Prince George's County Government
Rushern L. Baker, III, County Executive

OHRM
Office of Human Resources Management

Rushern L. Baker, III
County Executive

"Need to see a doctor or need a vaccine?
Make sure you're enrolled! It's Open Enrollment 2018!"

HEALTH BENEFITS
OPEN ENROLLMENT GUIDE
RETIRED EMPLOYEES
CALENDAR YEAR 2018

October 2, 2017 – October 27, 2017

Office of Human Resources Management
Benefits Administration Division
1400 McCormick Drive, Suite 245
Largo, Maryland 20774

Information

for

RETIRED EMPLOYEES

CALENDAR YEAR 2018

OPEN ENROLLMENT

October 2, 2017 – October 27, 2017

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NOTICE OF NONDISCRIMINATION STATEMENT

Prince George's County Government complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Prince George's County Government does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Prince George's County Government:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters; and
    - Written information in other formats (large print, audio, accessible electronic formats, other formats).

- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters; and
    - Information written in other languages.

If you need these services, contact Bridgette A. Greer, Esq., Deputy Director, in the Office of Human Resources Management.

If you believe that **Prince George's County Government** has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Bridgette A. Greer, Esq., Deputy Director, 1400 McCormick Drive, Suite 245, Largo, MD 20774, 301-883-6344, or fax to 301-883-6325, BAGreer@co.pg.md.us.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Bridgette A. Greer, Esq., Deputy Director, is available to assist you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or telephone at U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019 or 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

NOTICE OF NONDISCRIMINATION STATEMENT (*Continued*)

Español (Spanish)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1 (800) 368-1019 or 1 (800) 537-7697 (TDD).

繁體中文 (Chinese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電. 1 (800) 368-1019 or 1 (800) 537-7697 (TDD).

한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1 (800) 368-1019 or 1 (800) 537-7697 (TDD). 번으로 전화해 주십시오.

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1 (800) 368-1019 or 1 (800) 537-7697 (TDD).

Français (French)

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1 (800) 368-1019 or 1 (800) 537-7697 (TDD).

Tagalog (Tagalog – Filipino)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1 (800) 368-1019 or 1 (800) 537-7697 (TDD).

Русский (Russian)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1 (800) 368-1019 or 1 (800) 537-7697 (TDD).

አማርኛ (Amharic)

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1 (800) 368-1019 or 1 (800) 537-7697 (TDD).2

èdè Yorùbá (Yoruba)

AKIYESI: Bi o ba nsọ èdè Yorùbú ọfé ni iranlọwọ lori èdè wa fun yin o. Ẹ pe ẹrọ-ibanisọrọ yi
1 (800) 368-1019 or 1 (800) 537-7697 (TDD).

NOTICE OF NONDISCRIMINATION STATEMENT (*Continued*)

اُردُو (Urdu)

کال ۔ ہیں دستیاب میں مفت خدمات کی مدد کی زبان کو آپ تو ہیں، بولتے اردو آپ اگر :خبردار
11 (800) 368-1019 or 1 (800) 537-7697 (TDD). کریں

Kreyòl Ayisyen (French Creole)

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1 (800) 368-1019 or 1 (800) 537-7697 (TDD).

Português (Portuguese)

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1 (800) 368-1019 or 1 (800) 537-7697 (TDD).

العربية (Arabic)

) xxx-xxx-xxxx- ملحوظة: إذا تحدث كنت تتوافر اللغوية المساعدة خدمات فإن اللغة، اذكر تجانلك تتصل .برقم اتصل 1
(800) 368-1019 or 1 (800) 537-7697 (TDD).- والبكم الصم هاتف:

ગુજરાતી (Gujarati)

□ચુના: જો તમે □જરાતી બોલતા હો, તો ન:□લ્કુ ભાષા સહાય સેવાઓ તમારા માટ□ ઉપલબ્ધ છ. ફોન કરો 1 (800) 368-1019 or 1 (800) 537-7697 (TDD).

Persian-Farsi

کمک و که دارید را این حق با شنید داشته ، مورد در سوال ، میکنید کمک او به شما که به کسی یا شما، اگر
1 (800) 368-1019 or 1 (800) 537-7697 (TDD). نمایید دریافت رایگان طور به را خود زبان به اطلاعات
.نمایید حاصل تماس

GRANDFATHER NOTICE

The Prince George's County Government Health plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what may possibly cause a plan to change from a grandfathered health plan status can be directed to the Benefits Administration Division at (301) 883-6380 or 1-800-634-5231 (press option two [2] for Benefits). You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

PRIVACY NOTICE

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Why have you been sent this Notice?
Prince George's County Government (County) is required under the Medical Privacy Rules of the Health Insurance Portability and Accountability Act, Public Law 104-191 (HIPAA) to provide all of its employees and retirees eligible to participate in its healthcare plans with this Privacy Notice. This Notice concerns the personal, protected health information you have provided to the County as a condition of your employment and in connection with the provision of health or life insurance benefits provided to you. Prince George's County Government takes your privacy seriously. Your information will not be used or disclosed without your written permission, except as described in this Notice or as otherwise permitted by Federal and State laws. For example, in general and subject to specific conditions, we will not use or disclose your psychiatric notes; we will not use or disclose your protected health information for marketing; and, we will not sell your protected health information, unless you give us a written authorization.

How do we use your information?
We restrict access to your personal information to those employees of the County who need to know the information in order to provide services to you. We maintain physical, electronic and procedural safeguards that comply with HIPAA regulations to protect the security of your personal information. The County uses your protected health information for the following purposes:

- for administrative purposes related to our healthcare plans and other benefits, such as, accessing your health information to review the performance of our administrator or for underwriting, premium rating and other activities relating to health coverage; however, we will not use your genetic information for underwriting purposes;
- to evaluate the quality of care that you receive; and
- to inform you of health related benefits or services that may be of interest to you.

With whom do we share your information?
The County may share your personal information without your written permission to the vendors that assist the County in providing services to you. If we share your information, we will ensure that the vendors do not disclose or use your information for any other purpose, except as permitted by law.

When do we share your information?

There are limited circumstances when the County is permitted or required to disclose health information without your signed permission. These situations include:

- for public health purposes;
- for medical emergencies;
- for use by medical examiners, coroners and funeral directors and organ donation organizations;
- for judicial and administrative proceedings and law enforcement purposes;
- for specialized government functions, such as military, intelligence and correctional activities; and
- when otherwise required by law.

What are our duties?

The County is required by law to:

- maintain the privacy and security of your health information;
- provide this Notice of our duties and privacy and security procedures;
- follow the procedures described in this Notice; and
- the County reserves the right to change privacy and security procedures and make the new procedures effective for all information that the County maintains. Revised Notices will be made available to you.

What if there is a breach of unsecured protected health information?

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

What are your rights?

You have the right to:

- request that the County restricts how it uses or discloses your health information, please note, that the County will consider your request but is not legally required to agree to it, unless your request relates to payment or healthcare operations (but not for carrying out treatment) in situations where you have paid the healthcare provider out-of-pocket in full, in this case, the County is required to implement the restrictions that you request;
- request that the County communicate with you about health matters in a confidential manner;
- inspect and copy your health information (fees may apply, but any fee must be limited to the cost of labor involved in responding to your request if you requested a copy of an electronic health record);
- request additions or corrections to your health information;
- receive an account of how the County has disclosed your information for reasons other than treatment, payment, related administrative purposes (Note: this exception does not apply to electronic health records) and disclosures requested by you; and
- obtain a paper copy of this notice upon request.

How to contact us?

If you would like to exercise your rights, or if you feel that your privacy rights have been violated or if you need more information, contact the Office of Human Resources Management, Benefits Administration Division at (301) 883-6380 or 1-800-634-5231 (press number two [2] for Benefits, then select option nine [9]) with this information.

The Office of Human Resources Management
1400 McCormick Drive, Suite 245
Largo, Maryland 20774

All complaints will be investigated and you will not suffer retaliation for filing a complaint. If you believe that your rights have been violated, you may also file a complaint with the Office of Civil Rights of the U.S. Department of Health & Human Services in Washington D.C.

Prince George's County Government
Office of Human Resources Management


Stephanye R. Maxwell, Esq., CPM
Director, OHRM

October 2, 2017

Dear Plan Participant:

"Need to see a doctor or need a vaccine? Make sure you're enrolled! It's Open Enrollment 2018!" The annual open enrollment period will begin October 2 through October 27, 2017, for the health benefit plans. I encourage you to take this opportunity to review the health benefit plans you currently have and decide if you need to make changes to your existing benefit plan options for calendar year 2018.

Open enrollment is a time for you to review updated materials on the current health benefit plan options and make plan changes that would support the needs of you and your family. Making the right choices for your health benefit plan options will assist you and your family with living a healthier lifestyle now, as well as in the future. Please take a moment and mark the important dates mentioned above on your calendar.

Health Benefit Plan Changes

Each year, the Office of Human Resources Management (OHRM) reviews the level of benefit coverage, claims experience, and utilization data under the health benefit plans. It is important to note that Prince George's County Government (County) is not making any changes to the current co-payments, co-insurance or deductibles under the health benefit plans for calendar year 2018.

However, we reviewed the overall structure of the Health Benefits Program (Program) and identified some areas that we need to make changes in an effort to ensure the Program remains viable going forward. It is important to note these changes align with other public-sector and private employers in the marketplace. The County will modify the share of the premium paid by a participant and County. Currently, the premium share is as follows:

- Medical HMO Plan — County pays 78% of the premium and Participant 22%
- Medical PPO Plan — County pays 73% of the premium and Participant 27%
- Prescription and Vision Plans — County pays 88% of the premium and Participant 12%

Therefore, effective January 1, 2018, the County will change the premium share as follows:

- Medical HMO Plan — County pays 75% of the premium and Participant 25%
- Medical PPO Plan — County pays 70% of the premium and Participant 30%
- Prescription and Vision Plans — County pays 85% of the premium and Participant 15%

The share of the premium paid for the prescription and vision plans vary by participant group. An increase in the share of the premium paid for the prescription and vision plans will **not** apply to those whose current share is more than what is stated above. Additionally, due to clauses in the Collective Bargaining Agreements, the increase to the premium share for the above-stated health benefit plans **will not** apply to Police, Fire, Sheriff and Corrections retirees that retired prior to January 1, 2018. Please see pages sixty-two (62) through sixty-seven (67) that will outline the premium rate costs based on the previously stated.

The County will also implement a review and appeals process under the non-Medicare prescription plan administered by Express Scripts, Inc. (ESI), as of January 1, 2018. OHRM receives a number of requests for exceptions that are outside the requirements under the prescription plan. The review of these types of requests should be done by persons with a clinical background and ESI has personnel with the aforementioned. The review and appeals process will apply to requests that are considered Clinical or Administrative.

What is a Clinical or Administrative Request?

A Clinical Request is a review for coverage of a medication in which the prescription plan has certain clinical requirements that must be met to receive consideration for coverage under the plan. For example, a medication that the prescription plan states must have prior authorization in which certain medical rules must be satisfied for the plan to cover the medication.

An Administrative Request is for coverage of a medication in which the prescription plan has certain administrative rules that must be satisfied in order to receive consideration for coverage under the plan. Meaning, if an additional supply of medication is needed due to going on vacation and it is prior to the time period of being able to refill the prescription. The Clinical and Administrative Request review processes includes the ability to appeal, if a denial is received.

The above-stated process applies to the non-Medicare prescription plan only. The Medicare Part D plan has a review and appeals process that must align with the Federal Government's requirements.

Effective, January 1, 2018, the County will implement an additional option (Buy-Up) under the Vision Service Plan (VSP). Currently, the VSP plan provides one option (Base) that allows you to get an annual eye exam, lenses every year and frames every two years. The Buy-Up option will enable you to get annually an eye exam, lenses, and frames. This plan also covers Progressive Lenses in full at a participating VSP provider. Please see page fourteen (14) for a comparison of the Base and Buy-Up options under the VSP plan.

An Enrollment/Change Form must be completed to enroll or switch from the VSP Base to the Buy-Up option. You can go to page sixty (60) for a copy of the Enrollment/Change Form. It is important to note all eligible participants can enroll in the Buy-Up plan during the open enrollment period.

It is important for me to advise you that OHRM completed the procurement of the County's medical plans and it is with pleasure that I inform you the current providers: Cigna Healthcare and Kaiser Permanente were awarded the medical plan contract for a new term beginning January 1, 2018. Cigna Healthcare will continue to administer a Health Maintenance Organization (HMO) and Preferred Provider Organization (PPO) medical plans. Kaiser Permanente will administer the center based HMO medical plan.

