2023

Employee Benefit Summary

EFFECTIVE JANUARY 1, 2023

- MEDICAL, DENTAL, VISION, DRUG, FSA, LIFE INSURANCE, 403(b) & 457(b), AND RETIREMENT BENEFITS

Benefits Plan Highlights for 2023

- Cigna to replace CareFirst as a benefit plan provider
- Benefits-eligible employees to choose between one of the Cigna medical plans or the Kaiser Permanente HMO
- No changes to dental, vision, or prescription plans

Maryland's Largest School District

MONTGOMERY COUNTY PUBLIC SCHOOLS

Employee and Retiree Service Center ▪ 45 W. Gude Drive, Suite 1200, Rockville, MD 20850
301-517-8100 ▪ www.montgomeryschoolsmd.org/departments/ersc

VISION

We inspire learning by providing the greatest public education to each and every student.

MISSION

Every student will have the academic, creative problem solving, and social emotional skills to be successful in college and career.

CORE PURPOSE

Prepare all students to thrive in their future.

CORE VALUES

Learning
Relationships
Respect
Excellence
Equity

850 Hungerford Drive
Rockville, Maryland 20850
www.montgomeryschoolsmd.org

2023

Montgomery County Public Schools

2023 Employee Benefit Summary for Active Employees

Montgomery County Public Schools (MCPS) provides a comprehensive benefit plan for employees, retirees, and their eligible dependents. As an eligible MCPS employee, you have a variety of benefit options from which to choose, including benefits to protect your health, your income, and your future.

The *Employee Benefit Summary* provides an overview of the benefits available to eligible active employees, effective January 1, 2023. This summary includes information about eligibility for MCPS benefits, a list of benefit costs, opportunities to reduce benefit costs through the Wellness Initiatives program, and important contact information. It also includes instructions for accessing the online Benefits Enrollment System (BES) during Open Enrollment, for new employees enrolling in benefits for the first time and for employee experiencing a qualifying life event during the plan year.

Keep in mind that this is a *summary* of the MCPS benefit plan and is intended to help you understand and properly enroll in the plan. Full benefit plan details are available on the Employee and Retiree Service Center (ERSC) website at *www.montgomeryschoolsmd.org/departments/ersc*. The website includes summary plan and evidence of coverage documents, along with links to provider websites.

ERSC staff members are available to assist you in person Monday through Friday from 8:00 a.m.–4:30 p.m., by telephone Monday–Friday from 8:00 a.m.–4:15 p.m., and via email. Our address, telephone number, and email address are below:

Montgomery County Public Schools
Employee and Retiree Service Center
45 West Gude Drive, Suite 1200
Rockville, Maryland 20850
301-517-8100
ERSC@mcpsmd.org

Important Notice

You are not enrolled automatically in the MCPS employee benefit plan. New employees must enroll online within 60 days following employment or wait for a future Employee Benefits Open Enrollment, typically held for four weeks beginning in early October, with coverage effective January 1 of the following year. To enroll online, new employees must log in to the Benefits Enrollment System (BES) by visiting the Employee Self Service (ESS) web page at:

www.montgomeryschoolsmd.org/departments/ersc/employees/employee-self-service/

From there, click the **Benefits enrollment for new employees** link, log in with your Outlook username and password, and follow the onscreen instructions.

During Open Enrollment, employees visit the ESS web page and click the **Open Enrollment** link to log in to the BES and make changes to their benefits. Outside of Open Enrollment, employees who experience a qualifying life event or return from long-term leave must visit ESS and click the **Benefits enrollment/changes due to a qualifying life event** link to log in to BES and re-enroll in or make changes to their benefits.

BES also can be used at any time to designate and change beneficiaries for basic employee term life insurance.

2023

Table of Contents

About Your Benefits

WHO IS ELIGIBLE

You are eligible to enroll in the employee benefit plan if you are a permanent MCPS employee regularly scheduled to work 20 hours or more per week. If your spouse has health coverage through the MCPS employee benefit plan and you are a covered dependent, you may not enroll for coverage as an individual under the MCPS employee benefit plan.

Eligible Dependents

You may choose to cover your eligible dependents under the MCPS employee benefit plan. Eligible covered dependents must be enrolled in the same benefits plan in which you are enrolled.

Eligible dependents include your—

- spouse, and
- eligible children who meet the following age requirements:
    - until the end of the month in which they turn 26 for medical and prescription coverage
    - until the end of the month in which they turn 24 for dental and vision coverage
    - until September 30 following their 23rd birthday for life insurance coverage

The documentation you submit to show eligibility of a spouse or child(ren) must include but is not limited to the following:

Spouse:

- Social Security number and
- valid marriage certificate or current joint tax return (signed by both parties or a copy of the confirmation of electronic submission)

Newborn or Biological Children:

- Social Security number and
- valid birth certificate or valid birth registration

Stepchildren:

- Social Security number and
- valid birth certificate or valid birth registration and
- shared or joint custody agreement (court validated) up to age 18

Adopted Children, Foster Children, Children in Guardianship or Custodial Relationships:

- Social Security number and one of the following:
    - adoption documents (court validated)
    - guardianship or custody documents (court validated)
    - foster child documents (county, state, or court validated)

Disabled Dependents

Any disabled dependent child remains eligible for medical and prescription coverage until the end of the month in which he/she turns 26. A disabled dependent remains eligible for dental, and vision coverage until the end of the month in which he/she turns 24. Disabled dependents remain eligible for life insurance coverage until September 30 following his/her 23rd birthday. However, your disabled dependent child(ren)'s coverage may be continued beyond these age limits if—

- he or she is permanently incapable of self-support because of intellectual disability or physical disability, or he/she became disabled, and
- the disability occurred before he or she reached age 19.

It is your responsibility to notify MCPS of the child's incapacity and dependency to be considered for continuous benefits coverage. If MCPS is not notified prior to—

- the dependent's 26th birthday, medical and prescription benefits will be cancelled;
- the dependent's 24th birthday, dental and vision coverage will be cancelled; and

- September 30 following the dependent's 23rd birthday, life insurance will be cancelled.

