you must pay before the plan begins to pay for covered charges, when applicable. Benefit-specific deductibles may also apply.
Carryover Provision	Dental Expenses incurred and applied toward the Individual or Family Deductible during the last 3 months of the calendar year will be applied toward the next year's Deductible.
Pretreatment Review	Pretreatment review is available on a voluntary basis when dental work in excess of $200 is proposed.
Alternate Benefit Provision	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.
*Oral Health Integration Program**	The program offers enhanced dental coverage for customers with the following: cardiovascular conditions, cerebrovascular conditions (stroke), diabetes, maternity, chronic kidney disease (CKD), organ transplants, head and neck cancer radiation, rheumatoid arthritis, Sjogren's syndrome, lupus, Parkinson's disease, amyotrophic lateral sclerosis (ALS), Huntington's disease, and opioid misuse and addiction. There is no additional charge for the program. Those who qualify can receive reimbursement of their coinsurance for eligible dental services. Eligible customers can also receive guidance on behavioral issues related to oral health. Reimbursements under this program are not subject to the annual deductible, but will be applied to the plan annual maximum. For more information on how to enroll in this program and a complete list of terms and eligible conditions, go to www.mycigna.com or call customer service 24/7 at 1-800-Cigna24.
Timely Filing	Out of network claims submitted to Cigna after 365 days from date of service will be denied.
Benefit Limitations:	
Missing Tooth Limitation	Teeth missing prior to coverage effective date are not covered for 24 months.
Oral Evaluations/Exams	2 per calendar year.
X-rays (routine)	Bitewings: 2 per calendar year.
X-rays (non-routine)	Complete series of radiographic images and panoramic radiographic images: Limited to a combined total of 1 per 36 months.
Diagnostic Casts	Payable only in conjunction with orthodontic workup.
Cleanings	2 per calendar year, including periodontal maintenance procedures following active therapy.
Fluoride Application	1 per calendar year for children under age 19.
Sealants (per tooth)	Limited to posterior tooth. 1 treatment per tooth every 36 months for children under age 14.
Space Maintainers	Limited to non-orthodontic treatment for children under age 19.
Inlays, Crowns, Bridges, Dentures and Partials	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.
Denture and Bridge Repairs	Reviewed if more than once.
Denture Relines, Rebases and Adjustments	Covered if more than 6 months after installation.
Prosthesis Over Implant	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.

Benefit Exclusions:
Covered Expenses will not include, and no payment will be made for the following:

- Procedures and services not included in the list of covered dental expenses;
- Diagnostic: cone beam imaging;
- Preventive Services: instruction for plaque control, oral hygiene and diet;
- Restorative: veneers of porcelain, ceramic, resin, or acrylic materials on crowns or pontics on or replacing the upper and or lower first, second and/or third molars;
- Periodontics: bite registrations; splinting;
- Prosthodontic: precision or semi-precision attachments;
- Implants: implants or implant related services;
- Procedures, appliances or restorations, except full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of dysfunction of the temporomandibular joint (TMJ), stabilize periodontally involved teeth or restore occlusion;
- Athletic mouth guards;
- Services performed primarily for cosmetic reasons;
- Personalization or decoration of any dental device or dental work;
- Replacement of an appliance per benefit guidelines;
- Services that are deemed to be medical in nature;

- Services and supplies received from a hospital;
- Drugs: prescription drugs;
- Charges in excess of the Maximum Reimbursable Charge.

This document provides a summary only. It is not a contract. If there are any differences between this summary and the official plan documents, the terms of the official plan documents will prevail.

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DENTAL INSURANCE THAT FITS

Cigna Dental Care Plan[1] (DHMO)

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND HEALTH SERVICES AGREEMENT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Regular dental care is important for a healthy smile. And a healthy body. With the Cigna Dental Care® plan, you get comprehensive dental coverage that's easy to use. At a wallet-friendly price. Now that's something to smile about.

This overview shows you a sampling of covered services. And what your plan pays. For a full listing of covered services, please call Customer Service at **800.Cigna24 (800.244.6224).**

Get the most value from your plan

With your Cigna Dental Care plan, some preventive services are covered at 100%. (See chart below.) Your plan also covers many other dental services that help your mouth stay healthy.

Your Cigna Dental Care plan is a **copayment plan.** Here's how it works. When you get a dental service, Cigna allows your network dentist to charge a certain amount. Then **you pay a fixed portion** of that cost, in addition to any allowable charge for CAD/CAM services, or complex rehabilitation. And your plan pays the rest. There are **no annual maximums** and **no deductibles!**

Review your plan materials for more information about how your plan works. If you have questions before enrollment, call **800.Cigna24 (800.244.6224)** and select the "Enrollment Information" prompt.

	WHAT YOU'LL PAY[2]	
Sampling of covered procedures	With Cigna Dental Care	Without dental coverage
Adult cleaning (two per calendar year – each at $0) (additional cleanings available at $45.00 each)	$0	$68–$155 each
Child cleaning (two per calendar year – each at $0) (additional cleanings available at $30.00 each)	$0	$53–$121 each
Periodic oral evaluation	$0	$40–$90
Comprehensive oral evaluation	$0	$63–$143
Topical fluoride (two per calendar year – each at $0) (additional topic fluoride available at $15.00 each)	$0	$28–$63 each
X-rays – (bitewings) 2 films	$0	$33–$75
X-rays – panoramic film	$0	$83–$189
Sealant – per tooth	$12.00	$41–$94
Amalgam filling (silver colored) – 2 surfaces	$0	$117–$266
Composite filling (tooth – colored) – 1 surface, Anterior	$0	$118–$270
Molar root canal (excluding final restoration)	$335.00	$840–$1,914
Comprehensive orthodontic treatment of the adolescent dentition – Banding	$515.00	$967–$2,203
Periodontal (gum) scaling & root planning – 1 quadrant	$83.00	$182–$414
Periodontal (gum) maintenance	$53.00	$107–$243
Removal/extraction of erupted tooth	$12.00	$124–$282
Removal/extraction of impacted tooth – completely bony	$115.00	$362–$825
Crown – porcelain fused to high noble metal*	$450.00	$839–$1,911
Implant supported retainer for porcelain fused to metal fixed partial denture*	$750.00	$1,079–$2,458
Surgical placement of implant body within jawbone	$1,025.00	$1,487–$3,386
Occlusal appliance, by report (for treatment of TMJ)	$330.00	$730–$1,662

*The co-payments for fixed and removable restorations (crowns, bridges, implant/abutment supported prosthetics, complete and partial dentures) do not include additional charges for CAD/CAM services, or complex rehabilitation. Any additional allowable charge for these upgrades is the patient's responsibility as specifically outlined in your Patient Charge Schedule (PCS). For questions regarding these charges you may contact Customer Service at 800.Cigna24 (800.244.6224). Please refer to your PCS for full details.