In an effort to ensure you will have an opportunity to interact with Cigna Healthcare and Kaiser Permanente during the open enrollment period, OHRM has added additional provider sessions for the medical plan providers only. Please see page sixteen (16) for a listing of these sessions.

OHRM encourages you to mark these sessions on your calendar so you can address any questions, comments and/or concerns to Cigna Healthcare or Kaiser Permanente about the medical plans. We are committed to ensuring that the experience during this contract term is taken to the next level and continues to meet the health/wellness needs of you and/or your eligible dependents.

Health Benefit Plans Premium Rates

A review of the claims experience and utilization data revealed that we are still incurring a number of high dollar claims under the medical and prescription plans. In an effort to keep pace with the projected costs, some of the health benefit plans will experience a premium rate increase for calendar year 2018. The premium rate increases for calendar year 2018 are as follows:

- The Cigna Healthcare HMO medical plan will increase by 3.7%.
- The Cigna Healthcare PPO medical plan will increase by 3.7%.
- The Kaiser Permanente HMO (non-Medicare) medical plan will increase by 5.5%.
- The Kaiser Permanente HMO (Medicare) medical plan will increase by 1.03%.
- The Express Scripts, Inc., prescription plan will increase by 8.6%.
- The base plan option under the Vision Service Plan will increase by 3.9%.

It is important to note the above-stated is related to the increase of the premium rate and not the share of premium as outlined on pages eight (8) and nine (9). The premium rates for calendar year 2018 **did not** increase for the following plans: Aetna Dental Preferred Provider Organization (DPPO) and Aetna Dental Maintenance Organization (DMO) Plans.

Health Benefit Plans Enrollment Process

Open enrollment is the time when you may cancel your benefits or make changes such as, enroll in a plan, change from one plan to another or add an eligible dependent (e.g., spouse, child). This year, for your convenience, we have included an Enrollment/Change Form on page 60, if you need to terminate or make changes to your health benefit plans. **Please note, if you are not making any changes to the health benefit plans you are currently enrolled or adding/dropping a dependent, then you do not need to complete an Enrollment/Change Form.**

If you are adding an eligible dependent, you must submit documentation (e.g., marriage, birth certificate) to the Division by the close of business (5:00 p.m.), Friday, October 27, 2017. Please feel free to mail (envelope must be postmarked by October 27th), fax (301- 883-6358), bring to a provider session, email benefits@co.pg.md.us or hand deliver the document(s) to the Division. It is important for the first and last names and last four digits of your social security number be written on the document(s). **Failure to send the Division a copy of the document(s) will result in the dependent(s) not being enrolled in the health benefit plan(s) for calendar year 2018.**

It is important for you to adhere to the enrollment processes outlined above so that you will have the benefit plans you want for calendar year 2018. The Division will make **no exceptions** to the enrollment process.

It is strongly recommended that you review the pension check you receive in January 2018. This will ensure you have the benefit plan(s) and level of coverage that you want for calendar year 2018. If the deductions on your pension check are incorrect, you will have until the close of business, **Wednesday February 14, 2018**, to contact the Division to correct the error(s).

We hope that you will use this Open Enrollment Guide as a valuable source of important information about the County's health benefit plans. We strongly encourage you to read the Guide to learn more about the changes and requirements of the health benefit plans for calendar year 2018. This Guide also includes a list of the dates, times and locations of each of the provider (page fifteen [15]) and medical provider only (page sixteen [16]) sessions.

These sessions will provide you with opportunities to discuss with the health benefit plan providers any questions that you may have about the plans. Additionally, each provider session will have plenty of giveaways and raffle drawings.

OHRM will continue its efforts to offer health and wellness programs and activities so you can adopt lifestyle behavioral changes that will make a healthy you. We encourage you to incorporate changes in your lives that will result in a healthier lifestyle in 2018. **Have you completed an on-line health assessment?** If the answer is "no" and you are enrolled in a County medical plan, then completing an on-line health assessment is as simple as accessing the websites of Cigna Healthcare (www.myCigna.com) or Kaiser Permanente (www.kp.org).

OHRM strongly encourages you to complete an on-line health assessment and get a valuable tool that will provide you with information to make lifestyle choices to improve your health. Please contact the Division for information on the telephone numbers listed below and stay tuned for more wellness events and activities!

We invite you to come out and join us at one of the open enrollment provider sessions. Please feel free to contact the Division at (301) 883-6380 (press option nine [9]) or 1-(800) 634-5231 (press number two [2] for Benefits, then select option nine [9]), if you have any questions.

Don't forget to mark the open enrollment dates on your calendar. **"Need to see a doctor or need a vaccine? Make sure you're enrolled! It's Open Enrollment 2018!"**

Sincerely,

Stephanye R. Maxwell

Stephanye R. Maxwell, Esq., CPM
Director

What's coming for the Health Benefit Plans in 2018?

- Effective January 1, 2018, the County will change the share of the premium paid by the participant and the County. The share of the premium paid by the participant will increase by three (3) percent. Please see pages 8 and 9 for more details on the change to the premium share for calendar year 2018.

- The County will implement a Clinical and Administrative review process under the Express Scripts, Inc., prescription plan for medication request that are outside the plan's requirements effective January 1, 2018. It will include an appeal process for any plan denials. This process will only apply to the non-Medicare prescription plan. You can learn more about the review and appeal process on page 9.

- The Vision Service Plan (VSP) will offer you a Base plan option or Buy-Up plan option as of January 1, 2018. Under the Buy-up plan option, you can get annually an eye exam, lenses and frames. You can receive full coverage of progressive lenses at a VSP provider. Please see pages nine (9) and ten (10) for more details on the Buy-up plan option under the VSP plan. An Enrollment/Change Form must be completed to enroll or switch from the Base to the Buy-Up plan. See page 60 for the Enrollment/Change Form. Also, all eligible participants can enroll in the Buy-Up plan during the open enrollment period, if you elect to enroll.

- The Office of Human Resources Management completed the procurement of the medical plan contract. OHRM is pleased to announce the current providers, Cigna Healthcare and Kaiser Permanente, were awarded the medical plan contract as of January 1, 2018. Please see pages fifteen (15) and sixteen (16) and come out to one of the provider sessions to talk to Cigna Healthcare or Kaiser Permanente.

VSP Vision care for life

Base Plan and Buy-up Plan Comparison

Vision Benefit	Base Plan $10 Exam Copay $10 Materials Copay	Buy-up Plan $10 Exam Copay $10 Materials Copay
Examination	Every Plan Year*	Every Plan Year*
Lenses	Every Plan Year*	**Every Plan Year***
Frame	Every Other Plan Year*	**Every Plan Year***
VSP Provider		
Comprehensive Eye Examination	Covered in full	Covered in full
Contact Lens fitting and Evaluation	Covered in full after $60 copay	Covered in full after $60 copay
Lenses:		
Single Vision	Covered in full	Covered in full
Bifocal	Covered in full	Covered in full
Trifocal	Covered in full	Covered in full
Lenticular	Covered in full	Covered in full
Lens Enhancements		
Photochromic	Average 35%-40% off lens option	Average 35%-40% off lens option
Polycarbonate Lenses	Average 35%-40% off lens option	Average 35%-40% off lens option
UV Coating	Average 35%-40% off lens option	Average 35%-40% off lens option
Scratch Coating	Average 35%-40% off lens option	Average 35%-40% off lens option
Anti-Reflective Coating	Average 35%-40% off lens option	**Covered in full after $10 copay**
Progressive Lenses	Average 35%-40% off lens option	**Covered in full**
Frames	$150	**$250**
Elective Contact Lenses	$150	**$200**
Necessary Contact Lenses	Covered in full	Covered in full
DEP Plus	$20 Copay	$20 Copay
Non-VSP Provider	**Updated Open Access**	**Updated Open Access**
Examination	up to $55	up to $55
Single Vision	up to $50	up to $50
Bifocal	up to $75	up to $75
Trifocal	up to $100	up to $100
Lenticular	up to $125	up to $125
Progressive Lenses	up to $75	up to $75
Frame	up to $70	up to $70
Elective Contact Lenses	up to $150	up to $150
Necessary Contact Lenses	up to $230	up to $230

***Plan year is the period January through December.**

What, When and Where are the Open Enrollment Provider Sessions?

The open enrollment provider sessions are an opportunity for you to attend a benefit fair with each of the health benefit plan providers. It will also allow you to learn more about the health benefit plans and ask questions or express your concerns to the providers. The Benefits staff will be at the provider sessions collecting your **Enrollment/Change Form,** if you elect to enroll or make changes to the County's health benefit plans. The open enrollment sessions are as follows:

<table>
<tr><th colspan="2">2018 Open Enrollment Sessions – ALL PROVIDERS</th></tr>
<tr><td><u>Wednesday, October 4, 2017</u>
10:00 a.m. – 2:00 p.m.
RMS Building – First Floor Lobby
1400 McCormick Drive
Largo, MD</td><td><u>Wednesday, October 25, 2017</u>
10:00 a.m. – 2:00 p.m.
RMS Building – First Floor Lobby
1400 McCormick Drive
Largo, MD</td></tr>
<tr><td><u>Wednesday, October 11, 2017</u>
10:00 a.m. – 2:00 p.m.
County Administration Building (CAB)
Lower Level Lobby
14741 Governor Oden Bowie Drive
Upper Marlboro, MD</td><td rowspan="2">  </td></tr>
<tr><td><u>Wednesday, October 18, 2017</u>
12:00 p.m. – 4:00 p.m.
Maintenance Operations Center (MOC)
8400 D'Arcy Road
Forestville, MD</td></tr>
</table>

"Need to see a doctor or need a vaccine? Make sure you're enrolled! It's Open Enrollment 2018"

The Last Day of Open Enrollment is the Close of Business (5:00 p.m.) on October 27, 2017.

Medical Provider Only Sessions

Thursday, October 5, 2017 **9:30 a.m. – 12:30 p.m.** **RMS Building – First Floor Lobby** **1400 McCormick Drive** **Largo, MD 20774**	**Friday, October 6, 2017** **1:00 p.m. – 4:00 p.m.** **RMS Building – First Floor Lobby** **1400 McCormick Drive** **Largo, MD 20774**
Thursday, October 12, 2017 **9:30 a.m. – 12:30 p.m.** **County Administration Building (CAB)** **Lower Level Lobby** **14741 Governor Oden Bowie Drive** **Upper Marlboro, MD 20772**	**Friday, October 13, 2017** **1:00 p.m. – 4:00 p.m.** **County Administration Building (CAB)** **Lower Level Lobby** **14741 Governor Oden Bowie Drive** **Upper Marlboro, MD 20772**
Thursday, October 19, 2017 **12:30 p.m. – 4:00 p.m.** **Maintenance Operations Center (MOC)** **8400 D'Arcy Road** **Forestville, MD 20747**	**Friday, October 20, 2917** **12:30 p.m. – 4:00 p.m.** **Maintenance Operations Center (MOC)** **8400 D'Arcy Road** **Forestville, MD 20747**
Monday, October 23, 2017 **9:30 a.m. – 12:30 p.m.** **RMS Building – First Floor Lobby** **1400 McCormick Drive** **Largo, MD 20774**	**Thursday, October 26, 2017** **1:00 p.m. – 4:00 p.m.** **RMS Building – First Floor Lobby** **1400 McCormick Drive** **Largo, MD 20774**
Friday, October 27, 2017 **1:00 p.m. – 4:00 p.m.** **RMS Building – First Floor Lobby** **1400 McCormick Drive** **Largo, MD 20774**	

If I am Not Making Any Changes to My Health Benefit Plan(s) and I Want to Continue the Same Plans and Coverage of My Spouse/and or Dependents (if applicable) that are Currently on File, Do I Need to Complete an Enrollment/Change Form during Open Enrollment?

No. You do not need to complete an Enrollment/Change Form to continue the same health benefit plan(s) and coverage of your spouse and/or dependents (if applicable) that are currently on file.

What Kind of Change(s) Can I Make During This Open Enrollment Period?

Open enrollment is the time when you may cancel your benefits and/or make the following change(s):

- Enroll in a medical, dental, vision or prescription plan. Retirees or surviving spouses may drop a plan or a dependent at any time. Surviving spouses, County employees retiring under the MD State Retirement System, Deputy Sheriff's Comprehensive Plan, and Correctional Officer's Comprehensive Plan **are not** eligible to pick up a new benefit(s) unless they have a family status change. See pages eighteen (18), twenty (20), and twenty-one (21) for more information about family status changes.

- Change from one medical or dental plan to another.