Unless otherwise terminated in accordance with the plan terms, coverage will continue as long as the disabled child is incapacitated and dependent. You will be asked to provide the plan administrator with proof that the child's incapacity and dependency existed prior to age 19. Before the plan administrator agrees to the extension of coverage, the plan administrator may require that a physician chosen by your health plan examines the child. The plan administrator may ask for ongoing proof that the child continues to be disabled. If you do not provide proof that the child's incapacity and dependency existed prior to age 19, as described above, coverage for that child will end at the end of the month in which he/she turns age 26 for medical and prescription coverage, at the end of the month in which he/she turns age 24 for dental and vision coverage, and on September 30 following his/her 23rd birthday for life insurance.

If you change your medical plan, you will be required to submit new medical documentation to the new health plan provider for review.

Coverage ends if you predecease your disabled dependent, except as provided under federal *Consolidated Omnibus Budget Reconciliation Act* (COBRA) legislation.

WHEN BENEFITS COVERAGE BEGINS

New employees must enroll in benefits via the online Benefits Enrollment System (BES) within 60 days of initial employment or wait until a future Open Enrollment to enroll online. *(See Enrollment Basics in this booklet for benefits enrollment instructions.)* Coverage begins on the first day of the month following the month that you enroll, provided you submit your online enrollment by the 20th day of the month.

If you enroll online after the 20th day of the month, your benefits coverage begins on the first day of the second month. For example, let's assume you are hired on December 23. Refer to the chart below to see when your coverage would begin:

If you submit your online enrollment:	Your coverage will begin on:
On or before January 20	February 1
Between January 21 and February 20	March 1
On February 21	April 1

Special Rule for Newly Hired 10-Month Employees

If you are a 10-month employee reporting at the beginning of a school year, your coverage will begin October 1 if you enroll by September 20. If you enroll from September 21 to October 20, your coverage will begin November 1. You must enroll within 60 days of initial employment.

ENROLLING NEW DEPENDENTS

Your new dependents are not covered or enrolled automatically under the benefit plan—you must take action to enroll new dependents in your plan. You may enroll a new eligible dependent in your benefit plan during Open Enrollment or when you experience a qualifying life event.

Please note that you must enroll your new dependent through ERSC, not through the benefit plan provider.

When you enroll a dependent in your plan, whether as a new employee, during Open Enrollment, or due to a qualifying life event, you are required to use the BES. *(See Enrollment Basics in this booklet for benefits enrollment instructions.)* You will be required to provide supporting documentation.

Refer to the chart below for information about enrolling an eligible dependent if you experience a qualifying life event. It includes important deadlines and documentation you are required to submit. Note: All documentation must be translated to English prior to submitting it to ERSC.

Qualifying Life Event	Forms Required	Deadline to Add
Newborn/adopted child	Social Security number* Birth certificate/registration* or Legal court documentation	60 days from the date of birth or adoption
Legal guardianship/custody	Social Security number* Legal court documentation	60 days from the court award of legal guardianship
Spouse	Social Security number Marriage certificate	60 days from the date of marriage
Loss/gain of coverage	Insurance cancellation form or COBRA notice	60 days from the date of loss/gain of coverage

** If you cannot provide a Social Security number and a birth certificate or birth registration within the 60-day time frame, you may enroll your newborn with evidence that you have applied for a social security number and a birth certificate or birth registration. You must provide the social security number and birth certificate or birth registration to ERSC upon receipt. Failure to provide this information in a timely manner will result in termination of coverage.*

Coverage for your newborn/newly adopted dependent child(ren) will be retroactive to the date of birth, adoption, or legal guardianship when forms are submitted within the 60-day time frame.

If ERSC receives all required documentation by the 20th of the month, coverage for your new dependent will begin on the first day of the following month. If ERSC receives the forms and necessary documents after the 20th of the month, coverage for your new dependent will start on the first day of the second month.

If you do not enroll your new dependent within the 60-day time frame listed above, you must wait until a future Open Enrollment to enroll him or her using the BES.

CHANGES IN OR CANCELLATION OF COVERAGE

In general, you are not permitted to **make changes** to your benefits plan during the plan year. You may make changes to your benefits plan during the annual Open Enrollment held each fall.

Certain benefit changes may be made during the plan year if you experience a qualifying life or work event. Qualifying life or work events include:

- Marriage/divorce
- Birth of child; adoption or legal guardianship
- Death
- Aging off plan
- Change of work status (e.g., you are a .4 paraeducator, not benefits eligible, and your hours increase to .6—you now are benefits eligible)
- Loss of non-MCPS coverage

Changes due to qualifying life or work events may be made during the plan year, as described in the section **Enrolling New Dependents**.

You may **cancel** your coverage at any time, but you may not cancel your dependent's coverage without proof that the dependent has coverage elsewhere. **It is recommended that you notify ERSC promptly because removing a dependent could change your coverage level and reduce your cost. You must provide evidence of other coverage in order to drop a dependent from coverage**.

Also, while you may add or drop yourself, a spouse, or dependent(s) from your benefits plan outside of Open Enrollment due to a qualifying event, you may not make changes to your benefits plan outside of Open Enrollment. This means you may not change insurance plans or cancel individual components of your benefit plan during the plan year.

If you choose to cancel coverage outside of Open Enrollment, you must cancel the entire employee benefit plan—with the exception of life insurance coverage(s).

To cancel or change coverage due to a qualifying life event outside of Open Enrollment, you must visit the Employee Self-Service web page at *www.montgomeryschoolsmd.org/departments/ersc/employees/employee-self-service/* and click on the **Benefits enrollment/changes due to a qualifying life event** link. You have 60 days from the date of the qualifying event to enroll and submit the required supporting documentation to ERSC. You must either upload this information to the BES when you enroll or mail it to ERSC.

