ANNE ARUNDEL COUNTY GOVERNMENT

OPEN ENROLLMENT & BENEFITS REFERENCE GUIDE

FOR EMPLOYEES AND NON-MEDICARE-ELIGIBLE RETIREES

PLAN YEAR January 1, 2026 to December 31, 2026 • **OPEN ENROLLMENT** October 1, 2025 – October 31, 2025

ANNE ARUNDEL COUNTY MARYLAND

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The Anne Arundel County Government provides a very generous benefits package to eligible Employees and Retirees, with a wide range of benefit options. For more details about each plan, review the sections in this book, the summary plan documents on Ask Anne, 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 Government eligible employees and retirees, and reflects applicable Federal Health Reform Regulations as of January 2025. 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 the Benefits Team 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 consent of the participants.

ANNE ARUNDEL COUNTY
MARYLAND
Office of Personnel

2660 Riva Road, 1st Floor
Annapolis, MD 21401
Phone (410) 222-7595

Anne Budowski
Personnel Officer

October 1, 2025

MEMORANDUM

TO: All Employees & Retirees Eligible for Health Care Benefits

FROM: Anne Budowski, Personnel Officer Initial AB

SUBJECT: Benefits Open Enrollment for January 1, 2026 – December 31, 2026

Welcome to Anne Arundel County Government's Open Enrollment. Open Enrollment is your annual opportunity to review and make changes to your insurance benefit plans, your insurance coverage level, and/or your enrolled dependents. **The Open Enrollment period this year is October 1 – October 31, 2025.**

This is an active enrollment season, and ACTION is needed to secure your Medical plan for 2026. If you are currently enrolled in an Aetna medical plan and would like to maintain medical coverage January 1, 2026, you will have to select a new CareFirst plan. Other than the Medical plan, everything **except** the Flexible Spending Account (FSA) will carryover for 2026. You must re-enroll in the FSA plan every year.

What's New for 2026?

Medical Vendor Change:
Effective January 1, 2026, CareFirst will be our new medical plan vendor. We will offer two plans: BlueChoice Advantage EPO and BlueChoice Advantage PPO. By moving to CareFirst, County employees will have access to CareFirst's larger national network of providers and will still have the ability to go out of network depending on the plan you choose. Employees will continue to have increased flexibility and peace of mind knowing that they will have in-network coverage when traveling outside of Maryland or for their dependents who live in another state.

Rate Changes:
There is a rate increase of 6.00% across the board for both CareFirst medical plans. Slightly higher fixed costs are the main driver of the rate increase. There was a minimal increase in the rates for the dental and vision plans.

Telephone: 410-222-7595 www.aacounty.org Mail Stop: 9101
* Fax: Payroll/Records 410-222-7545 Recruitment 410-222-7650 Benefits/Pension 410-222-4512 Personnel Officer 410-224-3909

Dependent Care FSA:
Effective January 1, 2026, the annual contribution limit for Dependent Care FSA is raising from $5,000 to $7,500 for single individuals and married couples filing jointly. Married couples filing separately will have an annual contribution limit of $3,750 each.

Benefit Fairs:
Open Enrollment Benefits Fairs will be held both in-person and virtually during the month of October. The schedule of fairs and all the information on Open Enrollment for 2026 is located on-line here: https://aacounty.org/personnel/employee-retiree-information/county-employee-information/health-information. Additionally, medical plan offerings and design can be viewed by visiting CareFirst's microsite at carefirst.com/aacg. Please plan to attend a session and take advantage of the opportunity to learn about our plans and ask any questions you may have.

PLEASE REMEMBER – ALL EMPLOYEES WHO WISH TO MAINTAIN HEALTH INSURANCE COVERAGE THROUGH THE COUNTY IN 2026 MUST CHOOSE A NEW CAREFIRST MEDICAL PLAN BY OCTOBER 31, 2025.

Employees should use the ADP Portal to make your benefit elections for 2026. These elections must be made before the open enrollment deadline on October 31, 2025. Employees who wish to enroll in the Flexible Spending Account (FSA) plan for 2026 must enroll through the Self Service Portal by October 31st.

All required supporting documentation for changes that you make (*i.e.,* birth certificates, adoption paperwork, marriage certificate, etc.) must be **received** by the Benefits Office by **October 31, 2025**. You can fax your paperwork to (410) 222-4512 or send via email to the Benefits team at benefits_team@aacounty.org. Once Open Enrollment ends, benefits changes are only permitted within 31 days of a qualifying event. Qualifying events are outlined in the enrollment guide under **Benefits Eligibility and Rules for Mid-Year Changes**.

BENEFITS *Fairs*

We will have both in-person Health Fairs and virtual Vendor Fairs. Plan to attend one of these sessions for information from the County Health Benefit vendors. At the in-person Health Fairs, influenza shots will be administered on a first-come, first served basis to County employees and retirees enrolled in a County medical plan (bring your medical ID card). Please see the schedules below. The complete schedule of fairs and virtual fairs sign-up information is located at https://www.aacounty.org/personnel/employee-retiree-information/county-employee-information/health-information

IN-PERSON HEALTH FAIR SCHEDULE

Date	Location	Time
10/2/25	Personnel Training Room 2660 Riva Road, 1st Floor, Annapolis	11:00 a.m. to 1:00 p.m.
10/7/25	Arundel Center 44 Calvert Street, Lower Level Conference, Annapolis	11:00 a.m. to 1:00 p.m.
10/22/25	DPW Utility Operations Complex 445 Maxwell Frye Road, Building A, Millersville	11:00 a.m. to 1:00 p.m.

VIRTUAL VENDOR FAIR SCHEDULE

Log-in information regarding the virtual meetings will be sent one week prior to the event.

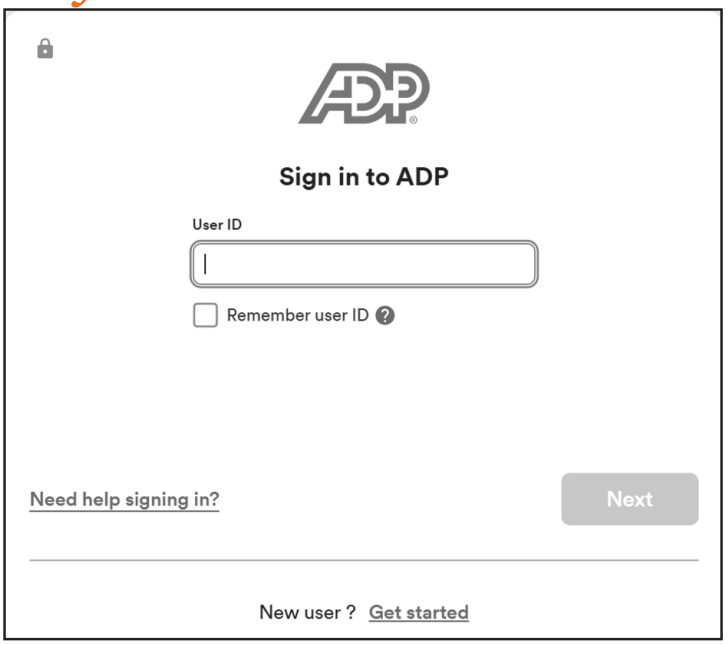
Date		Time
10/16/25	Caremark will be presenting about our pharmacy plan	12:00 p.m. to 1:00 p.m.
10/17/25	CIGNA will be presenting about our dental plans	12:00 p.m. to 1:00 p.m.
10/20/25	Ameriflex will be presenting about our Flexible Spending Account (FSA) plans	12:00 p.m. to 1:00 p.m.
10/21/25	EyeMed will be presenting about our vision plan	12:00 p.m. to 1:00 p.m.
10/23/25	MetLife will be presenting about our life and disability plans	12:00 p.m. to 1:00 p.m.
10/24/25	CareFirst will be presenting about our medical plans	12:00 p.m. to 1:00 p.m.
10/27/25	CareFirst will be presenting about our medical plans	12:00 p.m. to 1:00 p.m.
10/28/25	CareFirst will be presenting about our medical plans	12:00 p.m. to 1:00 p.m.
10/29/25	CareFirst will be presenting about our medical plans	12:00 p.m. to 1:00 p.m.
10/30/25	CareFirst will be presenting about our medical plans	12:00 p.m. to 1:00 p.m.

AAC *Employee & Retiree Benefits Center*

The AAC Employee & Retiree Benefits Center is your one stop-shop for managing your County health and welfare benefits.

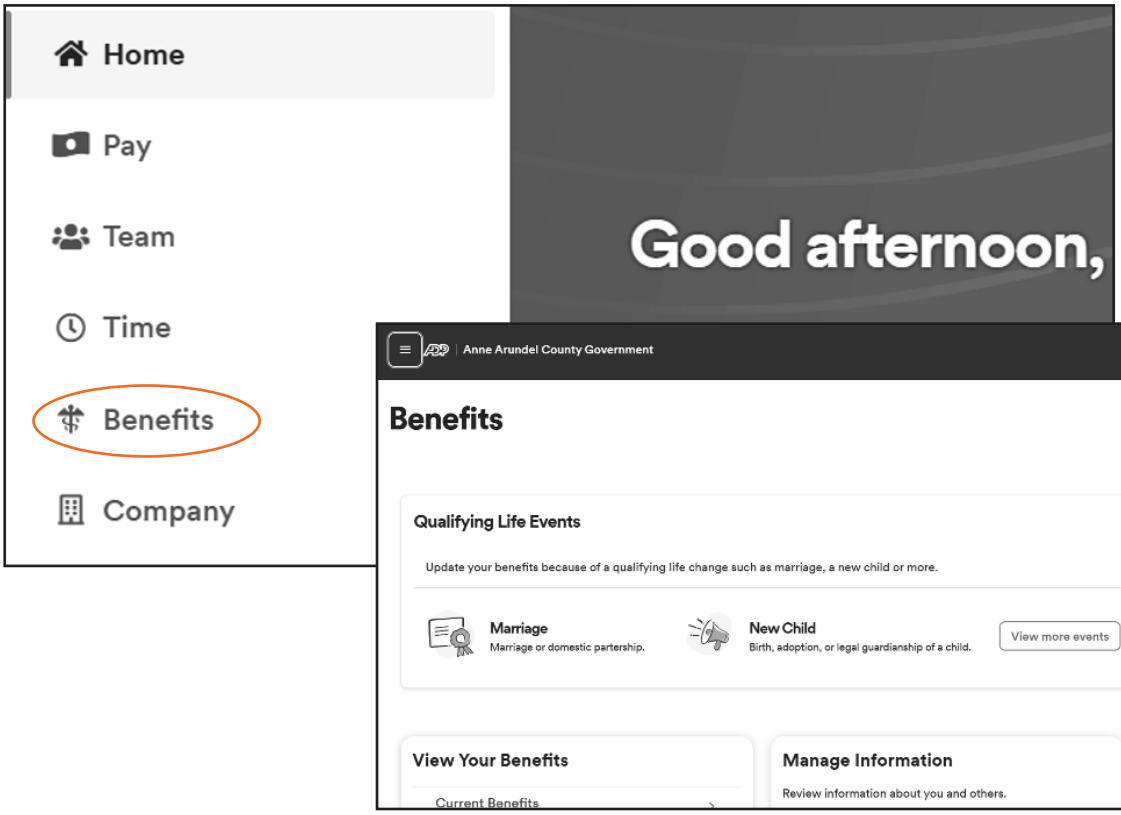
Register for ADP Portal through the employee self-service portal:
https://my.adp.com

If you need a registration code or your password reset for the self-service portal, please call **410-222-4535**.



After logging into the ADP Portal, employees and retirees can:

- **View** your current benefits elections
- **View** a list of dependents who are enrolled on your plan
- **Make changes** to your benefit elections following qualifying events
- **Make changes** to your benefit elections during the annual open enrollment
- **View and update** your life insurance beneficiaries (if applicable)
- **Obtain** benefits forms and plan summaries
- **Print** a summary of benefits in which you are enrolled



During Open Enrollment, you will see a box on your dashboard that says: Open Enrollment. Click the link and follow the prompts to make your selections.