Together, all the way.®

Cigna.

Offered by: Cigna Health and Life Insurance Company or its affiliates.

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Smile. You're covered.

You can save money on a wide range of services, including:

- **Preventive care** – cleanings, fluoride, sealants, bitewing X-rays, full mouth X-rays and more
- **Basic care** – tooth-colored fillings (called resin or composite) and silver-colored fillings (called amalgam)
- **Major services** – crowns, bridges, dentures (including those placed over implants), root canals, oral surgery, extractions, treatment for periodontal (gum) disease, and more
- **Orthodontic care** – braces for children and adults
- **General anesthesia** – when medically necessary
- **Teeth whitening** – using take-home bleaching trays and gel
- **Temporomandibular joint (TMJ)** – diagnosis and treatment, including cone beam x-ray and appliance
- **Athletic mouth guard** – including creation and adjustments
- **Dental implant surgery** or services associated with placement, repair, removal or restoration of a dental implant

More about your coverage

- **No deductibles or waiting periods.** You don't have to reach an out-of-pocket cost before your insurance starts.
- **No dollar maximums**. Your coverage isn't limited by a dollar amount.
- **Network dentists file claims for you.** No paperwork for you.
- **No age limit on sealants.** Helps prevent tooth decay.
- **Cancer detection**. Your plan covers procedures such as biopsy and light detection to help find oral cancer in its early stages.
- **24/7 access to dental information line.** Trained professionals can help answer your questions about dental treatment and clinical symptoms.
- **Cigna Identity Theft Program.**[3] Help resolving critical identity theft issues.
- **Cigna Dental Oral Health Integration Program®**. Enhanced dental coverage for customers with certain medical conditions who enroll in this program.

Choosing a Dentist

- You must choose a network general dentist to manage your overall care. You won't be covered if you go to a dentist who's not in our network.[4]
- Each family member can choose their own dentist
- Referrals are required for specialty care services, except for pediatric dentists for children under 7 and orthodontics.*

Finding a network dentist is easy.

Visit **Cigna.com** to find a network general dentist.

Call 800.Cigna24 (800.244.6224) to speak with a customer service representative. You can ask for a customized dental directory to be sent to you via email

* Coverage for treatment by a pediatric dentist ends on your child's 7th birthday. Effective on your child's 7th birthday, dental services generally must be obtained from a network general dentist.

Limitations

PROCEDURE	LIMIT
Oral evaluations	Oral evaluations are limited to a combined total of 4 of the following evaluations during a 12 consecutive month period: Periodic oral evaluations (D0120), comprehensive oral evaluations (D0150), comprehensive periodontal evaluations (D0180), and oral evaluations for patients under 3 years of age (D0145)
X-rays (non-routine)	Full mouth: 1 every 3 calendar years Panorex: 1 every 3 calendar years
Periodontal root planing and scaling	Limit 4 quadrants per consecutive 12 months
Periodontal maintenance	Limited to 4 per year and (Only covered after active periodontal therapy)
Crowns and inlays	Replacement 1 every 5 years
Bridges	Replacement 1 every 5 years
Dentures and partials	Replacement 1 every 5 years
Orthodontic treatment	Maximum benefit of 24 months of interceptive and/or comprehensive treatment. Atypical cases or cases beyond 24 months require an additional payment by the patient
Relines, rebases	One every 36 months
Denture adjustments	Four within the first 6 months after installation
Prosthesis over implant	Replacement 1 every 5 years if unserviceable and cannot be repaired

Limitations

PROCEDURE	LIMIT
Surgical placement of implant	Surgical Placement of Implants (D6010, D6012, D6040, and D6050) have a limit of 1 implant per calendar year with a replacement of 1 per 10 years
TMJ treatment	One occlusal orthotic device per 24 months
Athletic mouth guard	One athletic mouth guard per 12 months
General anesthesia/IV sedation	General anesthesia is covered when performed by an oral surgeon when medically necessary for covered procedures listed on the PCS. IV sedation is covered when performed by a periodontist or oral surgeon when medically necessary for covered procedures listed on the PCS. Plan limitation for this benefit is 1 hour per appointment.

Listed below are the services or expenses which are NOT covered under your Dental plan. You will be responsible for these services at the dentist's usual fees. There's no coverage for:

- Services for or in connection with an injury arising out of, or in the course of, any employment for wage or profit
- Charges which would not have been made in any facility, other than a hospital or a correctional institution owned or operated by the United States government or by a state or municipal government if the person had no insurance
- Services received to the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received
- Services for the charges which the person is not legally required to pay
- Charges which would not have been made if the person had no insurance
- Services received due to injuries which are intentionally self-inflicted
- Services not listed on the PCS
- Services provided by a non-network dentist without Cigna Dental's prior approval (except emergencies, as described in your plan documents)[4]
- Services related to an injury or illness paid under workers' compensation, occupational disease or similar laws
- Services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid
- Services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war[5]
- Services performed primarily for cosmetic reasons unless specifically listed on your PCS
- Consultations and/or evaluations associated with services that are not covered
- Endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis
- General anesthesia, sedation and nitrous oxide, unless specifically listed on your PCS
- General anesthesia or IV sedation when used for the purpose of anxiety control or patient management
- Prescription medications
- Procedures, appliances or restorations if the main purpose is to: a. change vertical dimension (degree of separation of the jaw when teeth are in contact); b. restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction
- Replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect
- Any services related to surgical implants, including placement, repair, maintenance, removal, and implant abutment(s) unless specifically listed on your PCS
- Services considered unnecessary or experimental in nature or do not meet commonly accepted dental standards
- Procedures or appliances for minor tooth guidance or to control harmful habits
- Services and supplies received from a hospital
- Services to the extent you or your enrolled dependent are compensated under any group medical plan, no-fault auto insurance policy, or uninsured motorist policy.[6]
- The completion of crowns, bridges, dentures, or root canal treatment already in progress on the effective date of your Cigna Dental coverage[7]
- The completion of implant supported prosthesis (including crowns, bridges and dentures) already in progress on the effective date of your Cigna Dental coverage, unless specifically listed on your PCS[7]
- Infection control and/or sterilization
- The recementation of any inlay, onlay, crown, post and core or fixed bridge within 180 days of initial placement

- Bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction unless specifically listed on your PCS
- Bone grafting and/or guided tissue regeneration when performed in conjunction with an apicoectomy or periradicular surgery
- Intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure
- Services performed by a prosthodontist
- Localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy
- Any localized delivery of antimicrobial agent procedures when more than eight of these procedures are reported on the same date of service
- The recementation of any implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement
- Services to correct congenital malformations, including the replacement of congenitally missing teeth
- The replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period, when this limitation is noted on the PCS
- Crowns, bridges and/or implant supported prosthesis used solely for splinting
- Resin bonded retainers and associated pontics
- As to orthodontic treatment: incremental costs associated with optional/elective materials; orthognathic surgery appliances to guide minor tooth movement or correct harmful habits; and any services which are not typically included in orthodontic treatment.