If ERSC receives all required documentation by the 20th of the month, changes to or cancellation of your coverage will become effective on the first day of the following month. If ERSC receives the forms after the 20th of the month, changes to your coverage will become effective on the first day of the second month.

If you do not enroll and provide the necessary documentation within the 60-day period, you must wait until a future Open Enrollment to make any changes using the BES.

Remember: It is your responsibility to promptly notify ERSC of any changes to your personal information (e.g., name or address) or coverage needs.

Loss of Non-MCPS Coverage

You may enroll in an MCPS-provided benefits plan during the plan year if you or your benefits-eligible dependents lose coverage provided by a business or organization other than MCPS. Your benefits coverage will be effective the first of the month following your enrollment.

PAYING FOR COVERAGE

You pay for your health plan coverage with premiums deducted from your paycheck on a pretax basis. Your premiums are deducted before income and payroll taxes are calculated, and your deductions are taken in equal amounts. The detailed cost is shown on your *e*Paystub.

- Ten-month employees have deductions taken from 20 paychecks during the school year.
- Twelve-month employees have deductions taken from 26 paychecks.

Refer to the rate chart at the end of this document for the base health coverage costs for 2023.

WHEN BENEFITS COVERAGE ENDS

If you terminate employment with MCPS, benefits coverage for you and any covered dependents ends on the last day of the month you terminate employment.

Dependent life insurance coverage for a dependent child automatically ends on September 30 following the child's 23rd birthday. For dental and vision plans, benefits coverage for a dependent child automatically ends at the end of the month in which he/she turns age 24. For medical and prescription plans, a dependent child's coverage automatically ends at the end of the month in which he/she turns age 26.

Special Rule for 10-month Employees

If you are a 10-month employee and you terminate employment with MCPS at the end of a school year (on your last duty day based on your work schedule), your coverage continues through September 30 because you have prepaid for benefits through the summer.

CONTINUATION OF BENEFITS (COBRA)

If your coverage ends, you and your dependents may be eligible to continue coverage as provided under COBRA.

You and/or your dependents may become eligible for coverage under COBRA if you terminate employment or you and/or your dependents become ineligible for coverage under the MCPS benefits plan. You may continue coverage by paying the full cost of coverage plus a 2 percent administrative fee for a period legally-mandated by COBRA regulations (generally 18–36 months).

MCPS does not share the cost of COBRA coverage. A COBRA rate chart can be found on the ERSC website. You will receive a qualifying event notice (QEN) from the MCPS third party administrator.

INSURANCE COVERAGE WHILE ON LEAVE

If you are on an approved leave of absence, you may elect to continue or terminate your coverage under the MCPS employee benefit plan. Depending on the type and duration of your leave of absence, you may be required to pay either the employee share or the full cost of coverage. For most unpaid leave categories, there is not an MCPS subsidy, and you are responsible for 100 percent of the cost of insurance while on leave. More information regarding leave of absence policies is available on the ERSC website at *www.montgomeryschoolsmd.org/departments/ersc/employees/leave/*.

You may elect to terminate coverage by indicating your choice on the appropriate BES screen(s). If you wish to continue coverage while on leave, no action is required.

You can continue life insurance coverage without continuing medical, dental, vision, or prescription coverage. If you elect to continue life insurance coverage, you will be billed by the MCPS Division of Controller. Failure to pay the required premium will result in cancellation of coverage.

Please be advised that if you terminate your coverage while on leave and, after returning to work at a later day, wish to re-enroll in benefits, you must do so using the BES within 60 days of returning to active work status. You must re-enroll in the same coverage you had prior to going on leave. If you marry, have a child, or adopt a child while on leave, they may be added to your plan when you return from leave via the BES. You will need to provide the appropriate documentation.

In most cases, you cannot continue your participation in a flexible spending account (FSA) while on leave. Your FSAs are cancelled as of the last deduction taken once you are on leave, and you must reenroll within 60 days of returning from leave. You can incur expenses up to the date your leave begins and have until April 30 following the plan year to submit claims for reimbursement.

While on an approved leave of absence protected by the Family and Medical Leave Act (FMLA), you may choose to re-enroll in an FSA. To do so, complete and submit MCPS Form 450-3, *Flexible Spending Account Election* to have your FSA contributions direct billed to you.

If you fail to reenroll in the employee benefit plan within 60 days of returning to active work status, you must wait until a future Open Enrollment. In order to reenroll for basic employee life insurance or optional employee and optional dependent life insurance, you and your spouse must provide evidence of insurability and be approved by MetLife.

If you are absent from work without approved leave, you still are required to pay health insurance premiums. If in any given pay period you do not have sufficient funds to cover the cost of your insurance premiums, the premiums will be withheld from your next paycheck. In the event of a longer unapproved absence from work, you will be billed the full cost premium rate. Please keep in mind that you could

jeopardize your eligibility to continue health insurance coverage if you are absent without approved leave. For additional information about leave of absence policies, visit the ERSC website at *www.montgomeryschoolsmd.org/departments/ersc/employees/leave/*

OUT-OF-AREA COVERAGE

If you are enrolled in the Kaiser Permanente Health Maintenance Organization (HMO) medical plan, any eligible dependents that reside or attend school outside the service area of the HMO will be covered only for urgent care or emergency services.

You are covered anywhere in the world for emergency and urgent care with your Kaiser Permanente plan. If you regularly travel to another service area where you will receive Kaiser Permanente care, you can get a health/medical record number and a *kp.org* account to seamlessly receive care. When travelling in an area outside of any Kaiser Permanente service area, you can get care at a MinuteClinic® and you will be charged your standard copay or coinsurance. Learn more at *kp.org/travel*. Refer to the HMO summary plan document for details.

Members of the Cigna OAP (POS) plan or OAPIN (HMO) plan have access to a national network of doctors and medical facilities. Both plans provide *in-network* benefits should you and/or your dependents seek medical care while travelling or living outside the service area. If you are covered by the Cigna OAP plan, you also have the option to see a nonparticipating provider, but your out-of-pocket expense will be higher if you do. If you receive services from a provider outside of the network, you will have to—

- pay the provider's actual charge at the time you receive care,
- file a claim for reimbursement, and
- satisfy a deductible and coinsurance.