YOUR BENEFIT *Options At-a-Glance*

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

TYPE OF BENEFIT		YOUR BENEFIT OPTIONS FOR 2026	PAGE
Medical Care *(includes Caremark Prescription Drug coverage)*	BlueChoice Advantage EPO	CareFirst national network allows you to seek care within the state or outside of Maryland within their network of providers. Care received outside the network is not covered. Referrals are not necessary for visits with network specialists.	15
	BlueChoice Advantage PPO	Offers two levels of coverage depending on the provider you visit, along with the freedom to see any provider you wish. Annual deductible and co-payment/ co-insurance vary by coverage level. Choose in-network providers for lower out-of-pocket cost.	18
Dental Care	CIGNA Dental HMO (DHMO)	Plan payments are based on a schedule of co-pays for dental services. All care must be coordinated by a CIGNA DHMO Network Dentist. No benefits are paid for out-of-network care. CIGNA DHMO is a national network--contact Cigna for a list of participating DHMO dentists.	28
	CIGNA Dental PPO (CORE)	Plan pays a percentage of most dental services and supplies. $1,000 annual benefit maximum plus separate $1,000 orthodontia benefit. Participants may use CIGNA PPO network or non-network dentists. Use of network dentists for the lowest out-of-pocket cost.	32
	CIGNA Dental PPO (Buy-Up)	Plan pays a percentage of most dental services and supplies. $2,000 annual benefit maximum for in-network benefits and $1,500 for out of network benefits. Separate orthodontia benefit of $2,500 for dependent children (up to age 26) for both in network and out of network providers. Participants may use CIGNA PPO network or non-network dentists. Use of network dentists for the lowest out-of-pocket cost.	34
Vision Care	EyeMed	Plan pays set amount towards annual eye exams, eyeglasses or contact lenses. Use EyeMed providers for the lowest out-of-pocket cost.	41
Flexible Spending Accounts Must enroll Annually *(Employees Only)*	Health Care FSA	Set aside up to $3,300 to pay for eligible healthcare expenses with tax-free dollars. Must Enroll Annually. *(Employees Only)*	44
	Dependent Care FSA	Set aside up to $7,500 ($3,750 if married, filing separately) to pay for eligible dependent day care expenses with tax-free dollars. 13 is the age limit for dependent children. Must Enroll Annually. *(Employees Only)*	44

YOUR BENEFIT *Options At-a-Glance (Cont.)*

TYPE OF BENEFIT		YOUR BENEFIT OPTIONS FOR 2026	PAGE
Life Insurance with MetLife	Basic Life Insurance	In the event of your death, pays your beneficiary a benefit based on your employment classification. *(Employees only)*	46
	Supplemental Life Insurance	Elect additional life insurance coverage in amounts from $25,000 to $400,000. Completion of the Evidence of Insurability form is required for increased coverage during Open Enrollment *(Employees Only; Retirees may not add or increase coverage)*.	46
	Spouse Life Insurance	Elect to receive $5,000, $25,000 or $50,000 in the event of your spouse's death. Policy value may not exceed 50% of the Employee's policy value. Completion of the Evidence of Insurability form is required for increased coverage during Open Enrollment and $50k for new hires or newly benefit eligible employees. *(Employees Only)*.	47
	Dependent Life Insurance	Elect to receive $2,500, $5,000 or $10,000 in the event of your dependent child(ren)'s death. Dependents up to age 26 are eligible. Policy value may not exceed 50% of the Employee's policy value. *(Employees Only)*	47
	AD&D Insurance	Pays your beneficiary an additional benefit if your death results from an accident. Also pays a benefit for certain injuries resulting from an accident. *(Employees Only)*	47
Short-term Disability Benefits (STD)	Voluntary Benefits	(STD) insurance pays a percentage of your salary for a specified amount of time, if you fall ill or get injured, and cannot perform the duties of your job. The benefit pays approximately 60 percent of your weekly gross income. Maximum duration is 6 months only). *(Employees Only)*	49
Long-term Disability Benefits (LTD)	Voluntary Benefits	(LTD) insurance pays a percentage of your salary if you fall ill or get injured, and cannot perform the duties of your job. The benefit pays approximately 60 percent of your weekly gross income. Benefit begins after 6 months of continued disability. (Employees Only)	49
Other Benefits	Voluntary and Other Benefits	Includes universal life insurance with a long-term care rider and group legal benefits.	53

2026 *Employee Contributions*

2026 Anne Arundel County General Employee Rate Schedule - Effective - 1/1/26 to 12/31/26

At Employee Cost Share of 25% for CareFirst BlueChoice Advantage PPO; 15% for CareFirst BlueChoice Advantage EPO

Employee Biweekly Pre-tax Deduction (or Taxable additional To Pay) — Bi-Weekly Rates

Medical and Dental Options	Individual	Parent and Child	Employee and Spouse	Family
BLUECHOICE ADVANTAGE PPO				
CareFirst BlueChoice Advantage PPO with No Dental Coverage	$122.09	$217.07	$260.71	$339.12
CareFirst BlueChoice Advantage PPO with CIGNA Dental Care (DHMO)	$122.94	$217.92	$261.56	$339.97
CareFirst BlueChoice Advantage PPO with CIGNA Dental PPO	$123.94	$218.92	$262.56	$340.97
CareFirst BlueChoice Advantage PPO with CIGNA Dental PPO Buy-Up	$133.03	$235.06	$283.47	$364.22
BLUECHOICE ADVANTAGE EPO				
CareFirst BlueChoice Advantage EPO with No Dental Coverage	$56.31	$103.12	$122.74	$158.99
CareFirst BlueChoice Advantage EPO with CIGNA Dental Care (DHMO)	$57.16	$103.97	$123.59	$159.84
CareFirst BlueChoice Advantage EPO with CIGNA Dental PPO	$58.16	$104.97	$124.59	$160.84
CareFirst BlueChoice Advantage EPO with CIGNA Dental PPO Buy-Up	$67.25	$121.11	$145.50	$184.09
CIGNA DENTAL				
CIGNA Dental Care DHMO*	$0.00	$0.00	$0.00	$0.00
CIGNA Dental Care PPO*	$0.00	$0.00	$0.00	$0.00
CIGNA Dental Care PPO Buy-Up	$9.09	$16.14	$20.91	$23.25
VISION				
EyeMed Vision	$0.00	$0.00	$0.00	$0.00
OPT OUT				
CIGNA Dental Care (DHMO) with No Health	($20.15)	($20.15)	($20.15)	($20.15)
CIGNA Dental Care (PPO) with No Health	($19.15)	($19.15)	($19.15)	($19.15)
CIGNA Dental Care (PPO Buy-Up) with No Health	($19.15)	($19.15)	($19.15)	($19.15)
No Coverage (Opt Out)	($21.00)	($21.00)	($21.00)	($21.00)
No Coverage (Opt Out) AFSCME Local 2563	($28.85)	($28.85)	($28.85)	($28.85)

Notes:
This Schedule is intended to provide a convenient cost comparison of various health plan options.
Bi-weekly means 26 times/year.
Amounts in ( ) indicate an addition to pay.
There is no charge for vision care.
**Cigna DHMO and DPPO 100% are Employer paid.*

Anne Arundel County

EMPLOYEE *Contribution Comparison Chart*

Effective – 1/1/26 to 12/31/26

This chart details the County medical insurance cost (plans bundled with CIGNA Core PPO Dental, Vision and the cost to employees.)

Medical Plans		Total Rate	Monthly County Contribution	Monthly Employee Contribution	Biweekly Employee Contribution (26 Pay Periods)
BLUECHOICE ADVANTAGE PPO	Individual	$1,074.14	$805.61	$268.53	$123.94
	Parent & Child	$1,897.30	$1,422.98	$474.32	$218.92
	Employee & Spouse	$2,275.56	$1,706.67	$568.89	$262.56
	Family	$2,955.08	$2,216.31	$738.77	$340.97
BLUECHOICE ADVANTAGE EPO	Individual	$840.13	$714.11	$126.02	$58.16
	Parent & Child	$1,516.30	$1,288.86	$227.44	$104.97
	Employee & Spouse	$1,799.57	$1,529.63	$269.94	$124.59
	Family	$2,323.19	$1,974.71	$348.48	$160.84

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PART-TIME *Rate Schedule*

Effective - 1/1/26 to 12/31/26 (for part-time employees eligible for medical insurance benefits)
This chart details the County medical insurance cost (plans bundled with CIGNA PPO dental) and the cost to employees.

	BI-WEEKLY DEDUCTION			
BLUECHOICE ADVANTAGE PPO	**50% FTE**	**60% FTE**	**70% FTE**	**80% FTE**
Individual	$309.85	$272.67	$235.48	$198.30
Parent & Child	$547.30	$481.62	$415.95	$350.27
Employee & Spouse	$656.41	$577.64	$498.87	$420.10
Family	$852.43	$750.14	$647.84	$545.55
BLUECHOICE ADVANTAGE EPO	**50% FTE**	**60% FTE**	**70% FTE**	**80% FTE**
Individual	$222.96	$190.00	$157.04	$124.08
Parent & Child	$402.40	$342.92	$283.43	$223.95
Employee & Spouse	$477.58	$406.98	$336.38	$265.78
Family	$616.54	$525.40	$434.26	$343.12

Dental Core and Vision coverage are included in the above rates. Bi-weekly means 26 times/year. All deductions are pre-tax.

CIGNA DENTAL (BUY-UP)	**50% FTE**	**60% FTE**	**70% FTE**	**80% FTE**
Individual	$9.09	$9.09	$9.09	$9.09
Parent & Child	$16.14	$16.14	$16.14	$16.14
Employee & Spouse	$20.91	$20.91	$20.91	$20.91
Family	$23.25	$23.25	$23.25	$23.25

Buy-Up Premium is the same cost for all employees regardless of FTE status

COBRA MONTHLY RATE SCHEDULE
January 1, 2026 - December 31, 2026 • (2% Surcharge)

BLUECHOICE ADVANTAGE PPO	**Monthly Total**
Individual	$1,095.62
Parent & Child	$1,935.25
Employee & Spouse	$2,321.07
Family	$3,014.18

VISION PLAN (EyeMed)	**Monthly Total**
Individual	$4.03
Parent & Child	$8.02
Employee & Spouse	$10.26
Family	$11.65

AETNA MEDICARE ADVANTAGE PPO ESA	$763.25

BLUECHOICE ADVANTAGE EPO	**Monthly Total**
Individual	$856.93
Parent & Child	$1,546.63
Employee & Spouse	$1,835.56
Family	$2,369.65

Anne Arundel County

COBRA *(continued)*

COBRA MONTHLY RATE SCHEDULE January 1, 2026 - December 31, 2026 • (2% Surcharge)			
CIGNA DENTAL	**Dental DHMO**	**Dental PPO**	**PPO (Buy-Up)**
Individual	$18.93	$36.79	$56.88
Parent & Child	$37.85	$65.25	$100.91
Employee & Spouse	$48.09	$84.64	$130.86
Family	$54.68	$94.04	$145.42

SCHOOL *Health*

RN, LPN, PDS Aides and Health Assistants

Effective - 1/1/26 to 12/31/26

At Employee Cost Chare of 25% for CareFirst BlueChoice Advantage PPO; 15% for CareFirst BlueChoice Advantage EPO. Rates are based on 20 paychecks per year and include Cigna Core Dental PPO & EyeMed Vision Coverage.

BLUECHOICE ADVANTAGE PPO	Monthly Total	Employee Deduction Bi-Weekly
Individual	$1,074.14	$161.12
Parent & Child	$1,897.30	$284.59
Employee & Spouse	$2,275.56	$341.33
Family	$2,955.08	$443.26
BLUECHOICE ADVANTAGE EPO	**Monthly Total**	**Employee Deduction Bi-Weekly**
Individual	$840.13	$75.61
Parent & Child	$1,516.30	$136.46
Employee & Spouse	$1,799.57	$161.96
Family	$2,323.19	$209.09
CIGNA DENTAL (BUY-UP)	**Monthly Total**	**Employee Deduction Bi-Weekly**
Individual	$55.76	$11.81
Parent & Child	$98.93	$20.98
Employee & Spouse	$128.29	$27.19
Family	$142.57	$30.22

RECREATION *and Parks*

Child Care Directors and Assistant Child Care Directors

Effective - 1/1/26 to 12/31/26

Rates are based on 20 paychecks per year and include Cigna Core Dental PPO & Vision Coverage.