    - Add an eligible dependent(s) who is not currently covered. To add your dependent to the health benefit plans, you must provide a copy of the marriage or birth certificate(s) or other supporting documentation and social security number to the Benefits Administration Division (Division). Please note that during the open enrollment provider sessions, the Division staff is unable to make copies of your documents for the dependent(s) being added. A copy of your document(s) must be submitted to the Division in an envelope postmarked by October 27, 2017. Please feel free to mail (USPS), fax (301) 883-6358, bring to a provider session, email benefits@co.pg.md.us or deliver document(s) to the Division (RMS Building, Suite 245). Your first and last name along with the last four digits of your **Social Security** number must be provided on the document(s). **Failure to send the Division a copy of your document(s) will result in your dependent(s) not being enrolled in the health benefit plan(s) for calendar year 2018.**

- Cancel enrollment in any health benefit plan(s) for you or your dependent(s).

Do I Have to Attend an Open Enrollment Provider Session to Make a Change?

No. You can obtain the **Enrollment/Change** Form (Form) on page 60, or you can pick up a Form from the Benefits Administration Division (Division) located at 1400 McCormick Drive, Suite 245, Largo, Maryland or you can call the Division at (301) 883-6380 or 1-800-634-5231 [press number two (2), then select option nine (9)] for the Benefits Division to receive the Form by mail. Remember, your Form must be submitted to the Division by the close of business, October 27, 2017, or mailed to us in an envelope **postmarked** October 27, 2017. You can also fax your completed Form to (301) 883-6358. **The Division will not accept your Form with open enrollment changes for calendar year 2018 after the above-stated time.**

May I Make a Change(s) to a Health Benefit Plan(s) During the 2018 Calendar Year?

Retirees or surviving spouses may drop a plan or a dependent at any time. It is important to note a health benefit plan(s) that is dropped by a surviving spouse, a retiree under the MD State Retirement System, or Deputy Sheriff's Comprehensive Pension Plan, or Correctional Officer's Comprehensive Pension Plan, are not eligible to pick up the plan in the future.

However, you may make a change to your health benefit plan(s) during the plan year (outside of open enrollment) if you have a **qualified family status change**. A qualified family status change is an event such as, a marriage, birth of a child or divorce. Please see pages 20 and 21 for the detailed list of what qualifies as a family status change. You may **add** a dependent (spouse/child) **within forty-five (45) days of a qualifying event**. ***Please note that surviving spouses may not add newly acquired spouses or dependents.***

Retirees who **lose** their health benefits coverage can enroll in the County's plans within forty-five (45) days of losing their coverage. The retiree must submit written documentation reflecting proof of the date the coverage was lost. The written documentation should also indicate the health benefit plan(s) lost. **The premium contribution schedule and health benefit plan(s) provisions in effect at the time the retiree enrolls in the plan(s) as a result of losing the coverage will apply.**

What are My Options for Enrolling in the County's Health Benefit Plans as a Rehired Retiree?

A retiree who is re-employed by the County must elect enrollment in the core health benefit plans (e.g., medical, prescription) either as a retiree or as an active employee. It is the retiree's responsibility to decide which option best fits his or her needs.

If you are a full-time or part-time Rehired Retiree and are actively working at least 15 hours per week, you can also elect to enroll in the voluntary benefit plans.

The County has reviewed the offerings under the Voluntary Benefits Plans and elected to place the following plans: Critical Illness, Enhanced Accident, Whole Life Insurance, and Short-term Disability under the provider, Unum effective **January 1, 2018**.

Unum will provide an array of benefits under each of the above-stated plans for you and your eligible dependents at an affordable cost. If you are currently enrolled in a voluntary benefit plan(s) with Aflac (Enhanced Accident), Transamerica and/or Lincoln Financial, the payroll deductions for the plans(s) will end as of **December 31, 2017**. You can continue the plan(s) that you currently have with the previously stated providers; however, you will need to contact them and arrange to pay them directly starting January 1, 2018. Listed below are the voluntary plans, the County will offer, as of January 1, 2018.

Unum

- Critical Illness Insurance Plan
- Accident Insurance Plan
- Whole Life Insurance Plan
- Short-term Disability Plan

Aflac

- Supplemental Dental

Legal Resources

- Legal Plan

Legal Shield

- Legal Plan

Please contact the Benefits Administration Division with any questions you may have concerning your eligibility to enroll in the County's health and voluntary benefit plans, and the enrollment process for the plans.

What is a Qualified Family Status Change?

- *Birth* - You must complete an Enrollment/Change Form (Form) to add your newborn child to your health benefits coverage, and submit the Form to the Benefits Administration Division within forty-five (45) days of the birth of your newborn child. **If you fail to add your newborn child to the coverage within the forty-five (45) day timeframe, you will have to wait until the next open enrollment period to make the change unless your dependent experiences a family status change such as loss of coverage. The Benefits Administration Division will not make an exception to this requirement.**

  You must provide a copy of the birth certificate and social security number to add your newborn child**. Please do not wait until you receive the birth certificate and social security number before you add the newborn child to your health benefit plan(s).** The Benefits Administration Division will send a letter to the address on file for you requesting a copy of the birth certificate and social security number. It is imperative that you respond with the requested documentation by the stated deadline in the letter.

- Death, divorce, legal separation, limited divorce, adoption or marriage;
- Termination or commencement of employment. Retirement is **not** a qualified family status change;
- Change in employment status from part-time to full-time;
- Covered dependent ceasing to be an eligible dependent; and
- Loss of health benefits coverage.

The above-stated will allow you to add, change and/or terminate a health benefit plan(s). Please contact the Benefits Administration Division with any questions and to obtain additional information on other qualified family status changes.

NOTE: Family status change(s) must be made within forty-five (45) days of the qualifying event. Newborns will be covered as of their date of birth, if you add the newborn to your health benefits coverage within forty-five (45) days of the birth of your child. Coverage for dependents you have adopted or have legal guardianship will be effective the date of the court order, if you add the dependent to your health benefits coverage within forty-five (45) days of the signed court order. Please see page twenty-two (22) for the termination date of coverage for dependents covered as a result of legal guardianship.

(Continued from Page 20)

The effective date for all other family status changes will be the first of the month following receipt of the Enrollment/Change Form. If notification is received after the end of the month in which the qualifying event occurs, the effective date of the change will be the first of the next month and there will be no refund of health benefit premiums even if the event results in a reduction in the coverage level.

Who are Eligible Dependents?

- ◊ A Spouse (to include a same sex spouse) can be added to the health benefit plan(s);
- ◊ Children under age 26. (The coverage for children ends the last day of the month in which they turn age 26). This includes stepchildren and children of the same-sex spouse. Note: If you are only adding the step-children or children of the same-sex spouse, you must submit the marriage certificate and the children's birth certificates and social security numbers. The birth certificate must list the spouse's name as the parent;
- ◊ Children certified to be totally unable to support themselves because of mental or physical disability occurring prior to age 26. **Medical documentation to support your dependent's disability must be submitted for approval. Please contact the Benefits Administration Division for additional information on the approval process. A dependent will not be added to the health benefit plans until an approval is received**;
- ◊ Legal Ward or Guardianship up to age 18. Dependents are terminated at the end of the month in which they turn age 18 or when the guardianship ceases, which is generally at age 18;
- ◊ Children that you are in the process of adopting and of whom you have custody. Plan Participants must submit a copy of the Petition for Adoption and the Temporary Custody Order;
- ◊ Legally adopted children. Plan Participants must submit a copy of the Judgment or Decree of Adoption upon termination of the Temporary Custody Order in order to continue coverage;
- ◊ Children legally adopted in a foreign country. Plan Participants must provide a certified copy of the English translation of the birth certificate and adoption order;
- ◊ Children for whom you have assumed a legal and financial responsibility. Plan Participants must provide a copy of the Court Order granting legal custody or guardianship; and
- ◊ Dependents for which a Qualified Medical Child Support Order has been received by the Benefits Administration Division.

What Documentation is Required to Add a Dependent(s)?

To add your dependent to the health benefit plans, you must provide a copy of the marriage, birth certificate(s), or other supporting documentation and social security number to the Benefits Administration Division. A court order and birth certificate are required for legal guardianship. An adoption of a child(ren) requires an adoption court order and/or adoption papers. Please note that during the open enrollment provider sessions, the Benefits Administration Division Staff is unable to make copies of your documents for the dependent(s) being added. **Failure to submit a copy of the supporting documentation will result in your dependent(s) not having coverage as of January 1, 2018.**

Can Your Dependent(s) Select a Different Benefit Plan Than You, the Member?

No. Your dependent(s) must be on the same health benefit plans that you select. However, you do not have to enroll a dependent in every plan that you select.

Do I Select a Primary Care Physician (PCP) if I Enroll in a Cigna Healthcare Medical Plan?

No. You are not required to select a PCP because the medical plans are open access network plans. The Open Access In-Network (OAPN) (HMO) and in-network option of the Open Access Plus (OAP) Preferred Provider Organization (PPO) medical plans require you to use a provider in the network in order for the plan to provide payment for covered services. <u>If you use a provider that is not in the network, you will be responsible for payment of the services you incurred under the Open Access Plus In-Network (OAPN) (HMO) medical plan</u>. However, the Open Access Plus (OAP) Preferred Provider (PPO) plan allows you to utilize a participating provider in the network and the coverage outlined under the in-network option applies or you can use a non-participating provider and the out-of-network option provides coverage for the medical services. The applicable deductible and co-insurance applies to services covered under the PPO out-of-network option. Cigna Healthcare (Cigna) will apply the reasonable and customary amount to the payment of claims for medical services under the out-of-network option.

Do I Select a Primary Care Physician (PCP) if I Enroll in a Cigna Healthcare Medical Plan?

(Continued from Page 23)

To obtain a list of the Cigna network providers, you can access Cigna's website at www.myCigna.com, pick up a Cigna Healthcare Directory during open enrollment, call the Member Services Department at 1-800-244-6224, or you can simply ask the provider if they are a network provider for the Open Access In-Network OAPN (HMO) or the Open Access Plus (PPO) medical plans.

How Can I Be Sure my Services Will Be Covered Since I Do Not Live in the Cigna Healthcare Service Area?

The County provides you with two medical plan options, Open Access Plus In-Network (HMO), and Open Access Plus Preferred Provider Organization (PPO) medical plans through Cigna Healthcare. The Open Access Plus In-Network (HMO) and Open Access Plus (PPO) medical plans have a wider provider network that has participating providers in most areas across the country. The Benefits Administration Division encourages you to make sure the provider participates in the network by asking if they accept the Cigna Healthcare Open Access Plus In-Network HMO or Open Access Plus PPO medical plan. You can also call Cigna Healthcare at 1-800-244-6224 to speak with a representative or access www.myCigna.com to locate a participating provider under the medical plans.

Do I Have to Select a Primary Care Dentist (PCD) if I Enroll in the Aetna DMO Dental Plan?

Yes. If you enroll in the Aetna DMO plan, in order to use your dental plan benefits you *must* complete the Aetna DMO PCD Election Form (PCD Election Form) on page sixty-one (61) and select a PCD for you and your covered family members. A copy of the PCD Election Form must be submitted to the Division in an envelope post-marked by October 27, 2017. The PCD Election Form can be sent either by mail (USPS) or fax (301-883-6358) or e-mail (benefits@co.pg.md.us) or brought to a provider session or the Benefits Division (RMS Building, Suite 245). To obtain a list of participating PCDs, you can visit Aetna's *DocFind* on-line provider directory at www.aetna.com, or obtain a paper directory of participating PCDs at an open enrollment provider session. You can also contact Member Services at 1-877-238-6200 to obtain the name of a PCD in the area where you reside. **Please note that if you do not select a PCD, you will not be able to use your DMO dental plan benefits on January 1, 2018.**

NOTE: If there is <u>not</u> a network in the area where you reside, you may select a PCD in the area where you work, <u>provided a network is available</u>. You must indicate your work address on the Aetna DMO PCD Election Form. You can also obtain an Aetna DMO PCD Election Form at an open enrollment provider session or from the Benefits Administration Division.

"Need to see a doctor or need a vaccine? Make sure you're enrolled! It's Open Enrollment 2018"

Can My Spouse and/or Children Continue the Health Benefit Plan(s) Coverage in the Event of My Death?

Yes, however, your spouse and eligible children must be enrolled in the health benefits plan coverage (coverage) at the time of your death. Coverage for your eligible children will end the last day of the month in which they turn age twenty-six (26).

Do I Have to Pay Taxes on the Basic Life Insurance (BLI) the County Provides to Me as a Retiree?