COORDINATION OF BENEFITS

If you or one of your dependents is covered by more than one insurance plan, there is an order of benefits determination established by the National Association of Insurance Commissioners. The primary plan will be the first to consider the medical services rendered for coverage. Any medical care not covered by the primary plan in full will be considered for payment by the secondary plan.

Your employee plan is your primary coverage over any other plan that covers you as a dependent spouse.

Birthday Rule

If dependent children are enrolled for insurance coverage with both biological parents (one MCPS plan, one non-MCPS plan), the primary insurance plan for the children is determined by the birthday of the parents.

The plan of the parent with the birthday that comes first in the calendar year (month and day only) is primary for the child(ren). This order of benefits determination for dependent children is known as the birthday rule.

All medical plans offered by MCPS use the birthday rule for primary insurance plan determination. The birthday rule does not apply to stepchildren. Primary care for dependent stepchildren is determined by the courts.

ENROLLMENT IN MEDICARE

As an active MCPS employee, if you and/or your covered dependent(s) are eligible for Medicare due to age, illness, or disability, you may defer Medicare Part B enrollment without penalty as long as you are covered by any active MCPS medical plan. Deferring Medicare enrollment will save you the cost of additional monthly Medicare Part B premiums while maintaining your MCPS medical coverage. Enrollment in Medicare Part B will not provide additional medical coverage beyond what already is included in all MCPS medical plans. Therefore, employees typically defer Medicare

Part B enrollment until retirement when deferral no longer is permitted.

If you and/or your qualified dependent(s) defer Medicare enrollment, you still will be required to enroll in Medicare Parts A and B when you retire and no longer are covered by the active employee health plan. Enrollment in Medicare must coincide with your retirement date and is arranged by contacting the Social Security Administration at least three months prior to your retirement. At the time of your retirement, you must submit a copy of the Medicare card(s) to ERSC with your retirement papers. Conveying this information to ERSC will initiate the necessary process to update your benefit enrollment and notify the insurance carriers.

All retirees and dependents covered by any MCPS retiree medical plan are required to enroll in Medicare Parts A and B when first eligible to remain covered by the MCPS plan. Once enrolled, Medicare will be your primary insurance, and the MCPS medical plan provides secondary coverage as a supplement to Medicare.

If you and/or your dependent(s) become Medicare eligible at any time due to end-stage renal disease (ESRD), you must notify ERSC at 301-517-8100.

Detailed information about post-retirement health coverage and Medicare is provided during the Retirement Informational Sessions offered by ERSC and also is included in the *Retiree Benefit Summary*, which is available online at *www.montgomeryschoolsmd.org/uploadedFiles/retiree_benefit_summary_current.pdf*.

Please Note
Application for Medicare Part B is completed through your local Social Security office or online at: *https://www.ssa.gov/benefits/medicare/*

Enrollment Basics

USING THE BENEFITS ENROLLMENT SYSTEM (BES)

Employees who wish to enroll in or make changes to their benefits either when first hired, during an annual Employee Benefits Open Enrollment, or when experiencing a qualifying life event or returning from long-term leave must make their elections using the BES. To access and use the system, visit the Employee Self-Service (ESS) web page at *www.montgomeryschoolsmd.org/departments/ersc/employees/employee-self-service/*.

If you are a new employee, click on the **Benefits enrollment for new employees** link. Those making changes during Open Enrollment click on the **Open Enrollment** link. Those experiencing a qualifying life event click on the **Benefits enrollment/changes due to qualifying life event** link. Then, log in using your Outlook username and password and follow the onscreen instructions.

The BES allows you to quickly and easily review, update, and confirm your benefit elections; elect a medical or dependent care flexible spending account (FSA); and designate your life insurance beneficiaries. Since it is online, there are no paper forms to fill out or send in. You simply make your elections and submit them with a series of clicks.

SUBMITTING SUPPORTING DOCUMENTATION

Employees adding a dependent to their benefit plan—whether during Open Enrollment or due to a qualifying life event—must submit the necessary supporting documentation to ERSC. Supporting documentation may be uploaded during the online enrollment process via the BES or mailed or delivered in one of the following ways:

- Email: ERSC@mcpsmd.org
- Mail: 45 W. Gude Drive, Suite 1200, Rockville, Maryland 20850
- Pony mail: ERSC at 45 W. Gude Drive
- Fax: 301-279-3651 or 301-279-3642

If you choose to submit supporting documentation via the BES or email, you must submit an electronically signed Adobe PDF file. When submitting hard copies of supporting documentation, please write your name and employee identification number in the upper right corner of each page.

Your Benefits at a Glance

The chart below is a brief overview of your benefit options for 2023. For more information, refer to the appropriate section in this benefits summary.

Benefit	Your Options
Protecting Your Health	
Medical Point-of-Service (POS) Health Plans Health Maintenance Organizations (HMO) Health Plans	• Cigna Open Access Plus (OAP) • Cigna Open Access Plus In-Network (OAPIN) • Kaiser Permanente HMO
Prescription Drug	• CVS Caremark Prescription Drug *(only available to Cigna plan participants)* • Kaiser Permanente Prescription Drug *(only available to Kaiser Permanente plan participants)*
Dental	• CareFirst Preferred Dental Plan (PPO) • Aetna Dental Maintenance Organization (DMO) • Kaiser Permanente Preventive Dental Coverage *(included in medical plan; available only to Kaiser Permanente medical plan participants)*
Vision	• Davis Vision (provided through CareFirst) • Kaiser Permanente Vision Plan *(included in medical plan; available only to Kaiser Permanente medical plan participants)*
Wellness Initiatives	• Health Risk Assessments • Biometric Health Screenings
Protecting Your Income	
Flexible Spending Accounts	• Medical spending account (up to $2,850/year) • Dependent care account (up to $5,000/year or $2,500/year if filing separately)
Basic Term Life Insurance	MetLife— • Employee (83 percent paid by MCPS)—2 times annual salary • Dependent (paid by MCPS)—$2,000/spouse, $1,000/each eligible dependent child up to age 23
Optional Life Insurance	MetLife— • Employee—1 times annual salary (paid by employee) • Dependent—$10,000/spouse or each eligible dependent child (paid by employee)
Protecting Your Future	
Defined Contribution Plans 403(b) Tax Shelter Savings Plan 457(b) Deferred Compensation Plan	Fidelity—You can elect a percentage of your gross bi-weekly pay or a flat dollar amount to contribute to one or both plans up to annual IRS limits (available at ***www.netbenefits.com/mcps***)
Defined Benefit Pension Plans	By completing the appropriate forms, you are enrolled in state and/or county-sponsored pension plans.