		85% County Subsidy Rate based on 20 deductions
BLUECHOICE ADVANTAGE EPO	**Total Monthly Rate**	**Employee Deduction Bi-Weekly**
Individual	$840.13	$75.61
Parent & Child	$1,516.30	$136.46
Employee & Spouse	$1,799.57	$161.96
Family	$2,323.19	$209.09
CIGNA DENTAL (BUY-UP)	**Total Monthly Rate**	**Employee Deduction Bi-Weekly**
Individual	$55.76	$11.81
Parent & Child	$98.93	$20.98
Employee & Spouse	$128.29	$27.19
Family	$142.57	$30.22

Anne Arundel County

RETIREE *Rate Schedule*

Effective – 1/1/26 to 12/31/26

At 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 Benefits Unit for specific subsidy rate information.

Retirees and spouses 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	Monthly Total Cost	Monthly County Cost	Monthly Retiree Cost
BLUECHOICE ADVANTAGE PPO			
Individual	$1,074.14	$859.31	$214.83
Retiree and Child	$1,897.30	$1,517.84	$379.46
Retiree and Spouse	$2,275.56	$1,820.45	$455.11
Family	$2,955.08	$2,364.06	$591.02
BLUECHOICE ADVANTAGE EPO			
Individual	$840.13	$672.10	$168.03
Retiree and Child	$1,516.30	$1,213.04	$303.26
Retiree and Spouse	$1,799.57	$1,439.66	$359.91
Family	$2,323.19	$1,858.55	$464.64

MEDICARE ADVANTAGE

(For retiree or spouse eligible for medicare due to age or disability)

AETNA MEDICARE ADVANTAGE PPO ESA	Total Cost	County Cost	Retiree Cost
Individual	$748.28	$598.62	$149.66
Retiree and Spouse	$1,496.56	$1,197.24	$299.32

	CIGNA Dental DHMO *(DHMO-network dentist required)*	CIGNA Dental PPO (Core)	CIGNA Dental PPO (Buy-up)	Vision EyeMed
Individual	$18.56	$36.07	$55.76	$3.95
Retiree and Child	$37.11	$63.97	$98.93	$7.86
Retiree and Spouse	$47.15	$82.98	$128.29	$10.06
Family	$53.61	$92.20	$142.57	$11.42

BlueChoice Advantage EPO Summary of Benefits

Anne Arundel County Government

Services	In-Network You Pay[1,2]	Out-of-Network You Pay[1,3]
	Visit **www.carefirst.com/doctor** to locate providers and facilities	
24-HOUR NURSE ADVICE LINE		
Free advice from a registered nurse. Visit **www.carefirst.com/needcare** to learn more about your options for care.	When your doctor is not available, call 800-535-9700 to speak with a registered nurse about your health questions and treatment options.	
WELLBEING PROGRAM		
Visit **www.carefirst.com/wellbeing** for more information.	You have access to a comprehensive wellbeing program as part of your medical plan.	
ANNUAL DEDUCTIBLE (Benefit period)[4]		
Individual	$100	None
Family	$200	None
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit period)[5]		
Medical[6]	$1,100 Individual/$3,600 Family	N/A
Prescription Drug[6]	N/A	N/A
LIFETIME MAXIMUM BENEFIT		
Lifetime Maximum	None	None
PREVENTIVE SERVICES		
Well-Child Care (including exams & immunizations)	No charge*	Not covered
Adult Physical Examination (including routine GYN visit)	No charge*	Not covered
Breast Cancer Screening	No charge*	Not covered
Pap Test	No charge*	Not covered
Prostate Cancer Screening	No charge*	Not covered
Colorectal Cancer Screening	No charge*	Not covered
OFFICE VISITS, LABS AND TESTING		
Office Visits for Illness	$15 PCP/$15 Specialist per visit	Not covered
Virtual Visits for Illness	Virtual Connect Plus through selected providers, including CloseKnit[7] - $15 per visit (**www.carefirst.com/virtualconnect**)	Not covered
Imaging (MRA/MRS, MRI, PET & CAT scans)[9]	No charge*	Not covered
Lab[9]	No charge*	Not covered
X-ray[9]	No charge*	Not covered
Allergy Testing	$15 PCP/$15 Specialist per visit	Not covered
Allergy Shots	$15 PCP/$15 Specialist per visit	Not covered
Physical, Speech and Occupational Therapy[8] (limited to 150 visits/benefit period)	$15 per visit	Not covered
Chiropractic	$15 per visit	Not covered
Acupuncture (limited to 50 visits/benefit period)	$15 per visit	Not covered

BlueChoice Advantage EPO Summary of Benefits

Services	In-Network You Pay[1,2]	Out-of-Network You Pay[1,3]
EMERGENCY SERVICES		
Urgent Care Center	$35 per visit	Not covered
Emergency Room—Facility Services	$75 per visit (waived if admitted)	$75 per visit (waived if admitted)
Emergency Room—Physician Services	No charge*	No charge*
Ambulance	No charge*	No charge*
HOSPITALIZATION—(Members are responsible for applicable physician and facility fees)		
Outpatient Facility Services	$25 per visit	Not covered
Outpatient Physician Services	$15 per visit	Not covered
Inpatient Facility Services	No charge* after deductible	Not covered
Inpatient Physician Services	No charge*	Not covered
HOSPITAL ALTERNATIVES		
Home Health Care	No charge* after deductible	Not covered
Hospice	No charge*	Not covered
Skilled Nursing Facility (limited to 120 days/benefit period)	No charge* after deductible	Not covered
MATERNITY		
Preventive Prenatal and Postnatal Office Visits	No charge*	Not covered
Delivery and Facility Services	No charge* after deductible	Not covered
Nursery Care of Newborn	No charge*	Not covered
Artificial and Intrauterine Insemination[10] (limited to 6 attempts per live birth)	$15 per visit	Not covered
In Vitro Fertilization Procedures[10] (limited to 3 attempts per live birth up to $100000 lifetime maximum)	$15 per visit	Not covered
MENTAL HEALTH AND SUBSTANCE USE DISORDER—(Members are responsible for applicable physician and facility fees)		
Inpatient Facility Services	No charge* after deductible	Not covered
Inpatient Physician Services	No charge*	Not covered
Outpatient Facility Services	No charge*	Not covered
Outpatient Physician Services	No charge*	Not covered
Office Visits	$15 per visit	Not covered
Virtual Visits	Virtual Connect Plus through selected providers, including CloseKnit[7] - $15 per visit (**www.carefirst.com/virtualconnect**)	Not covered
MEDICAL DEVICES AND SUPPLIES		
Durable Medical Equipment	No charge* after deductible	Not covered
Hearing Aids Limited to 2 hearing aids every 3 years; Limited to $1,400 per hearing aid.	No charge*	Not covered
VISION		
Routine Exam	Not covered	Not covered
Eyeglasses and Contact Lenses	Not covered	Not covered

*No copayment or coinsurance.

Note: Allowed Benefit is the fee that participating, in-network providers have agreed to accept for a particular covered service. The provider cannot charge the member more than this amount for any covered service. Example: Dr. Carson charges $100 to see a sick patient. To be part of CareFirst's network, he has agreed to accept $50 for the visit. The member will pay their copay/coinsurance and deductible (if applicable) and CareFirst will pay the remaining amount up to $50.

This summary is for comparison purposes only and does not create rights not given through the benefit plan. Not all services and procedures are covered by your benefits contract. Some services may have limitations or exclusions. For more information about plan benefits, limitations, exclusions and conditions of coverage, or for a copy of the complete terms of coverage please contact your employer or CareFirst.

1 When multiple services are rendered on the same day by more than one provider, Member payments are required for each provider.

2 This plan uses a provider network. In-network doctors and healthcare providers are those that are part of the plan's network (also known as participating providers). When an in-network provider is chosen, Members pay the lowest out-of-pocket costs. Members should confirm the plan's network and check with providers before accessing services.

3 If your plan has Out-of-Network coverage: Out-of-network doctors and healthcare providers have not contracted with CareFirst. If you choose to receive care from an out-of-network provider, you can expect to pay more and, in some cases, may be responsible for the entire amount billed. Members should confirm the plan's network and check with providers before accessing services.

4 Generally, you must pay all the costs from provider up to the deductible amount before this plan begins to pay. If you have other family member(s) on the plan, each family member may need to meet their own individual deductible, OR all family members may combine to meet the overall family deductible before the plan begins to pay, depending upon plan coverage. Please refer to your contract for further details.

5 The out-of-pocket limit is the most you could pay in a plan year for covered services. If you have other family member(s) on the plan, each family member may need to meet their own out-of-pocket limits, OR all family members may combine to meet the overall family out-of-pocket limit, depending upon plan coverage. Please refer to your contract for further details.

6 If plan has integrated medical and prescription drug, both contribute to the plan's out-of-pocket maximum. If plan has separate out-of-pocket maximums, medical and drug expenses accumulate independently.

7 CloseKnit is a registered Trademark owned by, and is the trade name of, Atlas Health, LLC. Atlas Health, LLC d/b/a and is providing in person and telehealth services to CareFirst members. Atlas Health, LLC is a corporate affiliate within the CareFirst, Inc. corporate umbrella of companies.

8 There are no visit limits for Physical, Speech or Occupational Therapy when included as part of Habilitative Services for Maryland members under the age of 19 or Washington, D.C. members under the age of 21, or for the treatment of Autism Spectrum Disorder for Virginia members.

9 Members accessing laboratory tests, x-rays, and specialty imaging services inside the CareFirst Service Area (Maryland, Washington, D.C., Northern Virginia) must use a designated Contracting Provider and/or Contracting Facility which may include a non-hospital/freestanding facility for In-Network benefits.

10 Members who are unable to conceive have coverage for the evaluation of infertility services performed to confirm an infertility diagnosis, and some treatment options for infertility. Preauthorization required.

For BlueChoice HMO, BlueChoice HMO Referral and BlueChoice Plus plans, members must live or work within the CareFirst service area of Maryland, Washington, D.C. or Northern Virginia.

Note: For Members enrolling in CareFirst BlueChoice plan, a Primary Care Provider (PCP) must be selected upon enrollment.

BlueChoice Advantage PPO Summary of Benefits

Anne Arundel County Government

Services	In-Network You Pay[1,2]	Out-of-Network You Pay[1,3]
	Visit **www.carefirst.com/doctor** to locate providers and facilities	
24-HOUR NURSE ADVICE LINE		
Free advice from a registered nurse. Visit **www.carefirst.com/needcare** to learn more about your options for care.	When your doctor is not available, call 800-535-9700 to speak with a registered nurse about your health questions and treatment options.	
WELLBEING PROGRAM		
Visit **www.carefirst.com/wellbeing** for more information.	You have access to a comprehensive wellbeing program as part of your medical plan.	
ANNUAL DEDUCTIBLE (Benefit period)[4]		
Individual	$125	$500
Family	$250	$1,000
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit period)[5]		
Medical[6]	$500 Individual/$1,000 Family	$1,500 Individual/$3,000 Family
Prescription Drug[6]	N/A	N/A
LIFETIME MAXIMUM BENEFIT		
Lifetime Maximum	None	None
PREVENTIVE SERVICES		
Well-Child Care (including exams & immunizations)	No charge*	Deductible, then 30% of Allowed Benefit
Adult Physical Examination (including routine GYN visit)	No charge*	Deductible, then 30% of Allowed Benefit
Breast Cancer Screening	No charge*	Deductible, then 30% of Allowed Benefit
Pap Test	No charge*	Deductible, then 30% of Allowed Benefit
Prostate Cancer Screening	No charge*	Deductible, then 30% of Allowed Benefit
Colorectal Cancer Screening	No charge*	Deductible, then 30% of Allowed Benefit
OFFICE VISITS, LABS AND TESTING		
Office Visits for Illness	$15 PCP/$35 Specialist	Deductible, then 30% of Allowed Benefit
Virtual Visits for Illness	Virtual Connect Plus through selected providers, including CloseKnit[7] - $15 PCP/ $35 Specialist (**www.carefirst.com/virtualconnect**)	Deductible, then 30% of Allowed Benefit
Imaging (MRA/MRS, MRI, PET & CAT scans)[9]	Deductible, then 5% of Allowed Benefit	Deductible, then 5% of Allowed Benefit
Lab[9]		
■ Independent Lab	No charge*	Deductible, then 5% of Allowed Benefit
■ All Others	Deductible, then 5% of Allowed Benefit	Deductible, then 5% of Allowed Benefit
X-ray[9]	No charge*	Deductible, then 5% of Allowed Benefit
Allergy Testing	Deductible, then 5% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Allergy Shots	$15 PCP/$35 Specialist per visit	Deductible, then 30% of Allowed Benefit
Physical, Speech and Occupational Therapy[8] (limited to 300 visits/benefit period)	$35 per visit	Deductible, then 30% of Allowed Benefit
Chiropractic	$35 per visit	Deductible, then 30% of Allowed Benefit
Acupuncture	$35 per visit	Deductible, then 30% of Allowed Benefit