Yes, for the amount of BLI that is greater than $50,000. The Internal Revenue Service (IRS) regulations limit to $50,000 the amount of group term life insurance paid by your employer that you can have as an individual on a tax-free basis. If the amount of BLI that the County provides for you is greater than $50,000, the value of the actual premium cost of insurance over $50,000 will be treated as taxable income. The IRS calls this imputed income. The imputed income is calculated using a table issued by the IRS, which is based on your age and the cost of the excess coverage above $50,000. The actual premium cost of the insurance would be reported on the annual W-2 Form. Remember, this provision only applies to you if the BLI the County provides to you is greater than $50,000.

Cigna Healthcare

Cigna One Guide® - NEW

The **Cigna One Guide**® service can help you make smarter, more informed choices and get the most from your plan. It's our highest level of support that combines the ease of a powerful app with the personal touch of live customer service. Your One Guide personal support, tools and reminders can help you stay healthy and save money. Get in touch with the new Cigna One Guide team by telephone, click to chat or via the enhanced myCigna app. To get started quickly, follow these five easy steps:

1. **Log in to myCigna.**[SM] Just visit **myCigna.com** to start or finish customizing your very own health journey. Watch a quick video at Cigna.com/myCigna-tour to get a sneak peek at all the great tools that are available to you.

2. **Set your preferences.** Once your account is set up, manage your profile to let us know the best way to contact you with important health information, like your Explanation of Benefits or claim updates.

3. **Find care.** You can search through all of the doctors in your network to find one you like. Keep these tips in mind to help avoid surprise expenses and get the most out of your plan:
   - › Make sure doctors, facilities and prescriptions are covered by your plan; and
   - › Know before you go. Search for lower-cost options, like urgent care centers, instead of the ER, if you can't see your doctor immediately.

4. **Connect with us, 24/7.** We are here whether you need to change doctors, transfer a prescription or you already have care like a surgery planned. We are here to make things easier, 24/7 and help you every step of the way.

   › Call the number on your Cigna ID card. If you don't have one, don't worry, you can download a copy from the app.

5. **Get the most from your plan.** The new **Cigna One Guide**® team is ready to help you every step of the way. Our personal support begins with making sure you select in-network providers and facilities and make the most of your current coverage. Call or click to chat with a Personal Guide any time.

Cigna Healthcare *(Continued)*

At Cigna, we understand that navigating your health care isn't always easy. And we're here to help with Cigna One Guide®, a highly personalized support system designed to make it easy to get the most out of your health care benefits.

Cigna has a variety of programs that can save you money and help you improve your health.

- **Cigna Care Designation/Centers of Excellence:** We know you want to visit a doctor who has a good reputation and provides quality care at an affordable cost. So, Cigna has identified the top performers in their network by awarding them with a **Cigna Care Designation on myCigna.com. Doctors in twenty-two (22) different medical specialties are evaluated annually for quality and cost, and only those who meet certain Cigna cost-efficiency and quality measures receive the recognition.** To find one of these doctors in the myCigna.com directory, just look for the "blue C" symbol.

  Online Health Assessment: Taking a health assessment is a quick and easy way to learn more about your health today, and to figure out how you can improve your health in the future. After completing the health assessment, you'll get a report that includes your wellness score, as well as recommended programs. This report is a great tool to share with your doctor and use as a guide to help you set and achieve healthy goals.

- **Health coaches:** Get one-to-one support to help you reach your health goals.

- **Health and Wellness Discounts:** Get discounts on the health products and programs you use every day such as:

  › Weight management and nutrition
  › Vision and hearing care
  › Alternative medicine
  › Healthy lifestyle and fitness

  Just use your ID card when you pay and let the savings begin.

Cigna Healthcare *(Continued)*

- **Healthy Babies Program**: Enroll in this prenatal program designed to help you and your baby stay healthy during your pregnancy and in the days and weeks following your baby's birth.
- **Lifestyle Management Programs:** If weight, tobacco or stress are affecting your health or your ability to live an active life, it may be time to make some changes. A health coach can provide you with personalized support to help you:

  › Learn to manage your weight using a non-diet approach that helps you build confidence, change habits, eat healthier and become more active; and

  › Develop a personal quit plan to become and remain tobacco free; and

  › Understand the sources of your stress, and learn to use coping techniques to better manage stress both on and off the job.

You can use an on-line or telephone coaching program or both for the support you need.

- **Free Diabetic Supplies**

  - The Cigna medical plan you are enrolled will cover your diabetic supplies at 100%.
  - You may even be eligible for a FREE glucose meter.
  - To obtain one of these glucose meters and test strips at no cost through Cigna Home Delivery Pharmacy, please call 1-800-238-4778 for details.

- **24-Hour Telephone Support**: Whenever you need us, just call the toll-free number printed on the back of your Cigna ID card 24 hours a day, seven days a week, 365 days a year. The 24-hour telephone support can provide the following:

Cigna Healthcare *(Continued)*

› Answers to health, claims and plan questions; or
› Order an ID card, update information and check claim status; or
› Find a health advocate for help with improving specific health issues; or
› Speak with a Spanish speaking service representative or someone who can translate one of 200 languages.

- **Telehealth Services – Cigna members will be able to access telehealth services to treat minor medical conditions (colds, flu, allergies, headaches, etc.). Connect with a board certified doctor via video or phone when, where and how it works best for you. Visit the website or call to register. AmwellforCigna.com 855-667-9722 or MDLIVE forCigna.com 888-726-3171.**

Kaiser Permanente

Kaiser Permanente Provides Care Where You Need It

- Five (5) urgent care medical centers open 24 hours a day, 7 days a week.
- Thirty (30) multi-specialty medical centers.

New and expanded:

- Gaithersburg, MD
- Largo, MD
- Glen Burnie, MD
- South Baltimore County, MD
- Tysons Corner, VA
- Downtown Baltimore City, MD
- Towson, MD
- Harford County, MD
- Alexandria, VA (coming in 2019)
- Bowie, MD (coming in 2019)

Many services under one (1) roof:

- Family medicine
- Internal medicine
- Lab
- Obstetrics/gynecology
- Pediatrics
- Pharmacy
- Radiology
- Specialties
- Vision

Find a facility near you. Visit *kp.org/locations*.

You Can Use Your Mobile Device To:

- Video Visit with your Primary Care Provider at **NO additional charge**;
- Email your doctor's office;
- View most lab results;
- Order prescription refills;
- Schedule and change routine appointments;

Kaiser Permanente (*Continued*)

- Refill most prescriptions;
- View past visits and more;
- Just download the Kaiser Permanente app at no cost from your preferred app site.

You Have A Healthcare Team Focused On You

Choose your PCP and OB/Gyn at kp.org/doctor—change at any time.

Kaiser Permanente doctors:

- Are carefully selected and board certified;
- Use our electronic systems to help discover gaps in patient care;
- Are up-to-date and connected to your care team through your electronic health record; and
- Can schedule most specialty consultations right in the exam room to take place within seven (7) days.

Urgent Care

At your Kaiser Permanente Urgent Care Plus Center, you get:

- Board certified emergency department physicians who are capable of handling any problem you may have day or night;
- Less wait time and lower co-pays than a typical hospital emergency room;
- 24/7 pharmacy and laboratory services;
- Advanced imaging services including Cat Scan (CT), Magnetic Resonance Imaging (MRI), and ultrasound;
- Expanded observation services, with ability to observe patients for up to 24 hours; and
- Expanded Urgent Care hours at Woodbridge, VA medical center.

Call 1-800-777-7904 (1-800-700-4901, TTY) to schedule an appointment, or just come on in, whichever is more convenient for you. If you believe you are experiencing a medical emergency, call 911.

Kaiser Permanente (Continued)

House Calls

Video chat consultations with emergency room physicians:

- When does my child's fever become serious?
- How can I tell the difference between a sprained ankle and a broken one?
- How severe is my burn?

When you speak to one of our advice nurses, the nurse may be able to schedule a same-day video consult with one of our emergency room physicians using the camera on your computer, tablet, or telephone.

Healthy Lifestyles

Give yourself the winning edge with our free healthy lifestyle programs* for Kaiser Permanente members 18 years and older. These personalized on-line programs can help you create an action plan to reach your health goals.

Get the advice, encouragement, and tools you need to make healthy changes, such as:

- Eating Healthy;
- Losing Weight;
- Quitting Smoking; or
- Reducing Stress.

Learn how to manage health conditions, including:

- Back Pain;
- Chronic Pain;
- Depression;
- Diabetes; and
- Insomnia.

To pick the program you want, sign on to kp.org/healthylifestyles.

Start now, take advantage of being a Kaiser Permanente member and have access to programs and classes that are offered at our medical centers to help you live healthier, such as:

- Prenatal and Lamaze;
- Breastfeeding;
- Nutrition;

Kaiser Permanente *(Continued)*

- Fall Prevention;
- Insulin Information sessions;
- Osteoporosis Awareness; or
- Commit to Quit.

*For more information on these programs and the many more offered to Kaiser Permanente members, please visit www.kp.org/healthylifestyles.

Wellness Coaching

Partner with a coach today to:

- Focus on healthy habits—Make healthy behavior changes to help you manage your weight, quit tobacco, reduce stress, get more active, or make healthier food choices;
- Create a customized plan—Work with your coach to outline manageable steps you can take to reach your goals. Little changes over time can help you achieve long-term success;
- Schedule convenient telephone sessions - coaching takes place over the telephone, so you can set up calls at times that work for you; and
- Wellness coaching is available at no charge for Kaiser Permanente members.

Coaching is offered in English and Spanish. No referral is needed. Coaches also have access to a language line to facilitate coaching in most languages.

Simply pick up the telephone and call to get started. Call 1-866-862-4295, Monday through Friday, from 7 a.m. to 8 p.m., Eastern Standard Time (EST) to make an appointment.

Aetna Dental

Aetna Dental DMO

The Aetna Dental DMO is personal and affordable. You will get care that is easy on your budget, and you can enjoy the following features of the DMO dental benefit plan:

- A primary care dentist to manage your dental care. You choose the dentist from the dental network. Your primary care dentist can refer you to specialists when necessary;
- No deductibles; and
- No annual dollar maximums.

For more information about the DMO dental plan, go to: www.aetnadmodental.com.

Aetna Dental PPO

The Aetna Dental PPO plan provides you with freedom. You can pick any licensed dentist in the network. Or you can go outside the dental plan's network. If you go to an in-network dentist it will cost you less, but the choice is yours. Either way, you will enjoy these features:

- No referrals; and
- No need to choose a primary care dentist.

For more information about the PPO dental plan, go to: www.aetnappodental.com.

Dental ID Cards

Good news. Life just got simpler. You no longer need a member ID card to get care with Aetna Dental.

Aetna wants to make doing business easier than ever. Plus, no card means no plastic and that's better for the environment – and good for everyone.

Aetna Dental (*Continued*)

How will my dentist know I'm an Aetna Dental PPO or DMO® member? When you go to your dentist, tell the office your name, date of birth and Member ID# (or your social security number).

But what if I want a card?

Easy — use our mobile app or go on-line. Log in to your secure member website at **www.aetna.com**. Your ID card will appear on your personal benefits page. You can print out an ID card for you and your dependents by clicking on **"Get an ID card."**

For DMO Members, if your electronic ID card says **"No Election"** or **"Invalid Choice,"** then your plan requires you to choose a Primary Care Dentist (PCD) who is in our network. Until you choose one, your benefits and claims may be limited to emergency services only. To be effective on the first (1st) of the month, PCD selections must be received at Aetna by the fifteenth (15th) of the prior month. In order to schedule an appointment with a PCD, your name must appear on the monthly roster sent to PCDs.

Call 1-877-238-6200 if you have any questions – 24 hours a day, 365 days a year.

Aetna Navigator Health Information Guide

You can make the most of your dental benefit plans using the Aetna Navigator Health Information Guide to find answers and access information on the following items:

- Review who is covered on your plan;
- Find a dentist who participates in your network;
- Compare in-and out-of-network costs for the most common dental procedures before you visit the dentist. You will also see how much you can save by visiting an Aetna network dentist;
- Print your Health History Report this is a handy summary of your dental visits, tests and more. You can share it with your dentist;
- Link to health information on-line; and
- Communicate with Member Services.

It's easy to get started! Go to www.aetna.com. Click on "Register Now" in the "Members: Secure Information" section.

Aetna Dental (*Continued*)

Aetna Mobile — find what you need, wherever, whenever

There are two (2) ways to download the free Aetna Mobile app to access your ID card or dental benefits information when you're on the go.

- Text "Apps" to 44040 to download now; and
- To learn more, visit us at **www.aetna.com/mobile**.