Wellness Initiatives

To develop a culture of wellness within MCPS, the Wellness Initiatives program was established as part of the school system's benefit program. Expanding the efforts of the MCPS employee wellness program, Well Aware, the program is intended to educate employees about their health while offering incentives to those who participate. Wellness Initiatives is in accordance with Montgomery County Education Association (MCEA), Service Employees International Union (SEIU) Local 500, and Montgomery County Association of Administrators and Principals (MCAAP)/ Montgomery County Business and Operations Administrators (MCBOA) contracts.

Each year, if you are covered by an MCPS-provided medical insurance plan through Cigna or Kaiser Permanente, you can reduce your contributions to your health insurance by completing a biometric health screening and/or an online health risk assessment. **You must complete them between the first day of fall Open Enrollment and the Friday before the next Open Enrollment begins a year later.** Once you have completed your biometric health screening and/or health risk assessment, the incentive(s) will go into effect January 1 of the calendar year that follows the deadline.

BIOMETRIC HEALTH SCREENINGS

Biometric health screenings monitor for disease and assess risk for future medical problems. By completing a biometric health screening of your blood pressure, blood sugar, body mass index (BMI), and cholesterol, you will be eligible for a 1 percent increase in MCPS contributions toward your health insurance. This means that your contribution to your health insurance will be reduced by 1 percent if you complete the biometric screenings within the above time frame. Your health screening may be completed by your primary care physician **or** at one of your medical plan's health screenings sponsored by Well Aware.

Note to Kaiser Permanente plan members: You must log in to the Kaiser Permanente website at *www.webmdhealth.com/kp/750/landing* to confirm your participation in the Wellness Initiatives program and determine if you must meet any additional requirements.

HEALTH RISK ASSESSMENTS

Health risk assessments are online surveys that ask basic health and lifestyle questions to provide you with a baseline of your current health status. If you complete a health risk assessment by the deadline, your contribution to your health insurance will be reduced by 1 percent.

Your online health risk assessment must be completed through the medical plan in which you are enrolled. If you have not already done so, you will need to create an online account with your medical plan. To set up your account, visit your medical plan's website (listed below) and complete a simple registration process:

- Cigna—*www.MyCigna.com*
- Kaiser Permanente—*www.kp.org*

MCPS will **not** receive the results of your biometric health screening or health risk assessment. Your health insurance carrier will only indicate whether you have completed your screening and/or assessment. Your personal information is protected by the federal *Health Information Portability and Accountability Act*.

Medical Coverage

You may choose one of the following medical plan options:

Point-of-Service (POS) option:

- Cigna Open Access Plus (OAP)

Health Maintenance Organization (HMO) options:

- Cigna Open Access Plus In-Network (OAPIN)
- Kaiser Permanente HMO

POINT-OF-SERVICE PLAN

A POS plan combines features of an HMO and an indemnity plan. You receive care in one of two ways. There is an in-network HMO-like component offering a full range of services provided or authorized by your primary care physician or by an in-network specialist. In addition, there is an out-of-network component similar to traditional indemnity insurance. The out-of-network benefit provides payment for treatments received from non-network physicians or specialists after the coinsurance and a yearly deductible are met. You also will be responsible for any amount above the usual, customary, and reasonable (UCR) charges determined by the plan.

The POS plans do not require you to obtain a referral to visit a participating in-network physician or specialist for medically necessary care.

Cigna Open Access Plus (POS Plan)

MCPS offers this POS plan to employees and their eligible dependents through Cigna. Cigna Open Access Plus (OAP) is designed to provide the highest quality healthcare while maintaining the freedom to choose from a wide selection of personal physicians. You have the option to choose a PCP who specializes in one of these areas: family practice, internal medicine, general medicine, or pediatrics. Your PCP or personal physician can be a source for routine care and for guidance if you need to see a specialist or require hospitalization. To access an online provider directory, please visit *www.cigna.com*.

With this plan, you have the option to go to any medical person and facility. However, when choosing the providers in the OAP network, your benefit coverage will be greater than opting to receive services outside the network.

Cigna OAP provides well-managed services to deliver cost-effective, quality care through the physicians' private offices and facilities. To ensure full and proper medical treatment, and reduce unnecessary procedures, this plan emphasizes preadmission screening and prior authorization for specific services.

As a participant in this plan, you have access to Cigna's national network of doctors and facilities. The availability of a national network allows access to in-network care for members wherever you are in the country, when traveling, and for dependent children when they are living out of state.

Diabetic supplies are covered under the prescription drug benefit administered by CVS/Caremark. Refer to the POS comparison chart later in this document for more details.

HEALTH MAINTENANCE ORGANIZATIONS

A health maintenance organization (HMO) plan offers a full range of services provided by your PCP or by an in-network specialist. You may receive benefits only for medical services and supplies received from a network provider, except in a true emergency. However, you do not have to meet a deductible before the plan pays benefits.

Refer to the HMO comparison chart outlined later in this document for further details.

Cigna Open Access Plus In-Network (HMO Plan)

The Cigna Open Access Plus In-Network (OAPIN) option allows participants to visit any Cigna network provider without a referral.