BlueChoice Advantage PPO Summary of Benefits

Services	In-Network You Pay[1,2]	Out-of-Network You Pay[1,3]
EMERGENCY SERVICES		
Urgent Care Center	$35 per visit	$35 per visit
Emergency Room—Facility Services	$75 per visit (waived if admitted)	$75 per visit (waived if admitted)
Emergency Room—Physician Services	No charge*	No charge*
Ambulance	No charge*	No charge*
HOSPITALIZATION—(Members are responsible for applicable physician and facility fees)		
Outpatient Facility Services	Deductible, then 5% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Outpatient Physician Services	$15 PCP/$35 Specialist per visit	Deductible, then 30% of Allowed Benefit
Inpatient Facility Services	Deductible, then 5% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Inpatient Physician Services	Deductible, then 5% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
HOSPITAL ALTERNATIVES		
Home Health Care	No charge*	No charge*
Hospice	No charge*	No charge*
Skilled Nursing Facility	Deductible, then 5% of Allowed Benefit	Deductible, then 30% of Allowed Benefit (limited to 120 days per benefit period)
MATERNITY		
Preventive Prenatal and Postnatal Office Visits	No charge*	Deductible, then 30% of Allowed Benefit
Delivery and Facility Services	Deductible, then 5% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Nursery Care of Newborn	No charge*	Deductible, then 30% of Allowed Benefit
Artificial and Intrauterine Insemination[10] (limited to 6 attempts per live birth)	Deductible, then 5% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
In Vitro Fertilization Procedures[10] (limited to 3 attempts per live birth up to $100000 lifetime maximum)	Deductible, then 5% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
MENTAL HEALTH AND SUBSTANCE USE DISORDER—(Members are responsible for applicable physician and facility fees)		
Inpatient Facility Services	Deductible, then 5% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Inpatient Physician Services	Deductible, then 5% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
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Hearing Aids Limited to 2 hearing aids every 3 years; Limited to $1,400 per hearing aid	No charge*	No charge*
VISION		
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BlueChoice Advantage PPO Summary of Benefits

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Note: For Members enrolling in CareFirst BlueChoice plan, a Primary Care Provider (PCP) must be selected upon enrollment.

Take Charge of Your Diabetes

As a CareFirst BlueCross BlueShield (CareFirst) member, you have access to support resources that can help you live a longer, healthier life.

What is The Diabetes Virtual Care Program?

The program is a partnership between CareFirst and Omada Health[1] that helps you manage diabetes and reach your health goals. With support from a dedicated care team and smart tracking tools, you'll make lasting changes at your own pace.

Who is eligible for the program?

All CareFirst members who are 18 years and older and have a diagnosis of type 2 diabetes with an A1C level of 8% or greater are encouraged to apply to the program.

I already see my doctor about my diabetes. Do I still need the program?

The program provides day-to-day support that complements your doctor's treatment.

What are the program features?

You get a program valued up to $1,700—at no cost to you (if eligible), that includes a personal health coach and clinical specialist, a personalized care plan, tools for managing stress, and online peer groups.

Plus, you get smart devices to monitor your blood glucose and track your progress: two continuous glucose monitor sensors (CGMs)*†, a blood glucose meter with all the test strips and lancets you need, and a smart scale* (if eligible).

How does the program work?

The program guides you through a new health focus each week by covering topics like nutrition, physical activity, blood pressure monitoring, and more. You'll get interactive lessons, support from a personal health coach, and tools to help you build lasting habits. Your coach will help you take control of your health in a way that works for you.

What is a continuous glucose monitor (CGM), and how does it work?

A CGM is a small sensor worn on the back of your upper arm that tracks your glucose levels 24/7, with no fingersticks required. With a quick scan using your smartphone, you can see patterns in your glucose levels, helping you better understand your body. The program provides two CGMs, one at enrollment and another six months later, each worn for 14 days. A prescription is required, but CareFirst makes the process quick and easy.

How do I communicate with my health coach?

You can connect with your health coach through the Omada app using private messaging or the group board. Your coach is there to support and guide you, and you can decide how often and in what way you'd like to engage—whether that's regular check-ins, quick questions, or goal-focused updates.

What's the time commitment?

The program is flexible, so you can participate whenever you want. Most members spend about 1-2 hours per week and stay in the program for at least a year, building healthy habits at their own pace.

How much does the program cost?

The program is available at no cost to you as part of your CareFirst health benefits.

Will my information be safe?

We take your personal health information seriously. Your participation in the program is confidential and we follow all federal and state privacy regulations. To learn more, please read the Privacy Policy, Terms of Use and Notice of HIPAA Privacy Practices.

How do I get started?

If you meet the program eligibility requirements, you can call a CareFirst registered nurse at **833-944-1335** to get started with your enrollment.

omada®

*Certain features and smart devices are only available if you meet program and clinical eligibility requirements.

†The no cost CGM excludes Medicare, Medicaid, and other government payers. The Abbott FreeStyle Libre 14 day system is available to eligible participants with a valid prescription and compatible smartphone. Setup is required for continuous glucose monitoring. The circular shape of the sensor housing, FreeStyle, Libre, and related brand marks are marks of Abbott. FreeStyle Libre 14 day system: Failure to use FreeStyle Libre 14 day system as instructed in labeling may result in missing a severe low or high glucose event and/or making a treatment decision, resulting in injury. If readings do not match symptoms or expectations, use a finger stick value from a blood glucose meter for treatment decisions. Seek medical attention when appropriate or contact Abbott at 855-632-8658 or FreeStyleLibre.us for safety info.

Images, including apps, do not reflect real members or information about a specific person.

[1] Omada Health is an independent company offering certain care management and coordinated clinical care programs for eligible individuals, as further described at omada.com. Omada Health services are meant to be used in conjunction with regular in-person clinical services and not intended to replace routine primary care.

CVS CAREMARK *Prescription Benefit Program*

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

When to use your benefit:	**CarePlus Retail Pharmacy 2666 Riva Road, Annapolis, MD** For immediate and maintenance medication needs	**CVS Caremark Retail Pharmacy Network** For short-term medications (Up to a 30-day supply)	**Maintenance Choice® CVS Caremark Mail Service Pharmacy or CVS/pharmacy** For long-term medications (Up to a 90-day supply)
Where	2666 Riva Road, Suite 110 Annapolis, MD 21401 Phone: 410-573-1635 Fax: 410-573-5012 Hours of Operation 7:30am – 5:30pm Monday - Friday	The CVS Caremark Retail Network includes more than 64,000 participating pharmacies nationwide, including independent pharmacies, chain pharmacies, and CVS/pharmacy locations. To locate a CVS Caremark participating retail network pharmacy in your area, simply click on "Find a Pharmacy" at www.caremark.com or call a Customer Care representative toll-free at 1-866-409-8521.	You have the convenience of getting your long-term medications at one of our 7,100 CVS/pharmacy locations for your mail service copay. Or simply mail your original prescription and the mail service order form to CVS Caremark. Your medications will be sent directly to your home, office or a location of your choice.
Generic Medications Ask your doctor or other prescriber if there is a generic available, as these generally cost less.	**$5** for a generic prescription	**$5** for a generic prescription	**$10** for a generic prescription
Preferred Brand-Name Medications If a generic is not available or appropriate, ask your doctor or healthcare provider to prescribe from your plan's preferred drug list.	**$22** for a preferred brand-name prescription	**$25** for a preferred brand-name prescription	**$50** for a preferred brand-name prescription
Non-Preferred Brand-Name Medications You will pay the most for medications not on your plan's preferred drug list.	**$32** for a non-preferred brand-name prescription	**$35** for a non-preferred brand-name prescription	**$70** for a non-preferred brand-name prescription
Refill Limit	None	One initial fill plus one refill for long-term medications up to a 30-day supply	No refill limit for maintenance medications for a 90-day supply
Web Services	Register at www.caremark.com to access tools that can help you save money and manage your prescription benefit. To register, have your Prescription Card ready.		
Customer Care	Visit www.caremark.com or call toll-free at 1-866-409-8521.		

Note:

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

2. Copayment, copay or coinsurance means the amount a plan participant is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan.

3. When a generic is available, but the pharmacy dispenses the brand-name medication for any reason, you will pay the difference between the brand-name medication and the generic plus the brand copayment. A brand penalty appeal form is available on Ask Anne.

Important Things to Know about the

CAREMARK *Prescription Drug Program*

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

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

Maintenance Choice Program

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

Option 1: CVS Caremark Mail Service Pharmacy:

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

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

Option 2: CVS/pharmacy:

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

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

Mandatory Generic Requirement

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

Plan Exclusions

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

- Over the Counter Drugs
- Cosmetic Products
- Nutritional Supplements
- Adult Multivitamins (except prenatal vitamins)
- Injectable Allergy Serums
- Topical Nail Fungal Treatment
- Blood Glucose Meters – AACG is enrolled in the diabetic meter program, where members are eligible to receive a free, preferred meter. In addition, Diabetic Supplies are covered at $0 copay (Includes Syringes, Test Strips, Lancets, Lancet Devices)
- Nebulizers
- Peak Flow Meters
- Blood Plasma/Blood Transfusion Agents
- Weight-loss drugs
- Vitamins and minerals (except for prescription pre-natal)
- Drugs that are labeled by the FDA as "less than effective," and
- Cosmetic products (not including acne medications)

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

Other Clinical Management Programs

- Formulary Management (3-tier copay design + select formulary exclusions)
- Performance Generic Step Therapy (must use generic alternatives before select brands are covered)
- Mandatory Generic Requirement (Dispense as Written – DAW 1 and DAW 2 penalties)
- Compound Management Strategy Exclusions – includes bulk powders and miscellaneous formulations, such as kits, select topical analgesics, scar products, etc.
- Unapproved Product Strategy Exclusions

Prior Authorization (PA)

- Specialty Guideline Management (all Specialty drugs)
- Topical Acne Agents
- Core Compound Strategy (PA >$300 + exclusions)
- Diet/Weight Loss Drugs
- Cialis to treat Prostate Cancer or BPH
- Oral/Intranasal Fentanyl PA (with limits)

For more information call 1-866-814-5506. Fax your prior authorization requests to 1-866-443-1172.

Prescription Drug Quantity Limits

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

- Migraine Drugs (e.g., Imitrex)
- Erectile Dysfunction (e.g., Cialis); Post Limit PA on Cialis 5mg
- Influenza Drugs (e.g., Tamiflu) – with post-limit PA
- Opioids – with post-limit PA
- Topical Lidocaine Limits – with post-limit PA (Core program)

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

Preferred drugs are those medications that CVS Caremark has on its primary/preferred drug list. This list may change at any time, and is published on the Caremark website in January, April, July and October and also on Ask Anne.

The CVS Caremark pharmacists evaluate each medication approved by the Food and Drug Administration (FDA) before adding it to the primary/preferred drug list. Each drug is reviewed for safety, side effects, efficacy (how well the drug works), ease of dosage, and cost. The drugs that are judged the best overall are selected as primary/preferred drugs. Your out-of-pocket costs will be less if you choose primary/preferred drugs.

Performance Drug List

CVS/Caremark has a performance drug list that is printed and published in January, April, July and October of medications that have demonstrated enhanced clinical efficacy and/or provide more convenient dosage forms. They will remove products that may require less convenient therapy dosing, have more side effects or cost more when compared to available options on the list.