Aetna Life EssentialsSM Program* — Extra protection adds up to extra value at no extra cost

Aetna Life Essentials adds value to your life insurance policy by helping you make the most of every stage of your life. The program gives you and your family access to free resources during your lifetime and afterward:

- **Funeral services** — Manage all funeral details through Everest Funeral Planning and Concierge Services;
- **Accelerated death benefit** — Access a portion of your life insurance benefit, if you're terminally ill, before your death;
- **Legal services** — Benefit from on-line estate planning services;
- **Physical services** — Gain access to discount vision, hearing and fitness programs;
- **Care advocacy** — Receive professional counseling over the phone from a master's level social worker; and
- **End-of-life support** — Visit the Aetna Compassionate Care[SM] website. Also, talk to a licensed social worker to prepare for this challenging time of life.

Visit: www.aetna.com/aetnalifeessentials

***Legal Reference™ Program services are independently offered and administered by ARAG® Insurance Company of Des Moines, Iowa. Aetna does not participate in attorney selection or review, and does not monitor ARAG services, content or network. Everest Funeral Planning and Concierge Services ("Services") are independently administered by Everest Funeral Package, LLC ("Everest"). Access to these services is not insurance, may be discontinued at any time without Notice and is void where prohibited. Everest is solely responsible for furnishing these services and Aetna makes no guarantee or representations as to their quality or suitability. In no event will Aetna be responsible or liable for any acts or omissions by Everest and its agents, employees or representatives in connection with the services provided.

Aetna Life EssentialsSM Program (*Continued*)

Specific features of life insurance plans vary, depending on employers and states. Plan features and availability may vary by location and are subject to change. Plans contain exclusions and limitations. See policy or plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Information is believed to be accurate as of the production date; however, it is subject to change.

Express Scripts Prescription

My Rx Choices® makes it easy to find lower-cost alternatives available under your program to your current medications—either on-line or by calling Express Scripts at the number on the back of your card. To find lower-cost options on-line:

1. **Log on to** www.express-scripts.com/choices. If you're a first-time visitor to our website, you'll need to register, so have your member ID and a recent prescription number handy.
2. **Select a medication that you take on an ongoing basis, or enter the name of your medication.**
   My Rx Choices will search for available options and show you how much you could save by choosing available lower-cost options.
3. **Print the prescription savings report to discuss with your doctor.** Your doctor can review your choices and, as appropriate, write a new prescription for you.

Consumer Reports Best Buy Drugs™ In addition to saving you money, some lower-cost medications could be rated as *Consumer Reports Best Buy Drugs*. When visiting **My Rx Choices** on-line, click the *Consumer Reports Best Buy Drugs* icon to find out more about those alternatives. This additional information may be helpful when discussing lower-cost alternatives with your doctor.

The Prince George's County Government understands that you and your doctor need new ways to help reduce your healthcare costs. With **My Rx Choices,** you can do exactly that—without compromising quality.

Generics vs. Brand-Name Drugs

If you're taking a brand-name drug, ask your doctor whether an available generic may be right for you. FDA-approved generic drugs are safe and effective, and they must meet the same U.S. Food and Drug Administration standards of quality and purity as brand-name drugs. They provide the same health benefits as the brand versions but at a lower cost to you. **By considering a generic medication,** you're taking an important step in becoming more engaged in your prescription drug therapy.

If you have any questions, please call Express Scripts Member Services at the number on the back of your card, or visit us on-line at www.express-scripts.com.

Express Scripts Prescription *(Continued)*

Express Scripts' Extended Payment Program

Paying for your mail-order prescriptions just got easier.

Express Scripts has created a program to help make your mail-order prescriptions more affordable. It's called the Extended Payment Program (EPP).

EPP allows you to spread your prescription payments over **three (3)** credit or debit card installments so you don't have to pay all at once. And there's no waiting—your medication will be shipped after the very first payment.

When you're enrolled in EPP it will apply to every mail-order prescription for you and your eligible dependents going forward. If at any point you wish to opt out of the program, you may call Member Services or visit www.express-scripts.com.

Facts about EPP

- If you decide to cancel EPP at any time, payment for the remainder of your current prescriptions will be your responsibility.
- If the payment plan ends, invoices incurred while enrolled in EPP will continue to be charged in three (3) installments. New invoices will require your regular co-payments in full.

To learn more about Express Scripts extended payment program, please visit www.express-scripts.com or call Member Services toll-free at the number on the back of your prescription drug ID card.

Express Scripts Prescription *(Continued)*

Worry Free Fills™ Program

Refill your mail-order prescriptions automatically.

Ordering prescriptions and taking your medications are among the most important things you can do. But ordering isn't always easy to remember. You might even find it inconvenient. And that is why Express Scripts has created the **Worry-Free Fills™** program, so your prescriptions can be refilled automatically.

You can enroll your eligible prescriptions in **Worry-Free Fills** when you order your first refill. If they're already enrolled, there's no need to call for refills. As you near the end of your current supply, Express Scripts automatically send your next refill, using your existing address and payment information.

To enroll in **Worry-Free Fills,** visit www.express-scripts.com, or call Member Services at the number on the back of your prescription card.

Medications that qualify for *Worry-Free Fills* include:

- Cardiovascular medications, such as antiarrhythmic, calcium channel blockers, antihypertensive, beta-blockers, cholesterol-lowering medications, diuretics, and ACE inhibitors
- Certain HIV medications
- Diabetes medications
- Oral contraceptives
- Osteoporosis medications
- Parkinson's disease medications
- Thyroid medications
- Asthma and COPD medications, such as theophylline

For safety and other reasons, prescriptions for some medications are never allowed to be filled automatically. Specialty medications, controlled substances, and over-the-counter medications are examples.

Express Scripts Prescription *(Continued)*

When a prescription expires and you or your doctor sends in a new prescription without amendment, the medication will automatically be re-enrolled in **Worry-Free Fills**. If there's a change in the prescription, you'll need to re-enroll in the Worry-Free Fills program.

To see if you're eligible for **Worry-Free Fills** and to enroll your prescriptions, visit www.express-scripts.com or call Member Services toll free at the number on the back of your prescription drug ID card. If you enroll in the **Worry-Free Fills** program, please note that Express Scripts has a standard maintenance and review process. Standard maintenance will include an automated process for review and reporting of the drugs that qualify for the **Worry- Free Fills** program. Updates to the exclusion list are made as a part of the standard maintenance; therefore, the qualified medications under the program are subject to change. If your medication is no longer a qualified drug, you will be notified by Express Scripts.

Express Scripts Specialist Pharmacists…

Can help you understand your medications *and* could help you save money.

Express Scripts, which manages the prescription drug benefit for the Prince George's County Government, offers a great way to help members safeguard their health. You now have 24/7 access by telephone to the expertise and personalized support of Express Scripts Specialist Pharmacists and they're available through your prescription drug benefit at no additional cost.

Express Scripts Specialist Pharmacists have expertise in the medications used to treat specific conditions, such as high blood pressure, high cholesterol, depression, diabetes, asthma, osteoporosis, or cancer. This expertise comes from additional training in these medications, combined with experience gained from helping people with similar conditions.

Express Scripts Specialist Pharmacists can work with you and your doctor to help safeguard your health.

Often members with multiple conditions see multiple doctors, who may be unaware of what other doctors are prescribing. Express Scripts reviews *all* your medications on file from *all* your doctors and pharmacies to look for drug interactions that may be harmful.

Express Scripts Prescription *(Continued)*

If there is a potential problem with certain medications, an Express Scripts Specialist Pharmacist will review the prescription and contact you or your doctor to help make sure your medications will work safely together and work well for you.

These pharmacists could also help you save money on your prescriptions.
Taking your medication as your doctor directed is one of the best ways to help maintain or improve your health. But to take your medication regularly, it helps when it's affordable.

Express Scripts Specialist Pharmacists can help you see if there are any **lower-cost alternatives available under your plan.** They can work with your doctor to help you get the best drug for you.

You can address your concerns privately.
Like all our pharmacists, Express Scripts Specialist Pharmacists have the time to talk to you on the telephone—*in private,* 24/7—to help you understand and manage your medications.

This means that you can feel comfortable asking personal and sensitive questions about your medications—without the concern of bystanders listening to your conversation.

During your conversation, the pharmacist is fully available to help you understand how your medications work and their potential benefits for you.

An easy way to take advantage of this enhanced pharmacy support is to get your prescriptions through the mail from the **Express Scripts Pharmacy™**. You'll also benefit from the convenience of having medications delivered right to you. With the **Express Scripts Pharmacy™,** you'll get:

- Up to a 90-day supply of medication—which could be at a lower cost than at a local retail pharmacy; and
- 24/7 access to benefit specialists, who can answer questions and also arrange for you to talk to an Express Scripts Specialist Pharmacist; and
- An easy refill process over the telephone, by mail, or on-line.

Express Scripts Prescription *(Continued)*

You can call an Express Scripts Specialist Pharmacist to help you understand and manage your medications. Just call the toll-free number on your prescription drug ID card.

Remember….

Prince George's County Government has Exclusive Home Delivery. This allows members to receive two fills of their maintenance medication at a retail store. After the second fill at retail, members will pay a 100% co-pay penalty until they move to the Express Scripts Pharmacy.

Express Scripts Mobile Application

The Express Scripts mobile application (app) is an innovative tool that helps members make better decisions for healthier outcomes – anytime, anywhere. The app is compatible with most iPhone®, iPad®, Android™, Windows Phone® and BlackBerry® mobile devices and can be downloaded for free from the iTunes, Google Play, Windows Phone and BlackBerry App World app stores.

Locate a Pharmacy
Find the one closest to you

Switch to Home Delivery
Save the runaround,
and maybe some money

Drug Information
Get more detailed medication info

Prescription ID Card
With you whenever you need it

Scan the QR code to download the Express Scripts app from your mobile device's app store, or visit **Express-Scripts.com.**

Vision Service Plan (VSP)

- VSP has an enhanced Member Vision Card that members can access if they would like a vision insurance card. The print-on demand card is available through the member site at vsp.com. Please note that Protected Health Information (PHI) such as, the member ID number, social security number and date of birth are not included on the card. VSP is committed to protecting the privacy and security of their members and their data.

- Visit vsp.com from your computer or smart phone to access features such as, your benefits and claims, find a doctor, special offers and articles on eye health. On page forty-seven (47), is the Create an Account on VSP.com flier that provides you with more details.

- VSP has a passion for people, and their vision doesn't stop at those with VSP coverage. VSP believes everyone deserves to see well. That's why VSP actively seeks opportunities to give back to the community with programs like Sight for Students and Eyes of Hope.

- As of January l, 2013, the VSP Diabetic Eyecare Plus (DEP Plus) Program was added as an enhancement. The DEP Plus Program provides coverage for additional eyecare services targeted specifically for members with Type one (1) or Type two (2) diabetes, glaucoma, or age-related macular degeneration (AMD). No referral needed --pay only $20 co-pay for services. On page forty-eight (48), is the Diabetic Eyecare Plus flier that provides you with more details.

- New hearing aid discounts for VSP Members. VSP Members receive discounts on hearing aids through TruHearing. For information, please visit vsp.truhcaring.com or call TruHearing at 877-396-7194. On page forty-nine (49), is the TruHearing flier that provides you with more details.

- Contact Lens Rebates. VSP and Bausch+ Lomb Rebate, as a VSP member, you'll be eligible to receive savings via mail-in rebates when you purchase your annual supply of participating Bausch + Lomb contact lenses from your VSP doctor. Whether you're a new or existing contact lens wearer, you can take advantage of this VSP member exclusive. Just visit the “Exclusive VSP Members Rebates & Special Offers" on vsp.com to learn more.

- VSP has developed an innovative way to shop for eyewear. To meet the demands of the changing marketplace, VSP has developed Eyeconic, an exciting on-line optical store that offers members easy access to quality eyewear brands. To see the latest, check out eyeconic.com today.

- Big Value. More Savings with VSP Vision Care.

Vision Service Plan (VSP) (Continued)

- Get Social with VSP. Check out vspblog.com, join us on Facebook and Twitter, and check out YouTube channel, where you can catch the latest eye care news, enter contests, interact with VSP employees, and more.

- With Exclusive Member Extras, savings never looked so good. VSP puts members first by providing exclusive special offers from VSP and leading industry brands, totaling more than $2,500 in savings. On page fifty (50), is the VSP Exclusive Member Extras flier that provides you with more details.

Discover the information you need:

Once your benefit is effective, check your coverage.	Find a provider who's right for you and your family.	Exclusive Member Extras that maximize your savings.	View your personalized Vision Savings Statement after your appointment.	Print a member vision card if you'd like one.

Create your account on vsp.com today!

vsp Vision care for life

As the only national not-for-profit vision care company, VSP® Vision Care is committed to providing members with the best care. If you have diabetic eye disease, glaucoma, or age-related macular degeneration (AMD), you can receive your routine eye care and follow-up medical eye care services from your VSP doctor. You can also receive preventive retinal screenings if you have diabetes, but don't show signs of diabetic eye disease.