Cigna offers access to care from participating physicians and facilities, with low out-of-pocket expenses. You may have the option to choose a PCP to coordinate your care, and pay only a copayment for most services. You do not have to complete a claim form.

As a participant in this plan, you have access to Cigna's national network of doctors and facilities. The availability of a national network allows access to in-network care for members wherever you are in the country, when traveling, and for dependent children when they are living out of state.

In addition, Cigna offers member discounts on fitness, nutrition, and weight management programs. For more information on discounts, visit the MCPS Well Aware web page and navigate to the Discounts tab.

Kaiser Permanente HMO

Kaiser Permanente brings your doctors, specialists, pharmacy, labs, X-rays, and medical facilities under one plan. There are more than 33 medical centers within the MCPS service area. Included are 14 Urgent Care locations, six of which are Advanced Urgent Care centers open 24/7. You have the choice of more than 1,600 physicians in 50+ specialties from which to choose. You may receive information about locations at *www.kp.org/locations* or by telephoning 1-800-777-7902. Medical centers are staffed by doctors, nurses, and specialists and offer a wide range of services such as pharmacy, laboratory, X-ray, ambulatory surgery, and health education. We encourage you to select a center and PCP that best meets your needs when you enroll in the plan. If you do not choose a center, Kaiser Permanente automatically will assign a center nearest to your residence of record. You may change your doctor anytime.

When scheduling an appointment, be sure to ask for your PCP. You may call and change your PCP or medical center location at any time. Each of your covered family members may select a center and PCP of their choice. Your PCP is responsible for coordinating all health needs including hospital and specialty care if needed. If you enroll in the Kaiser Permanente HMO, your prescription drug benefits and diabetic supplies are provided under this plan.

Kaiser Permanente covers diabetic supplies and provides certain discount specialty services.

Refer to the HMO comparison chart for more information about the HMO plans.

PREVENTIVE CARE SERVICES

As a result of the *Patient Protection and Affordable Care Act,* certain preventive care procedures no longer will have copays when they are provided by in-network providers, regardless of your medical plan choice. The specific procedures provided for adults and children are listed separately in the following charts. Preventive care procedures not listed specifically will be covered by in-network providers with copays outlined in the HMO and POS comparison charts on the following pages. Out-of-network coverage remains unchanged, and copays are listed in the POS comparison chart later in this document.

Preventive Services Covered with Zero Copay for Adults*	
Preventive Service Covered	**Who is Eligible, Additional Details**
Abdominal Aortic Aneurysm Screening	one-time screening for men of specified ages who have ever smoked
Alcohol Misuse Screening and Counseling	all adults
Aspirin Use	men and women of certain ages
Blood Pressure Screening	all adults
Cholesterol Screening	adults of certain ages or at higher risk
Colorectal Cancer Screening	adults over 50
Depression Screening	all adults
Type 2 Diabetes Screening	adults with high blood pressure
Diet Counseling	adults at higher risk for chronic disease
HIV Screening	all adults at higher risk
Immunizations for: • Hepatitis A • Hepatitis B • Herpes Zoster • Human Papillomavirus • Influenza • Measles, Mumps, Rubella • Meningococcal • Pneumococcal • Tetanus, Diphtheria, Pertussis • Varicella	doses, recommended ages, and recommended populations vary
Obesity Screening and Counseling	all adults
Sexually Transmitted Infection (STI) Prevention Counseling	adults at higher risk
Tobacco Use Screening	all adults and cessation interventions for tobacco users, expanded counseling for pregnant tobacco users

** Using in-network providers only*

Preventive Services Covered with Zero Copay for Women *	
Preventive Service Covered	**Who is Eligible, Additional Details**
Annual well-woman visit	all women
Syphilis Screening	all pregnant women, all adults at higher risk
Anemia Screening	pregnant women, on a routine basis
Bacteriuria Urinary Tract or Other Infection Screening	pregnant women
BRCA Counseling about Genetic Testing	women at higher risk
Breast Cancer Mammography Screenings	women over 40, every 1 to 2 years
Breast Cancer Chemoprevention Counseling	women at higher risk
Breast Feeding Interventions	women (to support and promote breast feeding)
Breast Feeding Support, Supplies, and Counseling	women (to support and promote breast feeding)
Cervical Cancer Screening	sexually active women
Chlamydia Infection Screening	younger women and other women at higher risk
Contraceptive Methods and Counseling (FDA-approved**), including: • Female Condom (OTC) • Diaphragm (P) with Spermicide (OTC) • Sponge (OTC) with Spermicide (OTC) • Cervical Cap (P) with Spermicide (OTC)] • Spermicide (OTC) • Oral Contraceptive (P) Combined Pill Progestin Extended/Continuous • Patch (P) • Vaginal Contraceptive Ring (P) • Shot/Injection (P) • Morning After Pill (over 17 years of age OTC; under 17 years of age P) • IUD (P) • Implantable Rod (inserted by doctor) • Sterilization Surgery • Sterilization Implant (OTC) Over the Counter (P) Prescription Required	all women
Folic Acid Supplements	women who may become pregnant
Gonorrhea Screening	all women at higher risk
Gestational Diabetes Screening	pregnant women
Hepatitis B Screening	pregnant women at their first prenatal visit
Human Immunodeficiency Virus (HIV) Counseling and Screening	all women, on an annual basis
Human Papillomavirus (HPV) Testing	all women
Interpersonal and Domestic Violence Screening and Counseling	all women
Osteoporosis Screening	women over age 60 depending on risk factors
Rh Incompatibility Screening	all pregnant women and follow-up testing for women at higher risk
Sexually Transmitted Infections Counseling	all women, on an annual basis

** Using in-network providers only*

*** Includes surgical, prescription, medical, and OTC services/products. Sterilization is considered a contraceptive method. Abortion IS NOT considered a contraceptive method.*