The CVS/Caremark pharmacists evaluate each medication approved by the Food and Drug Administration (FDA) before adding it to the performance drug list. Your out-of-pocket costs will be less if you choose a drug on the performance drug list. These lists are updated quarterly. You can get a copy from Ask Anne or from the Caremark website

Specialty Pharmacies for Highly Specialized Drugs

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

To find out more about all the benefits that CVS Caremark Specialty Pharmacy Services has to offer—including express delivery, follow-up care calls, expert counseling, and more, contact CaremarkConnect® at **1-800-237-2767**.

DENTAL *Options*

Anne Arundel County Government offers eligible employees and retirees the choice of the following dental plan options: CIGNA Dental Care DHMO and CIGNA Dental PPO.

CIGNA Dental Care (DHMO)

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

Follow these Easy Steps to use your CIGNA Dental Care (DHMO) Plan:

1) Select a DHMO Network Dentist & Inform CIGNA of your Selected Dentist

- **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 including your patient charge schedule, replacement ID cards, provider look-up and much more.
- **Call us –** Our dedicated team of trained service professionals are ready to assist you with any questions about your coverage, they 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**

- **NOTE:** Each covered family member can choose his or her own network general dentist – near home, work or school. A dental ID card will be mailed to you only after you have informed CIGNA which network dentist you've selected.
- You can change your dental office at any time by visiting **myCIGNA.com**, using our automated Quick Transfer option or by simply calling customer service at **1-800-CIGNA24**. The change will become effective the first of the following month.

2) Visit your Network Dentist

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

CIGNA Dental PPO Options

The CIGNA Dental PPO (DPPO) plan balances choice and savings, giving you more reasons to smile! You have two options with the Dental PPO plan.

CIGNA Dental PPO (Core)

The Cigna Dental PPO (Core) plan allows you both in and out of network options. You and your covered family members have convenient access to the dental care you need through our nationwide network of dentists or you can see a dentist not in the network. There is a $1,000 maximum benefit per person per calendar year (in or out of network) & a separate $1,000 maximum benefit for orthodonti for children up to age 26.

CIGNA Dental PPO (Buy-Up)

Same benefits and options as the CORE plan, but you have the greater benefit of a higher annual maximum. There is a $2,000 maximum benefit per person per calendar year for in-network and a $1,500 maximum benefit for out of network, and a separate $2,500 maximum benefit for orthodontia for children up to age 26.

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

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

Oral Health Integration Program

The Cigna Dental Oral Health Integration Program is a program that reimburses out-of-pocket costs for specific dental services used to treat gum disease and tooth decay. The program is for people with certain medical conditions that have been found to be associated with gum disease. There's no additional cost for the program – if you qualify, you get reimbursed.

If you have a Cigna dental plan, you're eligible for this program. You must currently be under treatment by a doctor for any of the following conditions: heart disease, stroke, diabetes, maternity, chronic kidney disease, organ transplants, head and neck radiation.

When you visit your dentist, you will pay your usual copay or coinsurance amount. Next, your dentist will send Cigna the claim. Cigna will review the claim and refund your copay and/or coinsurance for eligible dental services. Once Cigna receives your claim, you can expect to be reimbursed in about 30 days. You must enroll in this program to receive the benefits.

When you join the program, you get discounts on prescribed mouthwashes, fluoride gels and toothpastes from your dentist through Cigna Home Delivery Pharmacy who will help you get these items sent right to your home.

You can ask Cigna for information on issues that affect your oral health and your overall wellness – such as fear of going to the dentist. Or the impact of stress or tobacco products. Cigna will also give you guidance on how to overcome these behaviors.

Estimate and Plan your Dental Care Costs

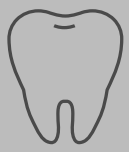
You can find out what treatment costs will be by asking your dentist for a predetermination of benefits or logging on to **myCIGNA.com** to access the Dental Treatment Cost Estimator. This user friendly, comprehensive web-based tool on **myCIGNA.com** allows you to get dental estimates based on your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

Contacting CIGNA

Visit us online – Register on **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.**

DENTAL INSURANCE THAT FITS



Cigna Dental Care Plan[1]

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 upgraded materials (such as gold, high noble metal or porcelain used in molar restorations), CAD/CAM services, complex rehabilitation or characterizations (for dentures). 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 material upgrades (such as gold/high noble metal or porcelain used in molar restorations), CAD/CAM services, complex rehabilitation or characterizations (for dentures). 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 13 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 13th birthday. Effective on your child's 13th 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 50% 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. You may 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.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation. Cigna Dental Care plans are insured by Cigna Dental Health Plan of Arizona, Inc., Cigna Dental Health of California, Inc., Cigna Dental Health of Colorado, Inc., Cigna Dental Health of Delaware, Inc., Cigna Dental Health of Florida, Inc., **a Prepaid Limited Health Services Organization licensed under Chapter 636,** Florida Statutes, Cigna Dental Health of Kansas, Inc. (KS & NE), Cigna Dental Health of Kentucky, Inc. (KY & IL), Cigna Dental Health of Maryland, Inc., Cigna Dental Health of Missouri, Inc., Cigna Dental Health of New Jersey, Inc., Cigna Dental Health of North Carolina, Inc., Cigna Dental Health of Ohio, Inc., Cigna Dental Health of Pennsylvania, Inc., Cigna Dental Health of Texas, Inc., and Cigna Dental Health of Virginia, Inc. In other states, Cigna Dental Care plans are insured by Cigna Health and Life Insurance Company or Cigna HealthCare of Connecticut, Inc., and administered by Cigna Dental Health, Inc. Policy forms: OK - HP-POL115; TN - HP-POL134/HC-CER17V1 et al. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.

Cigna Dental Benefit Summary
Anne Arundel County Government - Core
Plan Renewal Date: 01/01/2026

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.**

DPPO				
Network Options	***In-Network:*** **Total 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 (Note: This service is administered at the in-network coinsurance level.)	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 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 Cigna Dental Oral Health Integration Program offers enhanced dental coverage for customers with certain medical conditions. There is no additional charge to participate in 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 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.
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.

Cigna Dental Benefit Summary
Anne Arundel County Government – Buy Up
Plan Renewal Date:01/01/2026

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.**

DPPO				
Network Options	***In-Network:*** **Total 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 (Note: This service is administered at the in-network coinsurance level.)	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: $2,500	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 Cigna Dental Oral Health Integration Program offers enhanced dental coverage for customers with certain medical conditions. There is no additional charge to participate in 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.
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.

DENTAL CLEANINGS

Frequently Asked Questions

Dental cleanings are important for maintaining healthy teeth and gums.

But there are different types of cleanings, and each may require a different patient payment.* The information below will help you understand the differences between types of cleanings and the role each can play in the prevention and/or treatment of dental disease. Your dentist will recommend the right cleaning for you.

Q. What is a Prophylaxis – D1110?

A. A prophylaxis, sometimes called a "regular cleaning," is considered a preventive procedure where the dentist or dental hygienist removes plaque, calculus (tartar) and stains from the teeth. The dentist may recommend this procedure at regular intervals, typically twice per year, for patients whose gum health is generally good (healthy gum color and texture, minimal plaque and calculus, and shallow gum pockets around the teeth). A regular cleaning may also be appropriate for a patient with a gum condition limited to mild gingivitis (gum inflammation).

Q. What is Scaling in the Presence of Inflammation – D4346?

A. Scaling in the presence of inflammation is considered to be a therapeutic procedure where the dentist or dental hygienist removes plaque, calculus, and stains from the teeth. Unlike a prophylaxis (D1110) that may be recommended when there is *mild* gingivitis (gum inflammation), scaling in the presence of inflammation may be recommended when there is *moderate* to *severe* gum inflammation. This procedure is intended for patients who exhibit swollen, inflamed gums and moderate to severe bleeding when the dentist or hygienist probes the gum pockets. These gum pockets may be deeper than normal due to the swelling and inflammation of the gum tissue, but not due to any loss of bone that supports the teeth.

The type of cleaning you need – regular cleaning, cleaning in the presence of inflammation, debridement, deep cleaning or periodontal maintenance – is determined by your treating dentist based on:

- The clinical condition of your teeth and gums
- Your history of gum disease and treatment

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Q. What is Full Mouth Debridement – D4355?

A. On rare occasions when there has been significant buildup of plaque and calculus which makes it difficult to complete a thorough examination, the dentist may recommend full mouth debridement. Full mouth debridement is the removal of plaque and calculus buildup from the teeth and gums. This procedure is generally performed before an oral examination and diagnosis, and does not necessarily eliminate the need for additional scaling and/or teeth cleaning procedures.

Q. What is Scaling and Root Planing – D4341/D4342?

A. Periodontal scaling and root planing is often called a "deep cleaning." A dentist will recommend scaling and root planing when a patient shows signs of gum disease. These signs may include the finding of deeper gum pockets, loss of the bone that supports the teeth bleeding gums, and/or accumulation of plaque and calculus below the gumline. Scaling and root planing procedures are generally completed by quadrant, or sections of the mouth, and may require the dentist or dental hygienist to numb the treatment area so that the tooth and root surfaces of the teeth can be thoroughly scaled and cleaned.

Q. What is Periodontal Maintenance – D4910?

A. Periodontal maintenance is a procedure that is performed after active periodontal treatment, such as scaling and root planing or more extensive periodontal surgery. Periodontal maintenance includes removal of plaque and calculus above and below the gumline, scaling and root planing of specific areas as needed, and polishing. Ongoing maintenance is important because gum disease can recur without the appropriate follow-up. Periodontal maintenance continues at varying intervals as recommended by your dentist.

Do you have questions about the type of cleaning recommended for you? Take the time to discuss them with your dentist.

* Please refer to your plan documents to determine which procedures are covered by your specific dental plan and for more information, including costs and frequency limitations.

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CIGNA DENTAL VIRTUAL CARE

Access dental care 24/7/365 without leaving home

The dentist will see you now.

Toothaches, chipped teeth and oral infections don't care what time of day it is. But neither do the **Cigna Dental Virtual Care**[1] dentists. If you need dental care and are unable to reach your regular provider, you now have the option to consult with a dentist through a video call. The best part? **Cigna Dental Virtual Care** is available **24 hours a day, seven days a week, 365 days a year!**

Convenient dental consults at home.

While we recommend that you contact your dentist first to see if they can provide virtual care, we recognize that this may not always be possible. That's why we've partnered with The TeleDentists, a virtual dental care company that's been serving customers since 2018. The TeleDentists connects you with a licensed dentist who, through a video call, can help address urgent dental situations like toothaches, infection, swelling, bleeding, and more. They can also prescribe medication[2] to be filled at your local pharmacy, if necessary.

The nature of this type of care delivery precludes dentists from performing more involved procedures, but if the dentist determines such care is needed, they can help guide next steps.

Cost and claim information.

Cigna Dental Virtual Care consults are processed as in-network claims on your plan, and have no co-pay or coinsurance costs. Although Cigna Dental Virtual Care consults do not apply to frequency limits you may have on your plan, they do apply to your plan's annual maximum, if applicable.

How to access Cigna Dental Virtual Care.

If your dentist is unable to assist with your urgent dental care need, simply log on to your **myCigna.com** account and follow the prompts to the virtual care portal.

- You **must** connect to the portal via your **myCigna.com** account in order to use the service without having to enter a payment method.
- Once you've entered the online portal, you will be prompted to create an account on "The TeleDentists" website, and provide basic health information.
- You will be prompted to download and install a video chat application, and then confirm whether you want to see a dentist now, or schedule an appointment for a later time.
- When you are ready to consult with a dentist, you'll enter a virtual waiting room where a dentist will connect with you in ten minutes or less.

Together, all the way.®

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Frequently asked questions.

My dentist offers virtual visits and is in the Cigna network. Can I use them at no cost if I need urgent care?

Yes! We recommend calling your dentist first as many do provide virtual care.[3]

What if I already have an account with The TeleDentists? Can I use that and still have my costs waived?

In order to have your consult covered by your plan, you must link to The TeleDentists site from your myCigna.com account. This identifies you as a Cigna customer eligible for a consult. Once on the Cigna-branded landing page, you may sign in using your existing account information.