If any law requires coverage for any particular service(s) noted above, the exclusion or limitation for that service(s) does not apply.

This document outlines the highlights of your plan. For a complete list of both covered and non-covered services, including benefits required by your state, see your official plan documents (the Group Contract and Plan Booklet/Combined Evidence of Coverage and Disclosure Form/ Certificate of Coverage). If there are any differences between the information contained here and the plan documents, the information in the plan documents takes precedence.

1. "Cigna Dental Care" is the brand name used to refer to product designs that may differ by state of residence of enrollee, including but not limited to, prepaid plans, managed care (including Dental HMO) plans, and plans with open access features. Cigna Dental Care plans are not available in the following states: AK, HI, ME, MT, NH, NM, ND, PR, RI, SD, VI, VT, WV, and WY.
2. Costs listed for the Cigna Dental Care plan do not vary. Estimated costs without dental coverage may vary based on location and dentists' actual charges. These estimated costs are based on charges submitted to Cigna in 2015/2016 and are intended to reflect national average charges as of July 2018 assuming an annual cost increase of three percent. Estimates have been adjusted to reflect the 2016 Cigna Dental Care geographical membership distribution. Office visit fee may also apply.
3. **This is NOT insurance and does not provide for reimbursement of financial losses.** The Cigna Identity Theft Program is provided under a contract with Generali Global Assistance. Full terms,conditions and exclusions are contained in the client program description.
4. **Minnesota residents:** You must visit your selected network dentist in order for the charges on the PCS to apply. You may also visit other dentists that participate in our network or you may visit dentists outside the Cigna Dental Care network. If you do, the fees listed on the PCS will not apply. You will be responsible for the dentist's usual fee. We will pay 60% of the value of your network benefit for those services. Of course, you'll pay less if you visit your selected Cigna Dental Care network dentist. Call Customer Services for more information.
Oklahoma residents: Cigna Dental Care is an Employer Group Pre-Paid Dental Plan. Youmay also visit dentists outside the Cigna Dental Care network. If you do, the fees listed on the PCS will not apply. You will be responsible for the dentist's usual fee. We pay non-network dentists the same amount we'd pay network dentists for covered services. Of course, you'll pay less if you visit a network dentist in the Cigna Dental Care network. Call Customer Services for more information.
5. **Oklahoma residents:** This exclusion is replaced by the following: War or act of war (whether declared or undeclared) while serving in the military or an auxiliary unit attached to the military or working in an area of war whether voluntarily or as required by an employer.
6. **Arizona and Pennsylvania residents:** This exclusion does not apply. **Kentucky and North Carolina residents:** Services compensated under no-fault auto insurance policies or uninsured motorist policies are not excluded. **Maryland residents:** Services compensated under group medical plans are not excluded.
7. **California and Texas residents:** Treatment for conditions already in progress on the effective date of your coverage are not excluded if otherwise covered under your PCS. Dentists who participate in Cigna's network are independent contractors solely responsible for the treatment provided to their patients. They are not agents of Cigna.

VISION *Care*

EyeMed

The EyeMed vision plan will send all newly enrolled retirees an ID card, with your name on it in a welcome package. If you had coverage in 2020, you will not get a new card. The package will include two ID cards and a list of local doctors accepting your insurance near your home address. But, you don't need an ID card to receive care. EyeMed members can use an EyeMed network provider or an out of network (non-participating) provider. If you use a non-participating provider, you will get a lesser benefit. If you use an EyeMed provider, the provider can confirm your enrollment directly with EyeMed, and apply any benefits or discounts at the time of service.

When you obtain services from an EyeMed doctor, you get the most value from your vision 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 an EyeMed doctor or to locate an EyeMed doctor:

- Visit **www.EyeMed.com**, or
- Call Member Services at **1-866-804-0982**.

And using your EyeMed benefit is simple

To access your benefits, simply:

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

Anne Arundel County - MD

40% OFF
additional complete pair of prescription eyeglasses

20% OFF
non-covered items, including non-prescription sunglasses

Find an eye doctor
(Insight Network)

- 866.804.0982
- eyemed.com
- EyeMed Members App
- For LASIK, call 1.800.988.4221

Heads Up
You may have additional benefits. Log into eyemed.com/member to see all plans included with your benefits.

SUMMARY OF BENEFITS

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
EXAM SERVICES		
Exam	$10 copay	Up to $52
Retinal Imaging	Up to $39	Not covered
CONTACT LENS FIT AND FOLLOW-UP		
Fit and Follow-up - Standard	Up to $40	Not covered
Fit and Follow-up - Premium	10% off retail price	Not covered
FRAME		
Frame	$0 copay; 20% off balance over $150 allowance	Up to $70
LENSES		
Single Vision	$0 copay	Up to $55
Bifocal	$0 copay	Up to $75
Trifocal	$0 copay	Up to $85
Lenticular	$0 copay	Up to $72
Progressive - Standard	$30 copay	Up to $75
Progressive - Premium Tier 1 - 3	$50 - 75 copay	Up to $75
Progressive - Premium Tier 4	$30 copay; 20% off retail price less $120 allowance	Up to $75
LENS OPTIONS		
Anti Reflective Coating - Standard	$45	Not covered
Anti Reflective Coating - Premium Tier 1 - 2	$57 - 68	Not covered
Anti Reflective Coating - Premium Tier 3	20% off retail price	Not covered
Photochromic - Non-Glass	$75	Not covered
Polycarbonate - Standard	$40	Not covered
Polycarbonate - Standard < 19 years of age	$0 copay	Up to $32
Scratch Coating - Standard Plastic	$15	Not covered
Tint - Solid and Gradient	$15	Not covered
UV Treatment	$15	Not covered
All Other Lens Options	20% off retail price	Not covered
CONTACT LENSES		
Contacts - Conventional	$0 copay; 15% off balance over $150 allowance	Up to $105
Contacts - Disposable	$0 copay; 100% of balance over $150 allowance	Up to $105
Contacts - Medically Necessary	$0 copay	Up to $210
OTHER		
Hearing Care from Amplifon Network	Up to 64% off hearing aids; call 1.877.203.0675	Not covered
LASIK or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call 1.800.988.4221	Not covered
FREQUENCY	**ALLOWED FREQUENCY - ADULTS**	**ALLOWED FREQUENCY - KIDS**
Exam	Once every 12 months from the date of service	Once every 12 months from the date of service
Lenses	Once every 12 months from the date of service	Once every 12 months from the date of service
Frame	Once every 12 months from the date of service	Once every 12 months from the date of service
Contact Lenses	Once every 12 months from the date of service	Once every 12 months from the date of service