VSP® Vision care for life

Protect your eyes with a WellVision Exam®.

A WellVision Exam is the most thorough eye exam available and allows your VSP doctor to identify the early onset of medical conditions. If needed, your doctor can begin to provide monitoring and treatment that can help prevent vision problems and coordinate with your primary care physician to ensure you're getting the best care.

It's easy to use.

Visit your VSP doctor whenever you need to—services are covered with just a copay. No referral is needed.[1]

- Find the VSP doctor who's right for you. To find a VSP doctor, visit **vsp.com** or call **800.877.7195**.
- **At your appointment, tell them you have VSP.** There's no ID card necessary. If you'd like a card as a reference, you can print one on **vsp.com**.

That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP doctor.

29 MILLION AMERICANS HAVE DIABETES[2]

Questions? **vsp.com | 800.877.7195**

1. Some health plans require a referral from a primary care physician. 2. National Diabetes Statistics Report, 2014

VSP Diabetic Eyecare Plus Program coverage is only available through a VSP doctor and pays secondary to other medical insurance coverage. This coverage is for diabetes-related eyecare services and doesn't cover routine eye exams. Contact your VSP doctor for an appointment to use your routine eyecare benefits.

JOSM9-468.OM 0215

Save Up to 60% on Brand-name Hearing Aids

TruHearing

Like vision loss, hearing loss can have a huge impact on your quality of life. However, the cost of a pair of quality hearing aids usually costs more than $5,000, and few people have hearing aid insurance coverage.

TruHearing® makes hearing aids affordable by providing exclusive savings to all VSP® Vision Care members. You can save up to 60% on a pair of hearing aids with TruHearing. What's more, your dependents and even extended family members are eligible, too.

In addition to great pricing, TruHearing provides you with:

- Three provider visits for fitting and adjustments
- 45-day trial
- Three-year manufacturer warranty for repairs and one-time loss and damage replacement
- 48 free batteries per hearing aid

Plus, with TruHearing you'll get:

- Access to a national network of more than 3,800 hearing healthcare providers
- Straightforward, nationally-fixed pricing on a wide selection of the latest brand-name hearing aids
- Deep discounts on batteries shipped directly to your door

Best of all, if you already have a hearing aid benefit from your health plan or employer, you can combine it with TruHearing prices to reduce your out-of-pocket expense even more!

Here's how it works:

Contact TruHearing.
Call **877.396.7194**. You and your family members must mention VSP.

Schedule exam.
TruHearing will answer your questions and schedule a hearing exam with a local provider.

Attend appointment.
The provider will perform a hearing exam, make a recommendation, order the hearing aids through TruHearing, and fit them for you.

Learn more about this VSP Exclusive Member Extra at truhearing.com/vsp or, call 877.396.7194 with questions.

The relationship between VSP and TruHearing is that of independent contractors. VSP makes no endorsement, representations or warranties regarding any products or services offered by TruHearing, a third-party vendor. TruHearing is solely responsible for the products or services offered by them. Savings based on a survey of national average retail hearing aid prices compared to average TruHearing pricing. Actual customer savings will vary. Three follow-up visits must be used within one year after the date of initial purchase. Forty-five-day trial and hearing aid returns, repairs, and replacements subject to provider and manufacturer fees. For questions regarding fees, contact TruHearing customer service. Not available in the state of Washington.

JOB#5007-16-VOIA 6/16

SET YOUR SIGHTS ON SAVINGS.

With Exclusive Member Extras, savings never looked so good. We put our members first by providing exclusive special offers from leading industry brands, totaling more than $2,500 in savings.

- Extra $20 to spend on featured frame brands[1,3]
- Instant savings and satisfaction guarantees on popular lenses[2,3]
- Savings on LASIK at NVision and TLC eye centers
- Mail-in rebate savings and free trials on popular contact lens brands
- Savings on digital hearing aids and replacement batteries for you and your extended family through TruHearing[4]
- Savings on EyePromise vitamins for improved visual performance, night driving, and dry eye
- Financing for vision care expenses with the CareCredit credit card
- Discounts and savings for you and your family on medical care, prescription drugs, lab work, and more with VSP® Simple Values[5]

PREMIER PROGRAM

Visit vsp.com to find Premier Program locations that offer a wide selection of featured frame brands, Bonus Offers, and so much more.

For more great offers, scan or visit vsp.com/specialoffers.

1. Brands/promotions subject to change. 2. Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. 3. Available only to VSP members with applicable plan benefits. 4. Offer not available in WA. 5. Some members may not be eligible for this program; visit vsp.com/simplevalues for terms and conditions.

BAUSCH+LOMB
CareCredit
EXTRA $20 TO SPEND
eyeconic
EyePromise
Eyezen+
NVISION
sunsync LIGHT-REACTIVE LENSES
TLC Laser Eye Centers
Transitions
TruHearing
UNITY
VSP SIMPLE VALUES

JOB#646-46-VCOM 5/18

Healthy Steps for living in your Mind, Body and Soul! The Office of Human Resources Management (OHRM) remains committed to providing covered participants with health and wellness information designed to assist in making informed choices as it pertains to one's overall health. OHRM understands the importance of getting an annual physical, eating a healthy diet and incorporating physical activity as a part of one's daily routine; all important factors for maintaining good physical and emotional health.

In calendar year 2018, OHRM will continue sending to your address on file various wellness mailers and newsletters filled with helpful tips, articles and recipes that will lead you to **Healthy Steps for living in your Mind, Body and Soul!** Additionally, OHRM encourages you to connect with the wellness offerings and programs available at **no cost to you** under the Cigna Healthcare and Kaiser Permanente medical plans, if enrolled.

A Cigna Healthcare member is eligible to participate in programs to fit one's personal needs, connect with a Health Coach, access telephone seminars, obtain health and wellness articles from Cigna Healthcare's Library, engage with a dashboard that features active programs, daily to-do lists and much more!! Please access mycigna.com (click on Programs and Resources) or call the Customer Service Center at the toll-free number on the back of your Cigna Healthcare medical plan identification card to learn more about the wellness offerings.

The Kaiser Permanente medical plan offers its members podcasts, healthy lifestyle programs, information library to learn more about specific conditions and diseases, wellness coaching, center based classes and workshops and so much more!! You can learn more about the health and wellness offerings under the Kaiser Permanente medical plan by accessing www.kp.org or calling the Customer Service Department at the number listed on the back of your medical plan identification card.

Did you complete a health assessment this calendar year (2017)?

OHRM encourages you to complete an annual on-line Health Assessment. The health assessment provides you with important information that allows you to make lifestyle choices that will improve your health. The following will provide you with information on completing an on-line health assessment:

Enrolled in the County's Medical Plans with Cigna Healthcare:

- **Go to www.mycigna.com.**
- Click on the "My Health" tab to begin.

Enrolled in the County's Medical Plans with Kaiser Permanente:

- **Go to www.kp.org.**
- If you are new to the website, click on "Register now".
- At the "Health & Wellness tab," click on "Programs & Classes."
- Click on the "Total Health Assessment" in the left navigation.
- Click on "Start a Total Health Assessment now.

Please note that your personal health information is confidential. It is not provided to OHRM or the Prince George's County Government.

- **Utilize Express Scripts Mail-Order Service** – Receive a three-month supply of a prescription drug for a lower cost. **Note: The County's prescription plan requires all maintenance medications be purchased through the mail order. Also, Express Scripts has created a program to help make your mail order prescriptions more affordable. It's called the Extended Payment Program (EPP). See page forty (40) for more information about EPP.**

- **Select Generic Prescriptions over Brand** – Ask your doctor to prescribe generic drugs instead of brand-name drugs. The prescription plan (plan) has a mandatory generic program requirement. The mandatory generic program will result in the plan providing coverage of generics for all brand medications that have a generic alternative. You may still opt to receive a brand medication; however, the plan will only provide coverage that equates to the amount of the generic alternative. You will be responsible for the copayment for a generic plus the cost difference between the brand and generic medication.

  Note: This requirement only applies to retirees that will be enrolled in the non-Medicare Part D plan as of January 1, 2018.

- **Request Formulary Versus Non-Formulary** – A formulary is a preferred drug which is proven to be more effective and sometimes less expensive than a similar non-formulary drug. Ask your doctor to review Express Scripts list of formulary drugs to select an appropriate medication for you.

- **Use Prescription Plan Website** – You can see what a specific prescription drug will cost you, discover ways to save, order refills and track the status of your order on www.express-scripts.com.

- **Drop Ineligible Dependents** – The Benefits Administration Division must receive a completed Enrollment/Change Form before changes can be made to your enrollment options (i.e., individual, two-person or family coverage) and plan premiums.

Confirmation of Open Enrollment Changes for the County Health Benefit Plans

We strongly encourage you to review the pension check that you will receive for January 2018, to ensure the changes you requested during open enrollment were processed. If your pension check does not reflect your requested change(s), you should contact the Benefits Administration Division at 301-883-6380 [press option one (1)] or 1-800-634-5231 [press number two (2) for Benefits, then option one (1)] by the close of business, **Wednesday, February 14, 2018.**

Family Status Changes

A change(s) to your health benefit plan(s) as a result of a qualified family status change such as birth, marriage, or loss of health benefits coverage must be made within forty-five (45) days of the qualified event. You must complete an Enrollment/Change Form (Form) to make the change and the Form must be submitted to the Benefits Administration Division (Division) within the forty-five (45) day timeframe. The Division will not be able to make an exception to this requirement. Please see pages18, 20 and 21 for more information on Qualified Family Status changes or you may contact the Division if you have any questions concerning the requirement.

Beneficiary Form

Keep in mind that it is important to update and submit a County Beneficiary Form (Form) when you experience life changes. This Form identifies who receives the benefits payable under your life insurance and County Pension, if applicable.

Ask for a Form at one of the provider sessions this open enrollment or you may visit or call the Benefits Administration Division at (301) 883-6380 [press option nine (9)] or 1-800-634-5231 [press option two (2) for Benefits Division then select option nine (9)] to request a Form.

Address Change

If you recently changed your address, please contact either the Pensions and Investments Division (Pensions) or the Benefits Administration Division (Benefits) to provide them with your new address. The Pensions Division can be reached at (301) 883-6390 or 1-800-634-5231 (press number one [1] for Pensions) and the Benefits Division at (301) 883-6380 (press number nine [9]) or 1-800-634-5231, (press number two [2], then select option nine [9]). You may also submit your change of address to Pensions or Benefits by facsimile. The fax number for Pensions is (301) 883-6031 and Benefits is (301) 883-6358.

Vision Plan

Vision Service Plan (VSP) is the County's eye care provider. **It is important to note that VSP does not issue identification cards; however, members can access and print an enhanced Member Vision Card. See page forty-five (45) for more information.**

If you are choosing a participating eye doctor, simply call and make your appointment. The doctor will do the rest. If you choose a doctor outside of the network, you must pay for the services and submit the receipt, along with your name, social security number and address, to VSP. Check the VSP website, **www.vsp.com**, for up-to-date benefit eligibility for you and your dependents and the list of participating providers.

Aetna Dental Plans

Please note you no longer need a member identification card (ID) to obtain services under the Aetna Dental DMO or PPO plans. When you go to the dentist, tell the office your name, date of birth and Member ID number (or your social security number). If you want an ID card, you can use Aetna's mobile app or go on-line and log into your secure member website at www.aetna.com. Your ID card will appear on your personal benefits page. You can print out an ID card for you and your dependent(s) by clicking on "**Get an ID card."** Also, you can call Aetna Member Services at 1-877-238-6200, if you have any questions. Remember, the Aetna Dental DMO plan requires you to choose a primary care dentist (PCD) in Aetna's network. If you fail to select a PCD, your benefits and claims may be limited to emergency services only. Please see pages thirty-five (35) through thirty-seven (37) for more information.

Express Scripts Prescription

The prescription plan (plan) has a mandatory generic program requirement. The mandatory generic program will result in the plan providing coverage of generics for all brand medications that have a generic alternative. You may still opt to receive a brand medication; however, the plan will only provide coverage that equates to the amount of the generic alternative. You will be responsible for the copayment for a generic plus the cost difference between the brand and generic medication.

Note: The above requirement only applies to retirees that will be enrolled in the non-Medicare Part D plan as of January 1, 2018.

There is a $50 annual deductible per covered individual that must be met for retail and Express Scripts-by-Mail prescriptions combined prior to any plan coverage. **Please remember this plan requirement when you purchase a prescription(s) for yourself or your covered dependents on or after January 1, 2018.**

Express Scripts *(Continued)*

When you use Express Scripts by-Mail to purchase maintenance drugs for the first time, you should allow Express Scripts at least fourteen (14) days to receive, process and ship your order. Refills can be ordered on-line, by mail or by telephone and are usually delivered within three (3) to five (5) days after receipt of your order.