Can my enrolled dependents use this service and are there limitations on the age of patients?

Your enrolled dependents may also use the service. All ages can be evaluated by the dentists on The TeleDentists site, although those under the age of 18 will need to be "accompanied" by a parent or guardian.

Why do I have to create an account on The TeleDentist website? Is it secure?

- In order to provide care, The TeleDentists site needs some information about you, including basic health information, medications you take, allergies you have, etc. This will help the dentist make the most appropriate recommendations during your consult.
- The TeleDentists site meets all federal requirements for protecting personal health information under

Can The TeleDentist dentist prescribe medications if I need them?

Dentists can prescribe medications such as antibiotics and non-narcotic pain relievers. The dentist will send any required prescriptions to the pharmacy of your choice. **There may be pharmacy costs associated with filling the prescription, depending on your medical or prescription plan.[4]**

Do I have to use the video chat function to talk with a dentist? Can they just talk to me on the phone instead?

They are unable to provide consultations by telephone, because the dentist needs to be able to see you and any visual symptoms of the problem you're having. Video chat is the only way a consult can be performed. It's convenient because it allows you to show the dentist things like a broken tooth, inflammation or other problems you're experiencing.

If you have questions, log on to myCigna to chat with a representative or call 1-800-Cigna24. You can also call the number on the back of your ID card.

Cigna

1. Cigna provides access to virtual care through national teledental care providers via myCigna.com as part of your plan. Providers are solely responsible for any treatment provided to their patients. Video chat may not be available in all areas or with all providers and is a requirement for this service. See your plan materials for the details of your specific Dental plan. This service is separate from coverage for virtual dental care obtained by your Dental plan's network and may not be available in all areas. A referral is not required for this service.
2. Dentists are unable to prescribe opioid or narcotic medications, and are subject to all laws in your residence state regarding the prescribing of medication.
3. Virtual consultations with Cigna network dentists are subject to applicable frequency limits and annual plan maximums.
4. Prescription medications are not covered on Cigna Dental plans. For information on out-of-pocket costs for prescribed drugs, please refer to your medical or pharmacy plan documents.

In-network gets you inside savings.

Save more on every dental visit.

Dentists in your plan's network offer you discounted rates on dental care. That means you can save money just by staying in-network and save time by not having to submit claims.

See for yourself how much more you save when you use an in-network dentist.

Crown replacement with an in-network dentist who offers a discounted rate*		Crown replacement with an out-of-network dentist without a discounted rate*	
Fee for crown	$650	Fee for crown	$1000
50% plan benefit	-$325	50% plan benefit up to a Maximum Allowable Charge of $650**	-$325
Total cost	**$325**	**Total cost**	**$675**

myCigna gives you inside information on in-network care.

Customers who use **myCigna.com®** or the **myCigna® App** save an average of $117 per year on their care.*** Plus myCigna allows you to:

Find the right dentist

Search and verify which dentists are in your network, view dentist profiles, read verified patient reviews and compare dental offices.

Preview pricing

Compare costs of hundreds of procedures specific to your plan, and view out-of-pocket costs including coinsurance and deductibles.

Call 800.Cigna24 or visit myCigna.com to find an in-network dentist near you.

cigna healthcare℠

* For illustrative purposes only. Cigna DPPO network fees and national average dental charges estimated for Procedure Code D2750, Porcelain Crown Fused to High Noble Metal. Your costs and savings may be different based on your local area charges and plan deductible and coinsurance levels. Your plan waiting periods and calendar-year maximum may also apply. Review your plan materials for the details of your specific dental plan.

** The Maximum Allowable Charge (MAC) is the maximum amount that can be billed for a covered procedure, based on contracted fees for network dentists.

*** Internal reporting as of November 2021 for DPPO customers who use myCigna and customers who do not use myCigna results may vary.

The dentists who participate in the Cigna Healthcare network are independent practitioners solely responsible for the treatment provided to their patients. They are not agents of Cigna Healthcare.

In Texas, the insured dental plan is known as Cigna Dental Choice, and this plan uses the national Cigna DPPO network.

VISION *Care*

EYEMED® PLAN

The EyeMed vision plan will send all enrolled employees an ID card, with your name on it, in a welcome package. 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 an EyeMed doctor
- Tell the doctor you are a EyeMed member when making the appointment
- Providers will ask for name and date of birth of the member seeking benefits.

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 $175 allowance	Up to $82
STANDARD PLASTIC LENSES		
Single Vision	$0 copay	Up to $55
Bifocal	$0 copay	Up to $75
Trifocal	$0 copay	Up to $95
Lenticular	$0 copay	Up to $95
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; paid in full	Up to $210
OTHER		
Hearing Care from Amplifon Network	Up to 66% 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
Frame	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
Contact Lenses	Once every 12 months from the date of service	Once every 12 months from the date of service

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

EyeMed reserves the right to make changes to the products available on each tier. All providers are not required to carry all brands on all tiers. For current listing of brands by tier, call 866.939.3633. No benefits will be paid for services or materials connected with or charges arising from: medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures; Refraction, when not provided as part of a Comprehensive Eye Examination; 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 Vision Materials required by a Policyholder as a condition of employment; safety eyewear; solutions, cleaning products or frame cases; non-prescription sunglasses; plano (non-prescription) lenses; plano (non-prescription) contact lenses; two pair of glasses in lieu of bifocals; electronic vision devices; 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 that are replaced before the next Benefit Frequency when Vision Materials would next become available. Fees charged by a Provider for services other than a covered benefit and any local, state or Federal taxes must be paid in full by the Insured Person to the Provider. Such fees, taxes or materials are not covered under the Policy. Allowances provide no remaining balance for future use within the same Benefit Frequency. Some provisions, benefits, exclusions or limitations listed herein may vary by state. 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.

Ready to live your best EyeMed life?

There's so much more to your vision benefits than copays and coverage. Get ready to see the good stuff for yourself.

Your network is the place to start

See who you want, when you want. You have thousands of providers to choose from – independent eye doctors, your favorite retail stores, even online options.

Keep your eyes open for extra discounts*

Members already save an average 76% off retail using their EyeMed benefits,[1] but our long list of special offers takes benefits even further.

Remember, you're never alone

We're always here to help you use your benefits like a pro. Stay in-the-know with text alerts or healthy vision resources from the experts. If it can make benefits easier for you, we do it.

* Discounts are not insurance. Available at participating providers.
[1] Based on weighted average of sample transactions: EyeMed Insight network/$10 exam copay/$10 materials copay/$150 frame or contact lens allowance. 2021 EyeMed Commercial BOB stats.

Create a member account at eyemed.com/member

Everything is right there in one spot. Check claims and benefits, see special offers, estimate costs and find an eye doctor – search for one with the hours, location and brands you want. For maximum mobility, try the EyeMed App (Google Play or App Store).

This information is available broadly and is not plan or state specific.

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION EST. 1961 OPTICAL

PDF-2301-M-651

FLEXIBLE *Spending Accounts (FSA)*

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

Ameriflex manages the FSA plan for our participants. **You must enroll each year if you want to participate in a Health Care or Dependent Care FSA, even if you are currently contributing to a reimbursement account.**

Health Care Spending Account

You may set aside $120 to $3,300 annually in a Health Care Spending Account to pay for qualified medical, prescription drug co-payments and certain over-the-counter (OTC) medications, dental and vision care expenses. The health care expenses may be for you, your spouse, or your eligible dependents. It is no longer necessary that a FSA dependent qualify as a "tax dependent" for purposes of income taxes in order for the employee to claim reimbursements. By signing the FSA Claim form you certify the eligibility of your dependent. The Health Care FSA allows the reimbursement of medical expenses of an employee's child up to age 26.

The Health Care FSA is used for tax-deductible health care expenses not paid by insurance. Whether an expense is eligible for reimbursement under the Health Care FSA is determined under IRS rules. For information on whether an expense is eligible visit Ameriflex website at **https://myameriflex.crunch.help/participants/eligible-expenses**

Dependent Care Spending Account

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

A "Qualifying Individual" is defined as:

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

If you are single or are married and filing a joint tax return, you may contribute up to $7,500 each calendar year. If you are married and filing a separate tax return, you may contribute up to $3,750 per year. However, your total contributions for the year cannot exceed the lesser of your earned income or, if you are married, your spouse's earned income. For purpose of this limit, if your spouse is either a full-time student or is incapable of self-care, your spouse will be deemed to have earned income for each month that he or she is a full-time student or incapacitated. The amount of deemed earnings will be $250 a month, if you provide care for one Qualifying Individual, or $500 a month, if you provide care for more than one Qualifying Individual.

The Dependent Care FSA is used for dependent care expenses that allow you (or you and your spouse, if married) to work or look for work, or that allow your spouse to attend school full-time. Expenses incurred for services outside your household may be reimbursed only if incurred for the care of (i) a Qualifying Individual who is a qualifying child under thirteen years of age or (ii) another Qualifying Individual who regularly spends at least eight hours each day in your household. In addition, if the services are provided by a Dependent Care Center, the Center must comply with applicable laws and regulations of a State or local government. A "Dependent Care Center" is any facility services for any of the individuals.

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

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

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

Receiving Your Reimbursement

Ameriflex processes reimbursement claims daily. You can download their mobile app and take photos of your receipt and upload it to your account or you can submit paper claims via fax or on the computer. If you sign up for direct deposit reimbursement your claims will process and pay to your bank within 2 days. You may be reimbursed from the Health Care FSA at any time throughout the year for expenses up to the annual amount you elected to contribute. For the Dependent Care FSA, however, you may only be reimbursed up to your current balance. If you file a reimbursement request for more than your Dependent Care FSA current balance, it will be held until additional contributions have been added to your account. In addition, day care expenses are not reimbursed until the end of the time period incurred. For example, expenses for summer camp from June 1 –15 would not be reimbursed until after June 15th. Sign up for Direct Deposit for faster access to your FSA reimbursement dollars. Visit the Ameriflex FSA website **www.myameriflex.com** to authorize direct deposit for FSA funds.

FSA Deadlines

All FSA claims must be submitted to Ameriflex by the next March 31 following the end of the Plan Year. **For the 2026 Plan Year, all FSA claims must be submitted by March 31, 2027.**

There is a 2 ½ month "Grace Period" following the end of the Plan Year in which you can continue to incur expenses for that Plan Year for both the Health Care and Dependent Care FSA. So, you actually have until March 15, 2027 to incur eligible expenses for reimbursement.

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

Special FSA Distributions for Reservists

The Heroes Earning Assistance and Relief Tax Act of 2008 (HEART Act) permits qualified reservist distributions of unused amounts in health flexible spending accounts to reservist ordered or called to active duty for at least 180 days or on an indefinite basis. Contact the Benefits Team for additional information.

Terminating or Retiring in 2026?

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

GROUP *Life Insurance*

Group Life Insurance Program Overview

County employees are offered group term life and accidental death and dismemberment insurance based on their employment classification. Life insurance benefits are pro-rated for eligible part-time employees.

Voluntary optional term life insurance for yourself, your spouse and/or your children (up to age 26) is also available. Refer to the chart below for details. The County group life insurance benefit is insured by MetLife.

Class 1 Group: includes employees who are represented by AFSCME 582. Class 1 also includes employees from Soil Conservation, the Circuit Court for AA County and the State's Attorney Office for AA County.

Class 2 Group: includes most Non-Represented employees. Class 2 also includes employees represented by the following unions: CO, FODCOP, IAFF, Detention Sergeants Association, Sheriff's Sergeants Association, Battalion Chiefs Association, Correctional Program Specialists, and Park Rangers.

Class 3 Group: includes AFSCME 2563.

Class 4 Group: Deputy Sheriffs. FOP Lodge 70.

Life Insurance Plan Description

Anne Arundel County's Life Insurance plans are term insurance. Term insurance policies provide protection while you are employed with Anne Arundel County. The policy does not earn interest or pay dividends to policyholders. Basic group life coverage from the County does not continue into retirement. Benefits are pro-rated for part-time employees eligible for life insurance. **Basic and Optional Life Insurance policy values reduce by 35% after age 65.**

Life Insurance Beneficiary Designation

All eligible new employees are required to identify a beneficiary who will receive the life insurance benefit in the event of the employee's death. It is important to review your beneficiaries – especially following major life events such as marriage, divorce, birth or adoption of a child or a death in your family. To change your life insurance beneficiary, please update your beneficiary online at **https://my.adp.com** or you may request a beneficiary form directly from the Benefits Team.