(Plan allows the member to receive either contacts and frame, or frame and lens services)

Fees charged by a Provider for services other than a covered benefit must be paid in full by the Insured Person to the Provider. Such fees or materials are not covered under the Policy. Benefit allowances provide no remaining balance for future use within the same Benefit Frequency. No benefits will be paid for services or materials connected with or charges arising from: services or materials provided by any other group benefit plan providing vision care; medical and/or surgical treatment of the eye, eyes or supporting structures; services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; any Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear; non-prescription sunglasses; plano (non-prescription) lenses; two pair of glasses in lieu of bifocals; services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; or lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available. Member receives a 20% discount on items not covered by the plan at In-Network locations. Discount does not apply to Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see online provider locator to determine which participating providers have agreed to the discounted rate. Discounts on vision materials may not be applicable to certain manufacturers' products The Plan reserves the right to make changes to the products on each tier and the member out-of-pocket costs. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Service and amounts listed above are subject to change at any time.

BRINGING IT ALL INTO FOCUS

Time for a little Q&A

A LOOK AT THE BENEFITS

What exactly do my EyeMed benefits cover?

If you're thinking about EyeMed, you'll want to connect with your employer to learn about the benefit options. Already a member? The easiest way to find your benefit information is to create a member account on eyemed.com or grab the EyeMed Members App (App Store or Google Play).

Does EyeMed offer any extra discounts?

We sure do. At participating in-network providers, members get 40% off an extra pair of eyeglasses or 20% off a partial pair (lenses only or frames only).* You also get 20% off non-prescription sunglasses and accessories, and discounts on LASIK laser vision correction. Call 1.800.988.4221 to find a LASIK location near you.

Can I use EyeMed benefits online?

Instantly apply your in-network benefits at checkout, with free shipping, free returns and no paperwork at these participating providers: lenscrafters.com, targetoptical.com, ray-ban.com, glasses.com and contactsdirect.com.

Can I get the same kind of care with a retail provider as I can with an independent doctor?

Many optometrists share space with a retail optical store, but operate a separate practice. All of them, wherever they practice, must meet the same state licensing and credentialing requirements. One advantage of using a vision carrier, like EyeMed, is that credentials of every in-network eye doctor are thoroughly examined and verified, so you can feel confident you're getting access to qualified eye doctors.

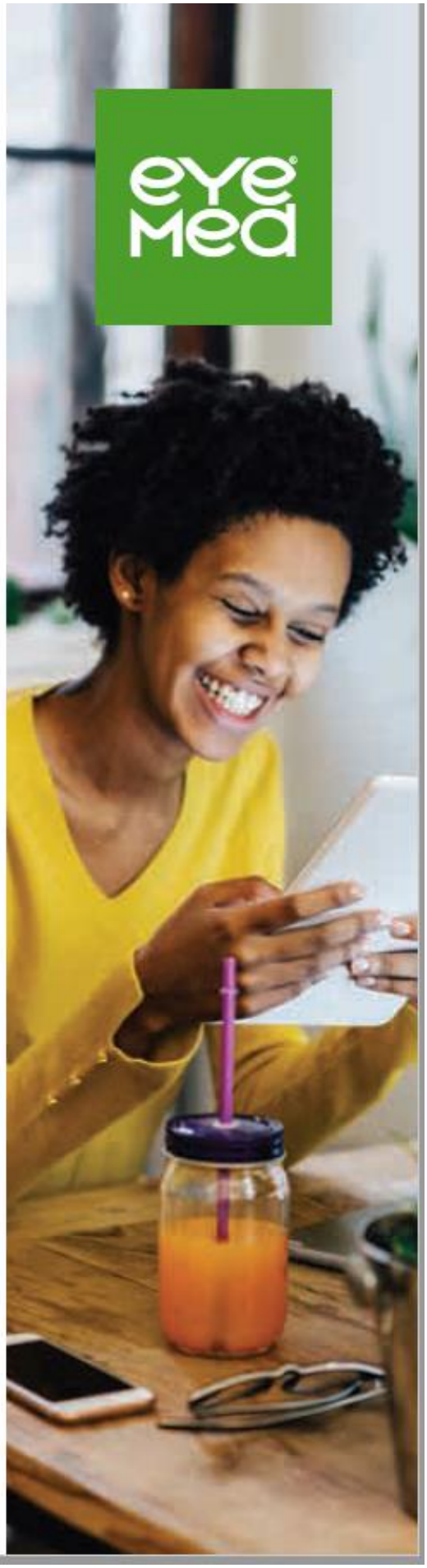
MEMBER HOW-TO TIPS

How do I use my benefits?

At EyeMed, we're all about easy. Just choose an in-network eye doctor from our Enhanced Provider Search, schedule your visit and go in for care or eyewear. You don't even need your ID card—just give them your name and birthday. When you stay in-network, we'll handle all the paperwork.

How do I find an eye doctor in my network?

The Enhanced Provider Search on Member Portal and the EyeMed Members App has thousands of in-network eye doctors to choose from. Filter your search to find ones near you with the brands, hours and services you most want.



RETIREE *Life Insurance*

Retirees are not eligible for Basic Life Insurance, Spouse Life Insurance or Child Life Insurance.

Active employees who are enrolled in the Optional Life Insurance plan for at least 60 days prior to retirement may elect to continue Optional Life coverage into retirement. The election must be made prior to your retirement date, and may not be made after retirement commences. Retirees who are enrolled in Optional Life Insurance may not increase their policy value during Open Enrollment. Optional Life policy values reduce by 35% the month following the retiree's 65th birthday.

2022 Optional Life Rate for Individuals Retired before 2/1/2000	
Policy Value	**Monthly Rate**
$6,500	**$29.51**

2022 Optional Life Rates for Individuals Retired after 2/1/2000

POLICY VALUE	MONTHLY <50 ($0.15 per $1000)	MONTHLY 50-64 ($0.45 per $1000)	MONTHLY 65+ ($1.76 per $1000)
$25,000	$3.75	$11.25	$44.00
$50,000	$7.50	$22.50	$88.00
$75,000	$11.25	$33.75	$132.00
$100,000	$15.00	$45.00	$176.00
$125,000	$18.75	$56.25	$220.00
$150,000	$22.50	$67.50	$264.00
$175,000	$26.25	$78.75	$308.00
$200,000	$30.00	$90.00	$352.00
$225,000	$33.75	$101.25	$396.00
$250,000	$37.50	$112.50	$440.00
$275,000	$41.25	$123.75	$484.00
$300,000	$45.00	$135.00	$528.00
$325,000	$48.75	$146.25	$572.00
$350,000	$52.50	$157.50	$616.00
$375,000	$56.25	$168.75	$660.00
$400,000	$60.00	$180.00	$704.00

BENEFITS *Eligibility*

Who is Eligible for Benefits

Individuals eligible for benefits include:

- Retirees who were eligible for health insurance as an active employee.
- Surviving Spouses of deceased AACG retirement system retirees who were previously covered by their spouse's insurance plan, and who will receive a surviving spouse County pension benefit.