Preventive Services Covered with Zero Copay for Children*	
Service	**Who is Eligible, Additional Details**
Alcohol and Drug Use Assessments	adolescents
Autism Screening	children at 18 and 24 months
Behavioral Assessments	children of all ages
Cervical Dysplasia Screening	sexually active females
Congenital Hypothyroidism Screening	newborns
Developmental Screening	children under age 3, and surveillance throughout childhood
Dyslipidemia Screening	children at higher risk of lipid disorders
Fluoride Chemoprevention Supplements	children without fluoride in their water source
Gonorrhea Preventive Medication for the Eyes	all newborns
Hearing Screening	all newborns
Height, Weight, and Body Mass Index Measurements	children of all ages
Hematocrit or Hemoglobin Screening	children of all ages
Hemoglobinopathies or Sickle Cell Screening	newborns
HIV Screening	adolescents at higher risk
Immunization Vaccines for: • Diphtheria, Tetanus, Pertussis • Haemophilus Influenzae Type B • Hepatitis A • Hepatitis B • Human Papillomavirus • Inactivated Poliovirus • Influenza • Measles, Mumps, Rubella • Meningococcal • Pneumococcal • Rotavirus • Varicella	children from birth to age 18; doses, recommended ages, and recommended populations vary
Iron Supplements	children ages 6 to 12 months at risk for anemia
Lead Screening	children at risk of exposure
Medical History	all children, available throughout development
Obesity Screening and Counseling	children of all ages
Oral Health Risk Assessment	young children
Phenylketonuria (PKU) Screening for Genetic Disorder	newborns
Sexually Transmitted Infection (STI) Prevention Counseling	adolescents at higher risk
Tuberculin Testing	children at higher risk of tuberculosis
Vision Screening	children of all ages

** Using in-network providers only*

Health Maintenance Organization (HMO) Plans	Kaiser Permanente HMO Plan	Cigna Open Access Plus In-Network (OAPIN) Plan
Annual Deductible	None	None
Preventive Care		
Routine Physical Exam	Covered in full	Covered in full
Well Baby/Child Care	Covered in full (under age 5)	Covered in full
Childhood Immunizations	Covered in full (under age 5)	Covered in full
Physician Services		
Physician Office Visit	$10 copay	$10 copay
Specialist Office Visit	$20 copay	$20 copay
Lab Work and X-rays	Covered in full	Covered in full
Allergy Shots	$10 copay	$10 copay $20 specialist copay
Maternity Care		
Prenatal and Postnatal Care	$10 copay, no charge once pregnancy is confirmed*	Covered in full
Physician Services	Covered in full	$10 copay
Hospital Services	Covered in full	Covered in full
Emergency Services (when medically necessary)		
Urgent Care Centers	$20 copay	$20 copay
Emergency Room	$150 copay (waived if admitted)	$150 copay (waived if admitted)
Emergency Physician Services	Covered in full	Covered in full
Emergency Ambulance	Covered in full if authorized	Covered in full
Hospital Services—Inpatient		
Semi-Private Room	Covered in full	Covered in full
Professional Services	Covered in full	Covered in full
Surgical Procedures	Covered in full	Covered in full
Specialty Care/ Consultation	Covered in full	Covered in full
Anesthesia	Covered in full	Covered in full
Radiology and Drugs	Covered in full	Covered in full
Intensive Care	Covered in full	Covered in full
Coronary Care	Covered in full	Covered in full
Hospital Services—Outpatient		
Surgical Procedures	$20 copay	$20 copay
Professional Fees	Covered in full	$10 copay/$20 copay for specialist
Mental Health/Substance Abuse Services		
Inpatient Days	Covered in full	Covered in full
Outpatient Visits	$10 copay	$10 copay
Other Services		
Catastrophic Illness	Covered in full	Covered in full
Durable Medical Equipment	Covered in full	You pay 25%
Home Health Care	Covered in full	Covered in full
Hospice Care	Covered in full	Covered in full
Skilled Nursing Care	Covered in full up to 100 days per contract year	Covered in full

**Applies to services not specifically listed in the previous preventive care charts.*

Open Point-of-Service (POS) Plan	Cigna Open Access Plus (OAP) Plan	
	In-Network	**Out-of-Network**
Annual Deductible	None	$300 individual, $600 family
Preventive Care		
Routine Physical Exam	$15 copay*	Not covered
Well Baby/Child Care	$15 copay*	80%, no deductible
Childhood Immunizations	Covered in full	80%, no deductible
Physician Services		
Physician Office Visit	$15 copay	80% after deductible
Specialist Office Visit	$25 copay	80% after deductible
Lab Work and X-rays	Covered in full	Diagnostic: 80% after deductible Routine: not covered
Allergy Evaluations	$15 copay each visit	80% after deductible
Allergy Shots	Covered in full	80% after deductible
Maternity Care		
Prenatal and Postnatal Care	$25 copay first visit, covered in full after*	80% after deductible
Physician Services	Covered in full	80% after deductible
Hospital Services	Covered in full	80% after deductible
Emergency Services (when medically necessary)		
Urgent Care Centers	$25 copay	$25 copay, then plan pays 80%
Emergency Room	$150 copay (waived if admitted)	$150 copay (waived if admitted)
Emergency Physician Services	Covered in full	Covered in full
Emergency Ambulance	Covered in full	Covered in full
Hospital Services—Inpatient		
Semi-Private Room	Covered in full	80% after deductible
Professional Services	Covered in full	80% after deductible
Surgical Procedures	Covered in full	80% after deductible
Specialty Care/ Consultation	Covered in full	80% after deductible
Anesthesia	Covered in full	80% after deductible
Radiology and Drugs	Covered in full	80% after deductible
Intensive Care	Covered in full	80% after deductible
Coronary Care	Covered in full	80% after deductible
Hospital Services – Outpatient		
Surgical Procedures	Covered in full	80% after deductible
Professional Fees	Covered in full	80% after deductible
Mental Health/Substance Abuse Services		
Inpatient Days	Covered in full	80% after deductible
Outpatient Visits	$15 copay	80% after deductible
Other Services		
Catastrophic Illness	Covered in full	Covered in full after $1,000 out-of-pocket expenses (excludes deductible)
Durable Medical Equipment**	Covered in full	80% after deductible
Home Health Care/	Covered in full	80% after deductible
Skilled Nursing Care	(Up to 60 visits for both in- and out-of-network)	
Hospice Care	Covered in full	80% after deductible