Medicare Eligibility for the Medical Plans

The County requires a retiree and/or spouse who reaches age 65 to enroll in Medicare Part A and Part B. This provision also applies to individuals who are eligible to receive disability benefits from the Social Security Administration.

In order to continue coverage in the County's medical plan, it is required that you enroll in one of the County's Medicare supplemental plans. The Medicare supplemental plan options are Kaiser Permanente (Kaiser) Medicare Plus Plan, Cigna Healthcare (Cigna) Open Access In-Network (OAPN) and Cigna Open Access Plus (OAP) plans. Medicare will become the primary payer of your medical claims and the supplemental plan will act as the secondary payer.

You will need to complete an Enrollment/Change Form (Form) to enroll in one of the supplemental plans and submit the Form with a signed copy of your Medicare card showing enrollment in Part A and Part B to the Benefits Administration Division.

Please note that if you and/or a dependent on the policy are eligible for Medicare and you need to provide medical plan coverage for more than one dependent, you must maintain family coverage; therefore, the senior premium rates will not be applicable until you remove the additional dependents. If the aforementioned applies to you, please contact the Division at (301) 883-6380 [press number five (5)] or 1-800-634-5231 [press number two (2) then option five (5)] for additional information on coordinating the Medicare and Cigna Healthcare plans.

Kaiser participants must complete a Kaiser Application for Group Enrollment Form to enroll in the Kaiser Medicare Plus Plan. It is important to note that the Kaiser Medicare Plus Plan offers prescription benefits. If you elect to enroll in the Kaiser Medicare Plus Plan, you must discontinue your enrollment in the County's prescription plan. The option to re-enroll in the County's prescription plan at a future open enrollment is available, if you elect to switch to another County Medicare supplemental plan. The enrollment in the Kaiser Medicare Plus Plan will not occur until approval is received from the Federal Government Agency, Centers for Medicare and Medicaid Services (CMS).

Medicare Part D Prescription Plan

Effective January 1, 2017, Prince George's County Government (County) implemented the Employer Group Waiver Plan (EGWP) under the prescription plan. It is administered by Express Scripts, Inc., (ESI). The EGWP plan offered through an employer is referred to as a "Medicare Part D" plan. The Medicare Part D is an extension of Medicare Part A and Part B. Since the County requires enrollment in Medicare Part A and B, as noted on page fifty-six (56), we will automatically enroll you in the Medicare Part D plan.

The following are some of the highlights the Medicare Part D plan will offer you:

- You will be able to purchase up to a ninety (90) day supply of maintenance medications (medications that you take every day) either at the retail or mail-order pharmacy;
- The mandatory generic requirement will not apply. Therefore, if a brand name medication has a generic alternative, you can get the brand name medication without penalty; and
- You may qualify for "Extra Help" from the Federal Government to assist with your prescription plan premium and co-payments.

ESI will provide you with important additional information regarding your enrollment in the Medicare Part D plan. We highly recommend that you retain and review the information you receive from ESI. It is important to note that Medicare does impose an additional Part D premium for high wage earners which is paid directly to Social Security. This requirement is known as the Part D Income Related Monthly Adjustment Amount (IRMAA). Social Security will notify you if the previously stated requirement applies to you. Please contact the Division at (301) 883-6380 or 1-800-634-5321, (press option nine [9]) or 1-800-634-5231 (press number two [2] for Benefits, then select option nine [9]), if you have any questions about the Medicare Part D prescription plan.

Telephone Numbers and Websites for Providers

For most plans, on-line Member Services allows you to find or change providers, request ID cards, check the status of claims and obtain information on the level of benefit coverage.

MEDICAL

Cigna Healthcare
1-800-244-6224
www.myCigna.com

Kaiser Permanente
301-468-6000
1-800-777-7904 (*For members outside of the Washington, DC area*)
www.kp.org

PRESCRIPTION

Express Scripts, Inc.
1-800-711-0917
1-866-544-6963 (***For Medicare Part D participants only)***
www.express-scripts.com

VISION

Vision Service Plan
1-800-877-7195
www.vsp.com

DENTAL

Aetna (PPO/DMO)
1-877-238-6200
www.aetna.com

Mark Your Calendars!!

"Need to see a doctor or need a vaccine? Make sure you're enrolled! It's Open Enrollment 2018"

Provider Session #1

Wednesday, October 4, 2017 – 10:00 a.m. to 2:00 p.m.
RMS Building – First Floor Lobby
1400 McCormick Drive
Largo, MD

Provider Session #2

Wednesday, October 11, 2017 – 10:00 a.m. to 2:00 p.m.
County Administration Building (CAB)
Lower Level Lobby
14741 Governor Oden Bowie Drive
Upper Marlboro, MD

Provider Session #3

Wednesday, October 18, 2017 – 12:00 p.m. to 4:00 p.m.
Maintenance Operations Center (MOC)
8400 D'Arcy Road
Forestville, MD

Provider Session #4

Wednesday, October 25, 2017 – 10:00 a.m. to 2:00 p.m.
RMS Building – First Floor Lobby
1400 McCormick Drive
Largo, MD

PRINCE GEORGE'S COUNTY GOVERNMENT
BENEFITS ADMINISTRATION DIVISION
1400 MCCORMICK DRIVE, SUITE 245
LARGO, MARYLAND 20774

FOR OFFICE USE ONLY
Transmitted: _____
Entered: _____

ENROLLMENT/CHANGE FORM – RETIREE/COBRA/SURVIVING SPOUSE

NAME: _____ **SOCIAL SECURITY #:** _____

STREET: _____ **DATE OF BIRTH:** _____

CITY/STATE: _____ **ZIP:** _____ **EFFECTIVE DATE:** _____

PHONE: WORK: _____ **HOME:** _____ **EMAIL:** _____ **GENDER:** _____

Status

- ☐ Retired MSRS
- ☐ Retired Police Officer
- ☐ Retired Fire Fighter, Paramedic, ERT
- ☐ Retired Correctional Officer
- ☐ Retired Deputy Sheriff
- ☐ Surviving Spouse
- ☐ Surviving Dependent
- ☐ COBRA
- ☐ Assessor
- ☐ Judge
- ☐ Other

Activity Requested

- ☐ Enroll Self
- ☐ Enroll Spouse
- ☐ Enroll Dependent (s)
- ☐ Reinstate Coverage
- ☐ Remove Spouse
- ☐ Remove Dependent (s)
- ☐ Switch to New Plan
- ☐ Other: _____

Reason – Change in Family Status

- ☐ Open Enrollment
- ☐ Relocate In/Out of Area
- ☐ Marriage
- ☐ Divorce
- ☐ Birth of Child
- ☐ Adoption or permanent legal guardianship of Child

Date of Event: _____

Attach documentation (i.e. Marriage License, Divorce Decree, etc.). Submit copy of Birth Certificate as soon as received.

Medical Coverage

- ☐ Individual
- ☐ Two-Person
- ☐ Family
- ☐ No Coverage
- ☐ One Senior
- ☐ Two Seniors
- ☐ Individual plus Senior

State Name of Medical Plan: _____

- ☐ HMO
- ☐ PPO

Primary Care Physician (PCP): _____

Center: _____

Dental Coverage

- ☐ Individual
- ☐ Two-Person
- ☐ Family
- ☐ No Coverage

- ☐ Dental DMO

(Must complete Aetna PCD Election Form for dentist selection)

- ☐ Dental PPO

Prescription

- ☐ Individual
- ☐ Two-Person
- ☐ Family
- ☐ No Coverage

Vision

Base Plan
- ☐ Individual
- ☐ Family
- ☐ No Coverage

Buy-Up Plan
- ☐ Individual
- ☐ Family
- ☐ No Coverage

Other Health Coverage: Must be completed if you or your dependents have other coverage.

Name of Carrier: _____

Policy Number: _____

DEPENDENTS	SS#	RELATION	CIRCLE COVERAGE	BIRTH DATE	PRIMARY CARE PHYSICIAN	CIRCLE ONE
1. _____	_____	Spouse	MED RX VIS DEN	_____	_____	ADD DROP
2. _____	_____	_____	MED RX VIS DEN	_____	_____	ADD DROP
3. _____	_____	_____	MED RX VIS DEN	_____	_____	ADD DROP
4. _____	_____	_____	MED RX VIS DEN	_____	_____	ADD DROP

EXPLAIN BENEFIT CHANGES (if needed): _____

If enrolled in Kaiser Medical HMO or the Dental DMO, you and your dependents must select a Center/Dentist. If you have any questions concerning your benefits and services either provided or excluded under your choice of health plan, please contact the Member Services Department of that health plan before signing this application below.

By signing this form, I understand that I cannot make changes during the plan year unless there is a family status change and I complete a benefits form within 45 days of the event. Rules for the plan changes will vary depending on my status. This form authorizes any licensed physician, hospital or health care provider to furnish my health plan with such medical information about myself and any eligible dependent as needed. I understand that my coverage and benefits may be adversely affected by my failure to provide complete and accurate information.

SIGNATURE: _____ **DATE:** _____

FOR OFFICE USE ONLY
Transmitted: _____
Entered: _____

PRINCE GEORGE'S COUNTY GOVERNMENT
BENEFITS ADMINISTRATION DIVISION, 1400 MCCORMICK DRIVE, LARGO, MARYLAND 20774

AETNA DMO DENTAL PLAN PRIMARY CARE DENTIST (PCD) ELECTION FORM ACTIVE EMPLOYEE / RETIREE

STEP 1: Please PRINT or TYPE when you complete this form.

NAME: _____ SOCIAL SECURITY #: _____

DATE OF BIRTH: _____ **EFFECTIVE DATE OF COVERAGE**: _____

STREET: _____ PHONE-WORK: _____ HOME: _____

CITY/STATE: _____ ZIP: _____ DEPARTMENT: _____

REASON: ☐ **Open Enrollment**

☐ **New Employee** *Hire Date*: _____

☐ **Family Status Change** *Event:* _____ *Date of Event:* _____

STEP 2: Complete this section for you and the dependent(s) you are adding to the DMO dental plan as of the above effective date. **If you fail to select a Primary Care Dentist, it will result in you not being able to utilize the DMO dental plan benefits on or after the effective date of your coverage.**

FULL NAME (PRINT) First Middle Initial Last	Relationship	Sex	Social Security No.	Birth Date	**Primary Care Dentist**	**Office ID #**
	SELF					
	SPOUSE					

STEP 3: You must complete this section with the Primary Care Dentist's address.

STREET: _____

CITY/STATE: _____ **ZIP CODE:** _____

STEP 4: Read the statement below and sign your name.

By signing this form, I understand that my Aetna DMO dental plan premiums will be deducted on a pre-tax basis. No changes can be made to my dental plan enrollment during the plan year unless there is a family status change and I complete the benefits enrollment process within 45 days of the event. This form authorizes any licensed physician, hospital, or health/dental care provider to furnish my health plan with such medical information about myself and any eligible dependent, as needed. I understand that my coverage and benefits may be adversely affected by my failure to provide complete and accurate information.