Eligible dependents include:

- Your legal spouse, as recognized in the State of Maryland (not including common law spouses).
- Your child, including a 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.
- Your dependent child for whom you are the legal guardian. Guardianship ends when the dependent turns 18. If you don't adopt the child, their coverage terminates the end of the month in which they turn 18.

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

Dependent Documentation

Dependent documentation is required with both new employee benefit enrollment and new retiree benefit enrollment. Documentation is also required for dependents added to your plan during Open Enrollment and following a mid-year qualifying event. Dependent documentation can include copies of your marriage certificate, dependent's birth certificates, dependent's social security cards, etc. AACG reserves the right to request dependent documentation at any time. Dependents may be dropped from coverage mid-year if documentation is not provided. Birth registration notices are not accepted as proof of birth.

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.
- Any qualifying life event throughout the year that has you adding your spouse (excluding marriage) will require proof of joint ownership. In addition to an official state marriage certificate dated and signed by the appropriate State or County official, you must provide one of the following documents to confirm joint ownership. Please redact all social security numbers and financial documentation.
- Standard proof of joint ownership includes:
  - Mortgage statement
  - Bank statement (bank account verification letter showing active status)
  - Active lease agreement
  - Homeowners Insurance
  - Renters Insurance
  - State Tax Return (within 1 year)
  - Credit card statement (includes: department stores; and care credit)
  - Property tax
  - Current-year state tax return listing spouse/partner
  - Current-year mortgage interest/mortgage insurance
  - Warranty deed
  - Auto loans
  - Current-year federal tax return listing the spouse/dependent as a dependent

Child

- 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 guardianships of grandchildren, and the appointment is for 12 months or longer provide a copy of court document signed by a judge. Guardianship ends when the child reaches the age of 18. This means that their coverage stops the last day of the month in which they turn 18. In order to continue coverage, you need to adopt the child.

Note: Temporary custody and guardianships under 12 months are not eligible for County insurance enrollment.

- A copy of the child's social security card.
- A copy of the child's birth certificate.
- A copy of Medicare card if the child is enrolled in Medicare.

Enrolling During Open Enrollment & Throughout the Year

Changes are permitted outside of Open Enrollment if you experience a qualifying event (i.e. marriage, birth, loss of coverage, becoming Medicare eligible, etc.). These changes shall be permitted in accordance with the plan and IRS rules.

Making Mid-Year Changes

If you wish to make a mid-year change to your benefit elections, you must contact the AACG Benefits Team within 31 days after the qualifying event, and provide a benefits change form with supporting documentation. Your change request must be consistent with the qualifying event. Proof of other coverage is required for mid-year requests to cancel dependent coverage.

Examples of Qualifying Status Change Events

- Birth of a child, adoption, marriage, divorce, death or reaching the maximum age limit for the plan, etc.
- Involuntary loss of other medical insurance coverage for yourself or your dependents.
- You or your dependent child's enrollment in or loss of SCHIP, Medicaid, Medicare or Medical Assistance coverage.
- Retiree moving out of the Blue Choice HMO service area.
- Significant mid-year change in cost or plan coverage in the Anne Arundel County sponsored plans.

Coverage Level for Retirees

Four coverage level options are available: Individual, Retiree & Child, Retiree & Spouse, or Family. Retirees may elect a different coverage level for each insurance plan.

Duplicate Coverage

A husband and wife who are both AACG retirees and/or is an active employee 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 parents' plans. This rule includes life insurance, medical, dental and vision coverage. It is your responsibility to make sure that you or your dependents do not have duplicate County coverage. Duplicate benefits will not be paid; however, in the event benefits are paid, you will be responsible for reimbursing the county.

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 towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your 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 the Human Resources at 410-222-7107 or at the address provided in this booklet.

Notification of Retiree/Dependent Death

Please contact the Human Resources at 410-222-7107 immediately following the passing of an AACPL retiree or dependent.

Notification of Address Changes

Please report an address change within 31 days following the move. Retirees can email their address change to humanresources@aacpl.net. Retirees can also request an address change by calling 410-222- 7107.

INSTRUCTIONS FOR BENEFIT ENROLLMENTS AND MID-YEAR CHANGES

Event	Action Required	Enrollment Deadline	Coverage Effective Date
Open Enrollment Change	Complete Enrollment Form and send along with all required dependent documentation to Human Resources before the enrollment deadline.	November 1, 2021	January 1, 2022
Marriage	Complete Enrollment Form and send along with all required dependent documentation to Human Resources before the enrollment deadline.	31 days after marriage	1st of the month following the marriage
Newborn	Complete Enrollment Form and send to Human Resources before the enrollment deadline. 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	Complete Enrollment Form and send along with all required dependent documentation to Human Resources before the enrollment deadline.	31 days after retirement date	Retirement date
Moving out of HMO service area	Provide new address information to Human Resources	31 days after move	1st of month after move
Loss of Coverage Elsewhere	Complete Enrollment Form and send along with a Certificate of Prior Coverage or employer letter listing the insurance end date, and all required dependent documentation to Human Resources before the enrollment deadline.	31 days after coverage end date	1st of month after coverage end date
Cancel Dependent Coverage Mid-Year	Complete Enrollment Form and send along with proof of other coverage for the dependent such as a letter from their employer or copy of insurance card to Human Resources.	31 days after other coverage began	1st of month following notice of change to Human Resources. Retroactive adjustments are not allowed.
Divorce	Complete Enrollment Form and send along with a copy of your divorce decree signed by a judge or court official to Human Resources.	31 days following divorce	Coverage ends at the end of the month of the divorce. Employees & retirees will be responsible for insurance claims incurred by ex-spouses who are not removed from the insurance plan within 31 days after the divorce.

IMPORTANT *Legal Notices and Information*

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-hour (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 the 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-hours (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-hour (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.

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 protections to patients who choose to have breast reconstruction in connection with a mastectomy. As required by the WSCRA 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; and
- Prostheses and physical complications 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.

Non-Assignment of Benefits

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

Benefits Appeal Process

The County Benefit vendors are committed to processing claims in accordance with the County contract. If you have questions regarding how a claim was processed, first contact the plan Member Services department. If the matter is not resolved by contacting Member Services, telephone the Human Resources staff on 410-222-7107. 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, and membership ID number. Also include the reasons why you believe the claim was improperly processed. Please refer to the plan member handbook for deadlines for submitting an appeal.