AACG Employees	Class 1	Class 2	Class 3	Class 4
Basic Term Life *(paid by County)*	$10,000	$50,000 or 2 times salary to maximum of $100,000	$20,000	2 times salary to maximum of $100,000
Optional Term Supplemental Life *($200,000 is Guaranteed Issue Amount) *New Hires Only are Guaranteed Issue**	$25,000 to $400,000	$25,000 to $400,000	$25,000 to $400,000	$25,000 to $400,000
Optional Spouse Life *($25,000 is the Guaranteed Issue Amount) *New Hires and Marriage Events are Guaranteed Issue**	$5,000, $25,000 or $50,000	$5,000, $25,000 or $50,000	$5,000, $25,000 or $50,000	$5,000, $25,000 or $50,000
Optional Child Life *(up to age 26)*	$2,500, $5,000 or $10,000	$2,500, $5,000 or $10,000	$2,500, $5,000 or $10,000	$2,500, $5,000 or $10,000

Note: Coverage for spouse and children cannot exceed 50% of the Employee's combined Basic & Optional Life Insurance policy value. Basic and Optional Life insurance policy values reduce by 35% the pay period following your 65th birthday.

Spouse Life Rates (Based on Employee's Age as of January 1st) All rates are Per $1,000	
Age	**RATE**
<25	$0.05
25-29	$0.06
30-34	$0.08
35-39	$0.09
40-44	$0.10
45-49	$0.15
50-54	$0.23
55-59	$0.43
60-64	$0.66
65-69	$1.27
70+	$2.06

Optional Life Rates (Based on Employee's Age as of January 1st) All rates are Per $1,000	
Age	**RATE**
<30	$0.06
30-34	$0.07
35-39	$0.08
40-44	$0.09
45-49	$0.12
50-54	$0.18
55-59	$0.31
60-64	$0.47
65-69	$0.89
70+	$1.54

Child Life Rates (Bi-weekly)
$2,500 = $0.13
$5,000 = $0.25
$10,000 = $0.51

Note: Coverage for spouse and dependent children cannot exceed 50% of the Employee's combined Basic & Optional Life Insurance policy value.

What is the "Excess Ins" deduction on my paycheck?

If you receive more than $50,000 in Basic Life Insurance benefits, the IRS requires that you be taxed on the value of employer-provided group term life insurance over $50,000. The taxable value of this life insurance coverage is called "imputed income" and reflected on your paycheck stub as "Excess Ins." Even though you don't receive cash, you are taxed as if you received cash in an amount equal to the value of this coverage. You pay taxes on the amount of term life coverage over $50,000. To avoid the Imputed Income Tax on Basic Life Insurance, you may elect to freeze your basic life policy at $50,000 instead of a policy value equal to two times your salary to a maximum of $100,000. Contact the Benefits Team for more information.

No Duplication of Benefits or Enrollment

You cannot have duplicate coverage under the County life insurance program. If you and your spouse are both County employees eligible for County life insurance, neither of you may enroll in Spouse Life insurance. (This also applies to County retirees enrolled in the life insurance program.) Also, children of County employees cannot have duplicate coverage under both parents, or coverage as a child and as an employee. MetLife will only pay benefits for one policy. Dependent eligibility requirements for group life insurance are the same as the requirements for all other County benefits.

Accidental Death & Dismemberment (AD&D)

The County plan includes AD& D coverage for employees that pays a benefit for loss of life or other injuries resulting from a covered accident. Injuries covered may include loss of sight or speech, paralysis and dismemberment of hands or feet.

Accelerated Benefit Option

If you are determined to be terminally ill (have a life expectancy of less than 12 months and meet other eligibility requirements), you may be eligible to receive up to 75 percent, or a maximum of $500,000, of your group term life insurance benefit. This benefit allows you to use the proceeds as you desire — whether to cover medical expenses or to maintain your quality of life. In the event

of your death, your beneficiary will receive a benefit payout which has been reduced by the amount you receive.

Continuation of Coverage

Active employees enrolled in Optional Life Insurance for at least 60 days prior to retirement may elect to continue Optional Life insurance coverage into retirement under the County group policy.

If any of your Life insurance from MetLife ends or reduces for any reason other than failure to pay premiums, the Right to Convert provision allows you to convert your coverage to certain types of individual life insurance policies without having to provide evidence of insurability. You must apply for conversion and pay the required premium to MetLife within 31 days after group coverage ends or reduces. AD&D coverage may not be converted under this provision.

If your insurance ends because your employment terminates, you may be eligible to buy group life insurance from MetLife through the Portability provision, assuming you meet the eligibility requirements.

MetLife has arranged for financial professionals with Barnum Financial Group (Barnum) to help explain your options, since MetLife cannot provide you with individual guidance. To begin this process, you can arrange a meeting with a local Barnum financial professional by calling calling **877-275-6387.**

Premium Waiver

If you are enrolled in Optional Life Insurance coverage, and have not worked for a period of 180 days, and are completely disabled, you may be eligible for a waiver (no payment) of your Optional Life Insurance premium. You, the County, and your physician must complete the required forms. Please contact the Benefits Team for an application form.

Additional details on group life and AD& D benefits can be found in your group insurance certificate (MetLife plan booklet). The controlling provisions will be in the group policy issued by MetLife. Neither the certificate nor the information presented in this document modify the group policy or the insurance coverage in any way. If you have additional questions, please contact the Benefits Team.

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 Insurance 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 your policy value at any time. **Optional Life Insurance policy values reduce by 35% the pay period following your 65th birthday.**

2026 Optional Life Rates for Individuals Retired before 2/1/2000	
POLICY VALUE	**MONTHLY RATE**
$6,500	$41.31

2026 Optional Life Rates for Individuals Retired after 2/1/2000			
POLICY VALUE	**MONTHLY < 50** ($0.21 per $1000)	**MONTHLY 50-64** ($0.63 per $1000)	**MONTHLY 65+** ($2.45 per $1000)
$25,000	$5.25	$15.75	$61.25
$50,000	$10.50	$31.50	$122.50
$75,000	$15.75	$47.25	$183.75
$100,000	$21.00	$63.00	$245.00
$125,000	$26.25	$78.75	$306.25
$150,000	$31.50	$94.50	$367.50
$175,000	$36.75	$110.25	$428.75
$200,000	$42.00	$126.00	$490.00
$225,000	$47.25	$141.75	$551.25
$250,000	$52.50	$157.50	$612.50
$275,000	$57.75	$173.25	$673.75
$300,000	$63.00	$189.00	$735.00
$325,000	$68.25	$204.75	$796.25
$350,000	$73.50	$220.50	$857.50
$375,000	$78.75	$236.25	$918.75
$400,000	$84.00	$252.00	$980.00

Anne Arundel County
2026 Plan Overview and Cost of Coverage

Open Enrollment Period October 1 – October 31, 2025

Short term and long term disability insurance are designed to provide you with continuing income while you are out of work due to an illness or accident. Usually, long term disability benefits pick up where salary continuation/short term disability benefits leave off.

Learn more about the coverage options available to you, special plan features and services and costs for coverage.

Calculate your estimated monthly premium payment, which will be conveniently deducted from your paycheck.

Enroll in the ADP portat at: my.adp.com by October 31, 2025

Coverage options:

Short Term Disability Insurance

Choices	Maximum Benefit	Minimum Benefit	Requirements
60% of your weekly earnings	$1,154 per week	$92 per week	No health questions

Long Term Disability Insurance

Choices	Maximum Benefit	Minimum Benefit	Requirements
60% of your monthly earnings	$6,000 per month	$400 per week	No health questions

Additional plan benefits

When you are ill or injured for a long time, MetLife believes you need more than a supplement to your income. That's why we offer return to work services and financial incentives to help you get the maximum benefits from your coverage. We also offer assistance in obtaining Social Security Disability benefits.

Services to help you get back to work can include:

Nurse Consultant or Case Manager Services

Specialists who personally contact you, your physician and your employer to coordinate an early return-to-work plan when appropriate.

Vocational Analysis

Help with identifying job requirements and determining how your skills can be applied to a new or modified job with your employer.

Job Modifications/Accomodations

Recommending adjustments (e.g., redesign of work station tools) that enable you to return to your previous job or a similar one.

Retraining

Development programs to help you return to your previous job or educate you for a new one.

Financial Incentives

Allow employees to receive Disability benefits or partial benefits while attempting to return to work.

The Services of Social Security Specialists

Once you are approved for Long Term Disability benefits, MetLife can help you obtain Social Security Disability benefits. Our specialists can guide you through the initial application and appeals processes and may also help you access assistance from attorneys or vendors to pursue Social Security benefits.

Frequently asked questions

How do I apply for coverage?

Apply online at my.adp.com. Be sure to apply by October 31, 2025.

How do I pay for coverage?

Coverage is paid through convenient payroll deductions.

How is disability defined under this plan?

Generally, you are considered disabled and eligible for Short Term and Long Term benefits if, due to sickness, pregnancy or accidental injury, you are receiving appropriate care and treatment and complying with the requirements of treatment and you are unable to earn more than 80% of your predisability earnings at your own occupation for any employer in your national economy.

When do benefits begin and how long do they continue?

Short Term Disability:

Benefits begin after the end of the elimination period. The elimination period begins on the day you become disabled and is the length of time you must wait while being disabled before you are eligible to receive a benefit. The elimination periods are as follows:

For Injury: 7 days

For Sickness (includes pregnancy): 7 days

Benefits continue for as long as you are disabled up to a maximum duration of 26 weeks of Disability.

Long Term Disability:

Benefits begin after the end of the elimination period. The elimination period begins on the day you become disabled and is the length of time you must wait while being disabled before you are eligible to receive a benefit. Your elimination period for Long Term Disability is 180 days.

Your plan's maximum benefit period and any specific limitations are described in the Certificate of Insurance provided by your Employer.

Can I receive benefits if I return to work part-time?

Yes, as long as you are disabled and meet the terms of your Disability plan, you may qualify for adjusted Disability benefits.

Are there any exclusions for pre-existing conditions?

Yes. For the first 12 months following the effective date of your coverage, your plan may not cover a sickness or accidental injury that arose in the 12 months prior to your participation in the plan. A complete description of the preexisting condition exclusion is included in the Certificate of Insurance provided by your Employer or contact your MetLife benefits administrator with any questions.

Are there any exclusions to my coverage?

Yes. Short Term and Long Term Disability insurance does not cover any disability which results from or is caused or contributed to by:

- War, whether declared or undeclared, or act of war, insurrection, rebellion or terrorist act;
- Active participation in a riot;
- Intentionally self-inflicted injury or attempted suicide;
- Commission of or attempt to commit a felony;
- We will not pay Short Term Benefits for any Disability caused or contributed to by elective treatment or procedures, such as:
    - o Cosmetic surgery or treatment primarily to change appearance;
    - o Sex-change surgery;
    - o Reversal of sterilization;
    - o Liposuction;
    - o Visual correction surgery; and
    - o In vitro fertilization, embryo transfer procedure or artificial insemination. However, pregnancies and complications from any of these procedures will be treated as a Sickness.

Payment offset will be applicable for a disability caused or contributed to by any injury or sickness for which you are entitled to benefits under Workers' Compensation or a similar law.

Are there any limitations to my coverage?

Limitations to your coverage may apply. Please see the Disability Plan Certificates for specific details or contact your benefits administrator with any questions.