_____ _____
Signature **Date**

Schedule of Health Benefits Costs for 2018

FIRE CIVILIAN RETIREES AFTER 7/1/98 AND POLICE CIVILIAN RETIREES AFTER 7/1/96

		Participant Monthly	County Monthly	Total Monthly
MEDICAL	**Kaiser Permanente**			
	Individual	106.73	320.18	426.91
	Two-Person	212.93	638.78	851.71
	Family	308.51	925.52	1,234.03
	(Must Enroll in Senior if Enrolled in Medicare)			
	One Senior	75.81	227.42	303.23
	Two Seniors	151.09	453.27	604.36
	Senior + Individual	195.60	586.81	782.41
	CIGNA HMO*			
	Individual	113.55	340.67	454.22
	Two-Person	227.07	681.22	908.29
	Family	317.49	952.47	1,269.96
	(Must Enroll in Senior if Enrolled in Medicare)			
	One Senior	63.52	190.57	254.09
	Two Seniors	128.09	384.29	512.38
	Senior + Individual	177.62	532.87	710.49
	CIGNA PPO*			
	Individual	177.88	415.07	592.95
	Two-Person	358.66	836.89	1,195.55
	Family	503.67	1,175.22	1,678.89
	(Must Enroll in Senior if Enrolled in Medicare)			
	One Senior	68.69	160.27	228.96
	Two Seniors	138.44	323.04	461.48
	Senior + Individual	247.63	577.81	825.44
RXP	**Prescription Drug Plan**			
	Individual	26.50	150.20	176.70
	Two-Person	53.39	302.52	355.91
	Family	68.20	386.46	454.66
VSP	**Base Plan**			
	Individual	1.10	6.26	7.36
	Family	2.38	13.48	15.86
	Buy-Up Plan			
	Individual	1.74	9.83	11.57
	Family	4.54	25.74	30.28
DENTAL	**Aetna Dental Plan (DMO)**			
	Individual	25.67	N/A	25.67
	Two-Person	40.40	N/A	40.40
	Family	51.69	N/A	51.69
	Aetna Dental Plan (PPO)			
	Individual	39.04	N/A	39.04
	Two-Person	71.51	N/A	71.51
	Family	105.89	N/A	105.89

***Medical HMO - County pay 75% and Participant pays 25%**
Medical PPO – County pay 70% and Participant pays 30%
Prescription/Vision – County pays 85% and Participant pays 15%

Schedule of Health Benefits Costs for 2018

ALL POLICE RETIREES, FIRE RETIREES & CORRECTIONS RETIREES

		Participant Monthly	County Monthly	Total Monthly
MEDICAL	**Kaiser Permanente**			
	Individual	93.92	332.99	426.91
	Two-Person	187.38	664.33	851.71
	Family	271.49	962.54	1,234.03
	(Must Enroll in Senior if Enrolled in Medicare)			
	One Senior	66.71	236.52	303.23
	Two Seniors	132.96	471.40	604.36
	Senior + Individual	172.13	610.28	782.41
	CIGNA HMO*			
	Individual	99.93	354.29	454.22
	Two-Person	199.82	708.47	908.29
	Family	279.39	990.57	1,269.96
	(Must Enroll in Senior if Enrolled in Medicare)			
	One Senior	55.90	198.19	254.09
	Two Seniors	112.72	399.66	512.38
	Senior + Individual	156.31	554.18	710.49
	CIGNA PPO*			
	Individual	160.10	432.85	592.95
	Two-Person	322.80	872.75	1,195.55
	Family	453.30	1,225.59	1,678.89
	(Must Enroll in Senior if Enrolled in Medicare)			
	One Senior	61.82	167.14	228.96
	Two Seniors	124.60	336.88	461.48
	Senior + Individual	222.87	602.57	825.44
RXP	**Prescription Drug Plan**			
	Individual	21.20	155.50	176.70
	Two-Person	42.71	313.20	355.91
	Family	54.56	400.10	454.66
VSP	**Base Plan**			
	Individual	0.88	6.48	7.36
	Family	1.90	13.96	15.86
	Buy-Up Plan			
	Individual	1.39	10.18	11.57
	Family	3.63	26.65	30.28
DENTAL	**Aetna Dental Plan (DMO)**			
	Individual	25.67	N/A	25.67
	Two-Person	40.40	N/A	40.40
	Family	51.69	N/A	51.69
	Aetna Dental Plan (PPO)			
	Individual	39.04	N/A	39.04
	Two-Person	71.51	N/A	71.51
	Family	105.89	N/A	105.89

***Medical HMO - County pay 78% and Participant pays 22%**
Medical PPO – County pay 73% and Participant pays 27%
Prescription/Vision – County pays 88% and Participant pays 12%

Schedule of Health Benefits Costs for 2018

ALL SHERIFF RETIREES

		Participant Monthly	County Monthly	Total Monthly
MEDICAL	**Kaiser Permanente***			
	Individual	93.92	332.99	426.91
	Two-Person	187.38	664.33	851.71
	Family	271.49	962.54	1,234.03
	(Must Enroll in Senior if Enrolled in Medicare)			
	One Senior	66.71	236.52	303.23
	Two Seniors	132.96	471.40	604.36
	Senior + Individual	172.13	610.28	782.41
	CIGNA HMO*			
	Individual	99.93	354.29	454.22
	Two-Person	199.82	708.47	908.29
	Family	279.39	990.57	1,269.96
	(Must Enroll in Senior if Enrolled in Medicare)			
	One Senior	55.90	198.19	254.09
	Two Seniors	112.72	399.66	512.38
	Senior + Individual	156.31	554.18	710.49
	CIGNA PPO*			
	Individual	160.10	432.85	592.95
	Two-Person	322.80	872.75	1,195.55
	Family	453.30	1,225.59	1,678.89
	(Must Enroll in Senior if Enrolled in Medicare)			
	One Senior	61.82	167.14	228.96
	Two Seniors	124.60	336.88	461.48
	Senior + Individual	222.87	602.57	825.44
RXP	**Prescription Drug Plan***			
	Individual	21.20	155.50	176.70
	Two-Person	42.71	313.20	355.91
	Family	54.56	400.10	454.66
VSP	**Base Plan**			
	Individual	7.36	N/A	7.36
	Family	15.86	N/A	15.86
	Buy-Up Plan			
	Individual	11.57	N/A	11.57
	Family	30.28	N/A	30.28
DENTAL	**Aetna Dental Plan (DMO)**			
	Individual	25.67	N/A	25.67
	Two-Person	40.40	N/A	40.40
	Family	51.69	N/A	51.69
	Aetna Dental Plan (PPO)			
	Individual	39.04	N/A	39.04
	Two-Person	71.51	N/A	71.51
	Family	105.89	N/A	105.89

***Medical HMO - County pay 78% and Participant pays 22%**
Medical PPO – County pay 73% and Participant pays 27%
Prescription – County pays 88% and Participant pays 12%

Schedule of Health Benefits Costs for 2018

ALL OTHER RETIREES, ALL SURVIVING SPOUSES, AND COBRA

		Participant Monthly	County Monthly	Total Monthly	COBRA MONTHLY
MEDICAL	**Kaiser Permanente**				
	Individual	106.73	320.18	426.91	435.45
	Two-Person	212.93	638.78	851.71	868.74
	Family	308.51	925.52	1,234.03	1,258.71
	(Must Enroll in Senior if Enrolled in Medicare)				
	One Senior	75.81	227.42	303.23	309.29
	Two Seniors	151.09	453.27	604.36	616.45
	Senior + Individual	195.60	586.81	782.41	798.06
	CIGNA HMO*				
	Individual	113.55	340.67	454.22	463.30
	Two-Person	227.07	681.22	908.29	926.46
	Family	317.49	952.47	1,269.96	1,295.36
	(Must Enroll in Senior if Enrolled in Medicare)				
	One Senior	63.52	190.57	254.09	259.17
	Two Seniors	128.09	384.29	512.38	522.63
	Senior + Individual	177.62	532.87	710.49	724.70
	CIGNA PPO*				
	Individual	177.88	415.07	592.95	604.81
	Two-Person	358.66	836.89	1,195.55	1,219.46
	Family	503.67	1,175.22	1,678.89	1,712.47
	(Must Enroll in Senior if Enrolled in Medicare)				
	One Senior	68.69	160.27	228.96	233.54
	Two Seniors	138.44	323.04	461.48	470.71
	Senior + Individual	247.63	577.81	825.44	841.95
RXP	**Prescription Drug Plan**				
	Individual	132.52	44.18	176.70	180.23
	Two-Person	266.93	88.98	355.91	363.03
	Family	340.99	113.67	454.66	463.75
VSP	**Base Plan**				
	Individual	7.36	N/A	7.36	7.51
	Family	15.86	N/A	15.86	16.18
	Buy-Up Plan				
	Individual	11.57	N/A	11.57	11.80
	Family	30.28	N/A	30.28	30.89
DENTAL	**Aetna Dental Plan (DMO)**				
	Individual	25.67	N/A	25.67	26.18
	Two-Person	40.40	N/A	40.40	41.21
	Family	51.69	N/A	51.69	52.72
	Aetna Dental Plan (PPO)				
	Individual	39.04	N/A	39.04	39.82
	Two-Person	71.51	N/A	71.51	72.94
	Family	105.89	N/A	105.89	108.01

***Medical HMO - County pay 75% and Participant pays 25%**
Medical PPO – County pay 70% and Participant pays 30%
Prescription – County pays 25% and Participant pays 75%

Schedule of Health Benefits Costs for 2018

ALL POLICE RETIREES, FIRE RETIREES & CORRECTIONS RETIREES (RETIRING AFTER JANUARY 1, 2018)

		Participant Monthly	County Monthly	Total Monthly
MEDICAL	**Kaiser Permanente**			
	Individual	106.73	320.18	426.91
	Two-Person	212.93	638.78	851.71
	Family	308.51	925.52	1,234.03
	(Must Enroll in Senior if Enrolled in Medicare)			
	One Senior	75.81	227.42	303.23
	Two Seniors	151.09	453.27	604.36
	Senior + Individual	195.60	586.81	782.41
	CIGNA HMO*			
	Individual	113.55	340.67	454.22
	Two-Person	227.07	681.22	908.29
	Family	317.49	952.47	1,269.96
	(Must Enroll in Senior if Enrolled in Medicare)			
	One Senior	63.52	190.57	254.09
	Two Seniors	128.09	384.29	512.38
	Senior + Individual	177.62	532.87	710.49
	CIGNA PPO*			
	Individual	177.88	415.07	592.95
	Two-Person	358.66	836.89	1,195.55
	Family	503.67	1,175.22	1,678.89
	(Must Enroll in Senior if Enrolled in Medicare)			
	One Senior	68.69	160.27	228.96
	Two Seniors	138.44	323.04	461.48
	Senior + Individual	247.63	577.81	825.44
RXP	**Prescription Drug Plan**			
	Individual	26.50	150.20	176.70
	Two-Person	53.39	302.52	355.91
	Family	68.20	386.46	454.66
VSP	**Base Plan**			
	Individual	1.10	6.26	7.36
	Family	2.38	13.48	15.86
	Buy-Up Plan			
	Individual	1.74	9.83	11.57
	Family	4.54	25.74	30.28
DENTAL	**Aetna Dental Plan (DMO)**			
	Individual	25.67	N/A	25.67
	Two-Person	40.40	N/A	40.40
	Family	51.69	N/A	51.69
	Aetna Dental Plan (PPO)			
	Individual	39.04	N/A	39.04
	Two-Person	71.51	N/A	71.51
	Family	105.89	N/A	105.89

***Medical HMO - County pay 75% and Participant pays 25%**
Medical PPO – County pay 70% and Participant pays 30%
Prescription/Vision – County pays 85% and Participant pays 15%

Schedule of Health Benefits Costs for 2018

ALL SHERIFF RETIREES (Retiring After January 1, 2018)

		Participant Monthly	County Monthly	Total Monthly
MEDICAL	**Kaiser Permanente**			
	Individual	106.73	320.18	426.91
	Two-Person	212.93	638.78	851.71
	Family	308.51	925.52	1,234.03
	(Must Enroll in Senior if Enrolled in Medicare)			
	One Senior	75.81	227.42	303.23
	Two Seniors	151.09	453.27	604.36
	Senior + Individual	195.60	586.81	782.41
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	Individual	113.55	340.67	454.22
	Two-Person	227.07	681.22	908.29
	Family	317.49	952.47	1,269.96
	(Must Enroll in Senior if Enrolled in Medicare)			
	One Senior	63.52	190.57	254.09
	Two Seniors	128.09	384.29	512.38
	Senior + Individual	177.62	532.87	710.49
	CIGNA PPO*			
	Individual	177.88	415.07	592.95
	Two-Person	358.66	836.89	1,195.55
	Family	503.67	1,175.22	1,678.89
	(Must Enroll in Senior if Enrolled in Medicare)			
	One Senior	68.69	160.27	228.96
	Two Seniors	138.44	323.04	461.48
	Senior + Individual	247.63	577.81	825.44
RXP	**Prescription Drug Plan***			
	Individual	26.50	150.20	176.70
	Two-Person	53.39	302.52	355.91
	Family	68.20	386.46	454.66
VSP	**Base Plan**			
	Individual	7.36	N/A	7.36
	Family	15.86	N/A	15.86
	Buy-Up Plan			
	Individual	11.57	N/A	11.57
	Family	30.28	N/A	30.28
DENTAL	**Aetna Dental Plan (DMO)**			
	Individual	25.67	N/A	25.67
	Two-Person	40.40	N/A	40.40
	Family	51.69	N/A	51.69
	Aetna Dental Plan (PPO)			
	Individual	39.04	N/A	39.04
	Two-Person	71.51	N/A	71.51
	Family	105.89	N/A	105.89

***Medical HMO - County pay 75% and Participant pays 25%**
Medical PPO – County pay 70% and Participant pays 30%
Prescription – County pays 85% and Participant pays 15%

Notes

Prince George's County Government
Office of Human Resources Management
Benefits Administration Division
1400 McCormick Drive, Suite 245
Largo, Maryland 20774

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