Address your appeal to:

Aetna Medicare Grievance & Appeal Unit
PO Box 14067
Lexington, KY 40512

CareFirst Blue Choice
Central Appeals & Analysis Unit
PO Box 14114
Lexington KY 40512-4114

SilverScript Insurance Company
P.O. Box 52000, MC 109
Phoenix, AZ 85072-2000

General Notice Of COBRA Continuation Coverage Rights

*** Continuation Coverage Rights Under COBRA***

This COBRA Notice section applies to employees, retirees and covered spouses and dependents who have health coverage under the Plan. For purposes of this notice, "Plan" refers only to the medical, prescription drug, dental and vision benefits described in this Summary and this notice is not intended to apply to any other type of benefit.

Introduction

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Anne Arundel County Government and/or Anne Arundel County Public Library, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The re- tired employee's spouse, surviving spouse, and dependent chil- dren will also become qualified beneficiaries if bankruptcy re- sults in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or

- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: **Anne Arundel County Public Library, Human Resources, 5 Harry S. Truman Parkway, Annapolis, MD 21401.**

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

- Disability extension of 18-month period of COBRA continuation coverage
- If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. Your notice must include documentation of the Social Security Administration's decision and it must be provided within 60 days after the date of that decision, or, if later, within 60 days after the later of (1) the date the original qualifying event occurred or (2) the date that coverage would otherwise end because of the original qualifying event.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information
Anne Arundel County Public Library
Human Resources
5 Harry S. Truman Parkway
Annapolis, MD 21401
410-222-7107

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

To: Participants in health plans sponsored by Anne Arundel County Government

The health plans or options sponsored by Anne Arundel County Government (referred to in this Notice as the "Health Plans") may use or disclose health information about participants and their covered dependents as required for purposes of administering the Health Plans. Some of these functions are handled directly by County employees who are responsible for overseeing the operation of the Health Plans, while other functions may be performed by other companies under contract with the Health Plans (those companies are generally referred to as "service providers"). Regardless of who handles health information for the Health Plans, the Health Plans have established policies that are designed to prevent the misuse or unnecessary disclosure of protected health information.

Please note that the rest of this Notice uses the capitalized word, "Plan" to refer to each Health Plan sponsored by Anne Arundel County Government, including any County employees who are responsible for handling health information maintained by the Health Plans as well as any service providers who handle health information under contract with the Health Plans. This Notice applies to each Health Plan maintained by Anne Arundel County Government, including plans or programs that provide medical, vision, prescription drug, dental and health care flexible spending account benefits. However, if any of the Plan's health benefits are provided through insurance contracts, you will receive a separate notice, similar to this one, from the insurer and only that notice will apply to the insurer's use of your health information.

The Plan is required by law to maintain the privacy of certain health information about you and to provide you this Notice of the Plan's legal duties and privacy practices with respect to that protected health information. This Notice also provides details regarding certain rights you may have under federal law regarding medical information about you that is maintained by the Plan.

You should review this Notice carefully and keep it with other records relating to your health coverage. The Plan is required by law to abide by the terms of this Notice while it is in effect. This Notice is effective beginning July 1, 2013 and will remain in effect until it is revised.

If the Plan's health information privacy policies and procedures are changed so that any part of this Notice is no longer accurate, the Plan will revise this Privacy Notice. A copy of any revised Privacy Notice will be available upon request to the Privacy Contact Office indicated later in this Notice. Also, if required under applicable law, the Plan will automatically provide a copy of any revised notice to employees who participate in the Plan. The Plan reserves the right to apply any changes in its health information policies retroactively to all health information maintained by the Plan, including information that the Plan received or created before those policies were revised.

Protected Health Information

This Notice applies to health information possessed by the Plan that includes identifying information about an individual. Such information, regardless of the form in which it is kept, is referred to in this Notice as Protected Health Information or "PHI". For example, any health record that includes details such as your name, street address, date of birth or Social Security number would be covered. However, information taken from a document that does not include such obvious identifying details is also Protected Health Information if that information, under the circumstances, could reasonably be expected to allow a person who receives or accesses that information to identify you as the subject of the information. Information that the Plan possesses that is not Protected Health Information is not covered by this Notice and may be used for any purpose that is consistent with applicable law and with the Plan's policies and requirements.

How the Plan Uses or Discloses Health Information

Protected Health Information may be used or disclosed by the Plan as necessary for the operation of the Plan. For example, PHI may be used or disclosed for the following Plan purposes:

Treatment. If a provider who is treating you requests any part of your health care records that the Plan possesses, the Plan generally will provide the requested information. (There is an exception for psychotherapy notes. If the Plan possesses any psychotherapy notes, those documents, with rare exceptions, will be used or disclosed only according to your specific authorization.)

For example, if your current physician asks the Plan for PHI in connection with a treatment plan the physician has for you, the Plan generally will provide that PHI to the physician.

Payment. If a provider who is treating you requests any part of your health care records that the Plan possesses, the Plan generally will provide the requested information. (There is an exception for psychotherapy notes. If the Plan possesses any psychotherapy notes, those documents, with rare exceptions, will be used or disclosed only according to your specific authorization.)

For example, if your current physician asks the Plan for PHI in connection with a treatment plan the physician has for you, the Plan generally will provide that PHI to the physician.

Other health care operations. The Plan also may use or disclose PHI as needed for various purposes that are related to the operation of the Plan. These purposes include utilization review programs, quality assurance reviews, contacting provid-

ers regarding treatment alternatives, insurance or reinsurance contract renewals and other functions that are appropriate for purposes of administering the Plan. This includes, if appropriate, disclosing information to the Plan Sponsor, as needed to facilitate the Plan's health care operations function.

For example, if the Plan wishes to undertake a review of utilization patterns under the Plan, it may request necessary PHI from your physician.

In addition to the typical Plan purposes described above, PHI also may be used or disclosed as permitted or required under applicable law for the following purposes:

Use or disclosure required by law. If the Plan is legally required to provide PHI to a government agency or anyone else, it will do so. However, the Plan will not use or disclose more information than it determines is required by applicable law.

Disclosure for public health activities. The Plan may disclose PHI to a public health authority that is authorized to collect such information (or to a foreign government agency, at the direction of a public health authority) for purposes of preventing or controlling injury, disease or disability.

The Plan also may disclose PHI to a public health authority or other government agency that is responsible for receiving reports of child abuse or neglect.

In addition, certain information may be provided to pharmaceutical companies or other businesses that are regulated by the Food and Drug Administration (FDA), as appropriate for purposes relating to the quality, safety and effectiveness of FDA-regulated products.

Also, to the extent permitted by applicable law, the Plan may disclose PHI, as part of a public health investigation or intervention, to an individual who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition.

Disclosures about victims of abuse, neglect or domestic violence. (The following does not apply to disclosures regarding child abuse or neglect, which may be made only as provided under Disclosure for public health activities.)