How to enroll for coverage

Apply online in the ADP Portal at my.adp.com by October 31, 2025. Have questions? Call 1-877-638-4671

HOW TO CALCULATE YOUR SHORT-TERM DISABILITY PREMIUMS		
FROM	TO	RATE
18	29	$0.8520
30	34	$0.8400
35	39	$0.8400
40	44	$0.8580
45	49	$1.0510
50	54	$1.2990
55	59	$1.4310
60	64	$1.6970
65	69	$1.9270
70+		$1.9270

Example on how to calculate our rate:

Let's say that you are 28 years are old and you make an annual salary of $55,000, you would calculate yours as follows:

Annual Salary = $55,000

Monthly Salary= $55,000 I 12 = $4,583.33

Monthly Benefit= 60% * $4,583.33 = $2,750.00

Monthly Rate per $100 of Monthly Benefit= $.852

Monthly Charge= $.852 * $2,750.00/$100 = $23.43

Bi-Weekly Charge Assuming 26 pays= $23.43 * 12/26 = $10.81

You would pay $10.81 per pay period for Short-term Disability. Your premiums are paid on an after-tax basis; benefit is not taxed.

HOW TO CALCULATE YOUR LONG-TERM DISABILITY PREMIUMS		
FROM	TO	RATE
<35		$0.1150
35	39	$0.1250
40	44	$0.2120
45	49	$0.3780
50	54	$0.5420
55	59	$0.6140
60	64	$0.6260
65+		$0.4330

Example on how to calculate our rate:
Let's say that you are 56 years old and you make an annual salary of $45,000 you would calculate your benefit as follows:

Annual Salary= $45,000
Monthly Salary= $45,000 / 12 = 3,750
Monthly Benefit = 60% * $3,750 = $2,250
Monthly Rate per $100 of Monthly Benefit $0.614
Monthly Charge= $0.614* $3,750/$100 = $23.03
Bi-Weekly Charge Assuming 26 pays = $23.03 * 12/26 = $10.63

You would pay $10.63 per pay period.

Here's another example:

Let's say that you are 45 years are old and you make an annual salary of $111,000 you would calculate your benefit as follows:

Annual Salary= $111,000
Monthly Salary= $111,000 / 12 = $9,250
Monthly Benefit = 60% * $9,250 = $5,550 (monthly benefit is capped at $6,000)
Monthly Rate per $100 of Monthly Benefit = $0.378
Monthly Charge= $0.378* $9,250/$100 = $34.97
Bi-Weekly Charge Assuming 26 pays = $34.97 * 12/26 = $16.14

You would pay $16.14 per pay period for Long-term Disability. Your premiums are paid on an after-tax basis so your benefit is not taxed.

The Plan Overview provides only a brief overview of the STD and LTD plans. A more complete description of the benefits provisions, conditions, limitations, and exclusions will be included in the Certificate of Insurance. If any discrepancies exist between this information and the legal plan documents, the legal plan documents will govern.

Long Term Disability and Short Term Disability coverages are provided under a group insurance policy (Form GPNP99, GPNP15-2T, GPNP15-3T, or G.2130-S) issued to your employer by MetLife. Like most group disability insurance policies, MetLife group policies contain certain exclusions (state variations may apply), waiting periods, reductions, limitations and terms for keeping them in force. Ask your MetLife sales representative for complete costs and details.

OTHER *Benefits*

VOLUNTARY BENEFITS

Voluntary Benefits are provided to employees and are completely optional. The County makes no contributions and receives no consideration in connection with the voluntary benefit programs. The County collects payroll deductions and remits collected amounts to the voluntary benefits provider. Enrollments, changes and cancellations must be made directly through the voluntary benefits provider. Employees may enroll in the voluntary benefit programs at any time, year round. Contact Select Benefits Communications Group at **1-888-711-4478** between the hours of 8:30am and 4:30pm daily.

Universal Life with Long Term Care Rider

Employees often realize that the cost of buying life insurance increases as they get older. Purchasing coverage as soon as possible will help keep those costs down in the future. Permanent, portable life insurance that pays in addition to the term life insurance paid for by the County provides supplemental coverage while working for the County and coverage that you can take with you into the future. Coverage is also available for spouses and children. Flexible underwriting for County employees means that no physicals or lab work are associated with applying for coverage. There are just a few underwriting health questions asked by the carrier to qualify.

In addition to the life insurance death benefit, your policy also contains cash value that grows on a tax deferred basis, waiver of premium payment in the event of more than 6 months of disability and a Long Term Care rider that allows you to use a portion of your life insurance for Long Term Care related expenses in and out of a facility. An Accidental Death benefit is also included that doubles the face amount of life insurance in the event of an accidental death. In the event of retirement or termination of employment, coverage is fully portable at the same cost as when you enrolled.

The United Legal Benefits Plan (ULB)

The ULB Plan is a group legal insurance plan that provides comprehensive legal protection for you and your family for only $19.50 per month. (12-month enrollment is required.) All legal matters are covered by the Plan. Many, such as preparation of wills, review of legal documents, unlimited advice and consultation, and legal representation are included for no additional charge. All other legal needs are provided at discounts of at least 25%. You select a local law firm and all contact is private and confidential between you and your chosen attorney.

Anne Arundel County Government (AACG)

BENEFITS *Eligibility*

Who is Eligible for Benefits

Benefits are effective the first of the month following your hire date or qualifying event date. The only exception is for birth or adoptions. They are effective the date of the event. **You have 31 days from the date of the event to notify the Benefits Team.**

Individuals eligible for benefits include:

- Full-time or part-time permanent budgeted employees (working 50% or more of the workweek) of Anne Arundel County Government (AACG) are eligible for all benefits in this guide.
- Retirees who are currently receiving a monthly County retirement pension who have not waived coverage. Retirees are eligible only if they 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 with the courts at age 18; so does your coverage for the child unless you adopt him/her.

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, a newborn's birth or loss of other insurance coverage.

Dependent Documentation

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

Dependent Type and Documentation Needed

Spouse

- Copy of official state marriage certificate dated and signed by the appropriate State or County official.
- A copy of your spouse's social security card.
- A copy of Medicare card if your spouse is enrolled in Medicare.
- 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 data.
- 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

- Copy of child's official state birth certificate dated and signed by the appropriate State. ***Note: Maryland Birth Registration Notices are not accepted as dependent documentation.***
- For stepchildren, provide a copy of the child's official state birth certificate and a copy of your official state marriage certificate.
- For adopted children, provide a copy of the court order placing the child pending final adoption or a copy of the final adoption decree signed by a judge.
- For court appointed guardianships of grandchildren, in cases where the guardianship is for 12 months or longer, provide a copy of court document signed by a judge.

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

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

Enrolling During Open Enrollment & Throughout the Year

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

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

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 supporting documentation, or go to the ADP portal to submit the change. 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:

- Change in dependents due to birth, adoption, marriage, divorce, death, or reaching the maximum age limit for the plan.
- Involuntary loss of other medical insurance coverage for yourself or your dependents.
- You or your dependent child's enrollment in or loss of SCHIP, Medicaid, Medicare or Medical Assistance coverage.
- Significant mid-year change in cost or plan coverage in the Anne Arundel County sponsored plans.

Consistent Coverage Level for Employees

Four coverage level options are available: Individual, Parent & Child, Employee/Retiree & Spouse, or Family. Employees must have a consistent coverage level for the medical, dental and vision plans. Retirees may elect a different coverage level for each insurance plan.

Duplicate Coverage

A husband and wife who are both active AACG employees and/or retirees may not have duplicate coverage under any plan by covering each other under separate enrollments. Also, children of two employees and/or retirees may not be covered twice under both 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. In the event benefits are paid, you will be responsible for reimbursing the County. There are no opt out credits for married County employees.

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 Benefits Team at 410-222-7400 or at benefits_team@aacounty.org.

INSTRUCTIONS FOR BENEFIT ENROLLMENTS AND MID-YEAR CHANGES

Event	Action Required	Enrollment Deadline	Coverage Effective Date
Open Enrollment Change	1. Enter and save your change election in the online Benefits Center. 2. Send all required dependent documentation to the Benefits Team before the enrollment deadline.	October 31, 2025	January 1, 2026
Marriage	1. Enter and save your election & your spouse's name, social security number & birth date in the online Benefits Center. 2. Send all required dependent documentation to the Benefits Team before the enrollment deadline.	31 days after marriage	1st of the month following the marriage
Newborn	Enter and save your election & your child's name and birth date in the online Benefits Center or contact the Benefits Team. Newborns will be temporarily enrolled for 31 days pending receipt of official birth certificate and social security card.	31 days after birth	Child's date of birth
Retirement	1. Enter your elections on the Retiree Benefits Election Form. 2. Send all required dependent documentation to the Benefits Team before the enrollment deadline.	31 days after retirement date	Retirement date
Loss of Coverage Elsewhere	1. Enter and save your election in the online Benefits Center. 2. Send a Certificate of Prior Coverage or employer letter listing the insurance end date, and all required dependent documentation to the Benefits Team before the enrollment deadline.	31 days after coverage end date	1st of month after coverage end date
Cancel Dependent Coverage Mid-Year	1. Enter and save your election in the online Benefits Center. 2. Send proof of other coverage for the dependent such as a letter from their employer or copy of insurance card to the Benefits Team.	31 days after other coverage began	1st of month following notice of change to the Benefits Team. Retroactive adjustments are not allowed.
Divorce	1. Enter and save your election in the online Benefits Center. 2. Send a copy of your divorce decree signed by a judge or court official to the Benefits Team.	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 the Office of Personnel 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 County Benefits Team on **410-222-7400**. 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:

CareFirst
PO Box 14114
Lexington, KY 40512-4114

CVS Caremark

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

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, vision and health care flexible spending account benefits described in this Summary and this notice is not intended to apply to any other type of benefit.

Introduction

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional 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.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as 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 are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- 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 any of the following qualifying events happens:

- 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 that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the plan.

When is COBRA 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. When the qualifying event is 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), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the 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 Admin-

istrator within 60 days after the qualifying event occurs. You must provide this notice to: **Anne Arundel County Office of Personnel – Benefits Team, 2660 Riva Road, Annapolis, MD 21401.** If the qualifying event is divorce, please provide a copy of your divorce decree showing the divorce date and signature of court official.

How is COBRA 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. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total 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 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 while receiving 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 notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

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 ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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 the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of 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 Office of Personnel – Benefits Team
2660 Riva Road • Annapolis, MD 21401
410-222-7400

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. The Plan's agents or representatives may use or disclose PHI about you to determine eligibility for plan benefits, facilitate payment for services you receive from health care providers, to review claims and to coordinate benefits. This includes, if appropriate, disclosing information to the Plan Sponsor, as needed to facilitate the Plan's payment function.

For example, if the Plan needs to process a payment to your current physician, but requires additional PHI to process that payment, it may request that PHI from 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 providers 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 notice, except as specifically authorized by you. 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 Office of Personnel, Benefits Division, Shaquisha Bishop, Anne Arundel County Government, 2660 Riva Road, Annapolis, MD 21401, **(410) 222-7400**.
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 prescription drug coverage is at the end of this notice. There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

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 19 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 Government
Office of Personnel ATTN: Benefits Team
2660 Riva Road, Annapolis, MD 21401
410-222-7400 or 1-800-870-6169

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-KIDS NOW** 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 March 17, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – 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://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US 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.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	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 March 17, 2025, 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

APPENDIX

CONTACT *Information*

BlueChoice Advantage EPO

BlueChoice Advantage PPO

1-833-536-2166
www.carefirst.com
carefirst.com/aacg
Nurse Line 24/7
1-800-535-9700

Caremark Prescription Plan

1-866-409-8521
www.caremark.com

CarePlus Pharmacy

2666 Riva Road Annapolis, MD
410-573-1635

CIGNA Dental PPO or DHMO

1-800-CIGNA-24 (800) 244-6224
www.cigna.com

EYEMED Vision Plan

1-866-804-0982
www.EyeMed.com

Ameriflex - Flexible Spending Accounts

1-888-868-3539
service@myameriflex.com
www.myameriflex.com

MetLife (Life Insurance)

1-800-638-6420

MetLife Disability Insurance

1-888-982-7972 (General Questions about Short-term Disability and Long-term Disability)
1-800-300-4296 (Claim Intake)

Office of Personnel

410-222-7400
1-800-870-6169
FAX: (410) 222-4512
Mail Stop: 9101
Email address: benefits_team@aacounty.org
Mailing address: PO Box 6675, Annapolis MD 21401

Select Benefits Communications

(Voluntary Benefits)

1-888-711-4478

Anne Arundel County Government
Office of Personnel
2660 Riva Rd
Annapolis MD 21401