If required by law, the Plan may disclose PHI relating to a victim of abuse, neglect or domestic violence, to an appropriate government agency. Disclosure will be limited to the relevant required information. The Plan will inform the individual if any PHI is disclosed as provided in this paragraph or the next one.

If disclosure is not required by law, the Plan may disclose relevant PHI relating to a victim of abuse, neglect or domestic violence to an authorized government agency, to the extent permitted by applicable law, if the Plan determines that the disclosure is necessary to prevent serious harm to the individual or to other potential victims. Also, to the extent permitted by law, the Plan may release PHI relating to an individual to a law enforcement official, if the individual is incapacitated and unable to agree to the disclosure of PHI and the law enforcement official indicates that the information is necessary for an immediate enforcement activity and is not intended to be used against the individual.

Health oversight activities. The Plan may disclose protected health information to a health oversight agency (this includes federal, state or local agencies that are responsible for overseeing the health care system or a particular government program for which health information is needed) for oversight activities authorized by law. This type of disclosure applies to oversight relating to the health care system and various government programs as well as civil rights laws. This disclosure would not apply to any action by the government in investigating a participant in the Plan, unless the investigation relates to the receipt of health benefits by that individual.

Disclosures for judicial and administrative proceedings. The Plan may disclose protected health information in the course of any judicial or administrative proceeding in response to an order from a court or an administrative tribunal. Also, if certain restrictive conditions are met, the Plan may disclose PHI in response to a subpoena, discovery request or other lawful process. In either case, the Plan will not disclose PHI that has not been expressly requested or authorized by the order or other process.

Disclosures for law enforcement purposes. The Plan may disclose protected health information for a law enforcement purpose to a law enforcement official if certain detailed restrictive conditions are met.

Disclosures to medical examiners, coroners and funeral directors following death. The Plan may disclose protected health information to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties authorized by law. The Plan also may disclose PHI to a funeral director as needed to carry out the funeral director's duties. PHI may also be disclosed to a funeral director, if appropriate, in reasonable anticipation of an individual's death.

Disclosures for organ, eye or tissue donation purposes. The Plan may disclose protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

Disclosures for research purposes. If certain detailed restrictions are met, the Plan may disclose protected health information for research purposes.

Disclosures to avert a serious threat to health or safety. The Plan may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information, (1) if it believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and the disclosure is made

to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat; or (2) if it believes the disclosure is necessary for law enforcement authorities to identify or apprehend an individual because of a statement by an individual admitting participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to the victim or where it appears that the individual has escaped from a correctional institution or from lawful custody.

Disclosures for specialized government functions. If certain conditions are met, the Plan may use and disclose the protected health information of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission. Also, the Plan may use and disclose the PHI of individuals who are foreign military personnel to their appropriate foreign military authority under similar conditions.

The Plan may also use or disclose PHI to authorized federal officials for the conduct of lawful intelligence, counter-intelligence, and other national security activities or for the provision of protective services to the President or other persons as authorized by federal law relating to those protective services.

Disclosures for workers' compensation purposes. The Plan may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs.

Uses and Disclosures That Are Not Permitted Without Your Authorization

The Plan will not use or disclose Protected Health Information for any purpose that is not mentioned in this.

If the Plan needs to use or disclose PHI for a reason not listed above, it will request your permission for that specific use and will not use PHI for that purpose except according to the specific terms of your authorization.

Any authorization you provide will be limited to specified information, and the intended use or disclosure as well as any person or organization that is permitted to use, disclose or receive the information must be specified in the Authorization Form. Also, an authorization is limited to a specific limited time period and it expires at the end of that period. Finally, you always have the right to revoke a previous authorization by making a written request to the Plan. The Plan will honor your request to revoke an authorization but the revocation will not apply to any action that the Plan took in accord with the authorization before you informed the Plan that you were revoking the authorization.

No Use or Disclosure of Genetic Information for Underwriting

Under applicable law, the Plan generally may not use or disclose genetic information, including information about genetic testing and family medical history, for underwriting purposes. The Plan may use or disclose PHI for underwriting purposes, assuming the use or disclosure is permitted based on the above rules, but any PHI that is used or disclosed for underwriting purposes will not include genetic information.

"Underwriting purposes" is defined under federal law and generally includes any Plan rules relating to (1) eligibility for benefits under the Plan (including changes in deductibles or other cost-sharing requirements in return for activities such as completing a health risk assessment or participating in a wellness program); (2) the computation of premium or contribution amounts under the Plan (including discounts or payments or differences in premiums based on activities such as completing a health risk assessment or participating in a wellness program); (3) the application of any preexisting condition exclusion under the Plan; and (4) other activities related to the creation, renewal, or replacement of a contract for health insurance or health benefits. However, "underwriting purposes" does not include rules relating to the determination of whether a particular expense or claim is medically appropriate.

Your Health Information Rights

Under federal law, you have the following rights:

You may request restrictions with regard to certain types of uses and disclosures. This includes the uses and disclosures described above for treatment, payment and other health care operations purposes. If the Plan agrees to the restrictions you request, it will abide by the terms of those restrictions. However, under the law, the Plan is not required to accept any restriction. If the Plan determines that a requested restriction will interfere with the efficient administration of the Plan or is otherwise inappropriate, it may decline the restriction. If you want to request a restriction, you should submit a written request describing the restriction to the Privacy Contact Office listed in this Notice.

You may request that certain information be provided to you in a confidential manner. This right applies only if you inform the Plan in writing (submitted to the Privacy Contact Office listed in this Notice) that the ordinary disclosure of part or all of the information might endanger you. For example, an individual may not want information about certain types of treatment to be sent to his or her home address because someone else who lives there might have access to it. In such a case, the individual could request that the information be sent to an alternate address. The Plan will honor such a request if it is reasonable, but reserves the right to reject a request that would impose too much of an administrative burden or financial risk on the Plan.

• You may request access to certain medical records possessed by the Plan and you may inspect or copy those records. This right applies to all enrollment, claims processing, medical management and payment records maintained by the Plan and also to any other information possessed by the Plan that is used to make decisions about you or your health coverage. However, there are certain limited exceptions. Specifically, the Plan may deny access to psychotherapy notes and to information prepared in anticipation of litigation.

If you want to request access to any medical records, you should contact the Privacy Contact Office listed in this Notice. If you request copies of any records, the Plan may charge reasonable fees to cover the costs of providing those copies to you, including, for example, copying charges and the cost of postage if you request that copies be mailed to you. You will be informed of any fees that apply before you are charged.

• You may request that protected health information maintained by the Plan be amended. If you feel that certain information maintained by the Plan is inaccurate or incomplete, you may request that the information be amended. The Plan may reject your request if it finds that the information is accurate and complete. Also, if the information you are challenging was created by some other person or organization, the Plan ordinarily would not be responsible for amending that information unless you provide information to the Plan to establish that the originator of the information is not in a position to amend it. If you want to request that any medical record maintained by the Plan be amended, you should provide your request in writing to the Privacy Contact Office listed in this Notice. Your request should describe the records that you want to be changed, each change you are requesting and your reasons for believing that each requested change should be made.

The Plan normally will respond to a request for an amendment within 60 days after it receives your request. In certain cases, the Plan may take up to 30 additional days to respond to your request.

If the Plan denies your request, you will have the opportunity to prepare a statement to be included with your health records to explain why you believe that certain information is incomplete or inaccurate. If you do prepare such a statement, the Plan will provide that statement to any person who uses or receives the information that you challenged. The Plan may also prepare a response to your statement and that response will be placed with your records and provided to anyone who receives your statement. A copy will also be provided to you.

• You have the right to receive details about certain non-routine disclosures of health information made by the Plan. You may request an accounting of all disclosures or health information, with certain exceptions. This accounting would not include disclosures that are made for Treatment, Payment and other health plan operations, disclosures made pursuant to an individual authorization from you, disclosures made to you and certain other types of disclosures. Also, your request will not apply to any disclosures made more than six years before the date your request is properly submitted to the Plan. You may receive an accounting of disclosures once every 12 months at no charge. The Plan may charge a reasonable fee for any additional requests during a 12 month period.

• You have the right to request and receive a paper copy of this Privacy Notice. If the Plan provides this Notice to you in an electronic form, you may request a paper copy and the Plan will provide one. You should contact the Privacy Contact Office identified at the end of this Notice if you want a paper copy.

• You have the right to be notified of a breach of unsecured PHI. If unsecured PHI is used or disclosed in a manner that is not permitted under applicable federal law, you will receive a notice about the breach of unsecured PHI, if such a notice is required by applicable law. Unsecured PHI is PHI that is either in paper form or is in an electronic form that is not considered secure.

Privacy Contact Office and Complaint Procedures

After reading this Notice, if you have questions or complaints about the Plan's health information privacy policies or you believe your health information privacy rights have been violated, you should contact **Human Resources, Anne Arundel County Public Library, 5 Harry S. Truman Parkway, Annapolis, MD 21401 (410) 222-7107.**

In addition to your right to file a complaint with the Plan, you may file a complaint with the U.S. Department of Health & Human Services. (Details are available on the Internet at http://www.hhs.gov/ocr/privacy) You will never be retaliated against in any way as a result of any complaint that you file.

Important Notice from Anne Arundel County Government About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Anne Arundel County Government 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 pre-

scription 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:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Anne Arundel County Government has determined that the prescription drug coverage offered by the Anne Arundel County Government 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 October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) 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 Anne Arundel County Government coverage will be affected. If you elect Part D coverage, coverage under Anne Arundel County Government's plan will end for you and all covered dependents.

If you do decide to join a Medicare drug plan and drop your current Anne Arundel County Government 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 should also know that if you drop or lose your current coverage with Anne Arundel County Government 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% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% 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 office listed on the next page for further information.

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

For More Information About Your Options Under Medicare Prescription Drug Coverage:

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

For more information about Medicare prescription drug coverage:

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

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

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

Anne Arundel County Public Library
Human Resources
5 Harry S. Truman Parkway
Annapolis, MD 21401
410-222-7107

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't 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 are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDSNOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't 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, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

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, 2019. Contact your State for more information on eligibility—

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 916-440-5676
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
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	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131	Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840
INDIANA – Medicaid	**MINNESOTA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA – Medicaid and CHIP (Hawki)	**MISSOURI – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS – Medicaid	**MONTANA – Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KENTUCKY – Medicaid	**NEBRASKA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA – Medicaid	**NEVADA – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE – Medicaid	**NEW HAMPSHIRE – Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740. TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP	SOUTH DAKOTA - Medicaid
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	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT– Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN–Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Anne Arundel County Public Library

ANNE ARUNDEL COUNTY PUBLIC LIBRARY

Retiree Open Enrollment Health Benefits Form – 2022 Plan Year

Name: _____ SS#: _____ Date of Birth: _____
Address: _____ City/State/Zip: _____
Daytime Phone # _____ Email Address: _____

Instructions: Use this form to make changes to your benefit elections for the 2022 calendar year. Return the completed form via email to humanresources@aacpl.net or by mail to AACPL Human Resources, 5 Harry S. Truman Pkwy, Annapolis, MD 21401 by November 1, 2021. **Non-Medicare eligible retirees/spouses must make a plan selection and submit an enrollment form in order to continue health benefits. If you and your spouse are enrolled in Medicare and are not making any changes, no response is necessary.**

Health Care Election – Enter coverage election(s) for 2022 calendar year

Medical Plans	**Medical Plan Coverage Level**
☐ Aetna Select Open Access HMO-EPO ☐ Aetna Open Choice PPO ☐ Aetna Medicare Advantage Plan (Attach copy of Medicare Card) ☐ No Coverage	☐ Individual ☐ Retiree & 1 Child ☐ Retiree & Spouse ☐ Family ☐ Split Option (Check Eligibility): Retiree: ___Medicare ___Non-Medicare Spouse: ___Medicare ___Non-Medicare
Dental Plans	**Dental Plan Coverage Level**
☐ Cigna PPO Dental (Core) ☐ Cigna PPO Dental (Buy-Up) ☐ Cigna Dental Care (DHMO Network Dentist Required) ☐ No Coverage	☐ Individual ☐ Retiree & 1 Child ☐ Retiree & Spouse ☐ Family
Vision Plan	**Vision Plan Coverage Level**
☐ EyeMed Vision ☐ No Coverage	☐ Individual ☐ Retiree & 1 Child ☐ Retiree & Spouse ☐ Family

Other Health Coverage? Check here ☐ if you or your dependents are covered by another insurance policy

In the section below, list all eligible individuals for whom coverage is requested
Attach copy of Marriage or Birth Certificate if you are adding dependents who were not covered in 2021

Full Name	Relationship	SS#	Gender	Birth Date
	SELF			

By signing below, I request enrollment as indicated above and agree to pay any premiums required to participate in the selected plans. I certify that any person for whom I am electing coverage meets the applicable requirements for spuose or dependent coverage under the Plan and I agree to inform the Benefits office if that changes while my election of coverage is in effect. I understand that I may change my elections only during Open Enrollment for coverage effective the next January 1, or by requesting a permitted change within 31 days of a family status change. I attest that the information provided above is complete and true to the best of my knowledge. I understand that false information will result in claim denial and possible termination fo eligibility for coverage.

Retiree Signature:_____Date _____

Return the completed form to AACPL Human Resources, 5 Harry Truman Parkway, Annapolis, MD 21401 by November 1, 2021.

NOTES