**Applies to services not listed in the previous preventive care charts.*
***Does not include diabetic supplies such as lancets, glucose strips, etc.*

Other Benefit Plan Coverage

In addition to medical coverage, you may choose dental, vision, and prescription drug coverage when you enroll (see the appropriate section in this document for details). Base rates for the 2023 plan year, which do not include Wellness Initiatives credit(s), are included in this document. Rates that factor in Wellness Initiatives credits are available during the plan year at *https://www2.montgomeryschoolsmd.org/departments/ersc/employees/benefits/*

You are responsible for updating beneficiary designations for your life insurance plans, the state and county pension plans, and the defined contribution plans [403(b) and 457(b)]. You may update life insurance beneficiary(ies) during Open Enrollment or if you experience a qualifying life event during the plan year, by visiting the Employee Self-Service web page at *https://www2.montgomeryschoolsmd.org/departments/ersc/employees/employee-self-service/* and selecting the appropriate link under the blue My Benefits banner. Pension plan forms are available on the ERSC website. To change your defined contribution plan beneficiaries, contact Fidelity directly at 800-343-0860 or *www.netbenefits.com/MCPS*.

Important Notice

New employees eligible for benefits are enrolled in the basic term life insurance plan automatically. You will need to designate a beneficiary for basic life insurance when you enroll in benefits via the BES. If you wish to decline basic term life insurance coverage, you must do so online by electing "decline" life insurance coverage. See the Life Insurance section of this document for additional details. You may update your life insurance beneficiaries at any time by using the BES. Make sure to update beneficiary designations as your circumstances change.

Dental Coverage

If you are eligible for benefits, you may choose from the following dental plans:

- CareFirst Dental Plan (PPO),
- Aetna Dental Maintenance Organization (DMO), or

Kaiser Permanente medical plan members are automatically enrolled in the Kaiser Permanente dental plan. They have the option of also enrolling in either the PPO plan or DMO plan.

You may change dental plans only during Open Enrollment or if a DMO participant and you move outside of the Aetna DMO service area.

CareFirst Preferred Dental Plan (PPO)

If you enroll in the CareFirst Dental PPO plan, you have the freedom to select the dentist of your choice. This plan offers in- and out-of-network benefits.

You can access in-network provider information by calling 1-888-755-2657 or visiting CareFirst's website at *www.carefirst.com/mcps*.

- Under Find a Doctor, click **Search Now.**
- Log in to My Account.
- Select Dental.
- Search by Name or Specialty.

You receive a higher level of benefits if you receive dental services from a participating (in-network) PPO dentist. If you receive dental services from a non-participating (out-of-network) dentist, you receive a less generous level of benefits. Reimbursement is based on the schedule of dental benefits and is subject to deductibles, copays, and reasonable and customary charges. Prophylaxis, including scaling and polishing, is covered up to two times per calendar year.

Orthodontic benefits are available to dependent children of active employees only if they were

enrolled in the MCPS plan and younger than age 20 when the treatment began. The in-network orthodontic benefit is 50 percent of the allowed charge, and the out- of-network orthodontic benefit is 30 percent of the allowed charge. There is a maximum lifetime orthodontic benefit of $1,000 per child (in- or out-of-network).

Aetna Dental Maintenance Organization (DMO)

If you wish to enroll in the Aetna DMO plan, you should contact Aetna directly to verify that you reside in the DMO service area. As a DMO participant, you must select a primary dentist from a list of participating DMO dentists and be on the dentist's roster before your first appointment. To obtain information and select a participating DMO provider, visit Aetna's website at *www.aetna.com/docfind* or call 1-800-843-3661.

The Aetna DMO does not require you to meet an annual deductible before benefits are paid, and there is no maximum annual benefit limitation. However, benefits are paid only if you receive care from a dentist who is part of the DMO network. Benefits are paid at a certain percentage (100 percent for preventive or basic or 75 percent for major).

Orthodontic benefits are available to dependent children of active employees only if they were enrolled in the MCPS plan and younger than age 20 when the treatment began. The orthodontic benefit is 50 percent of the scheduled fee, limited to one full treatment per eligible child. There is no lifetime maximum.

Refer to the chart on the next page for more information about your dental options.

Kaiser Permanente Dental Plan

The Kaiser Permanente medical and prescription plan includes a schedule of benefits for in-network dental care for both adult and pediatric patients. Participants pay $30 for a dental exam and cleaning. More extensive care is offered at fixed fees lower than the usual and customary charges for dental services. For more information visit *DominionNational.com/KaiserDentists*. This coverage is not available to those who are not Kaiser Permanente members.

Refer to the chart on the next page for more information about your PPO and DMO dental options. For details about the Kaiser Permanente dental plan, visit *www.montgomeryschoolsmd.org/departments/ersc/employees/benefits/health/medical/kaiser.aspx* and click on the Evidence of Coverage link.

Dental Benefits	CareFirst PPO		Aetna DMO
	In-Network Plan pays:	Out-of-Network Plan pays:	In-Network Only Plan pays:
Maximum Annual Benefit*	$2,000	$2,000	None
Annual Deductible **Class I** **Class II** **Class III**	 None $50 $50	 None $100 $100	 None None None
Diagnostic (Class I) Routine exams X-rays Prophylaxis (includes scaling and polishing) Fluoride (one treatment per year up to age 18) Sealants (one treatment every three years on permanent molars only under age 16) Oral Hygiene Instruction	100% Oral Hygiene Instruction not covered	80% Oral Hygiene Instruction not covered	100%
Basic (Class II) Amalgam Composite Filling (anterior tooth only) Pulp Capping Root Canal Therapy with X-rays and Cultures (other than molar root canal) Scaling and Root Planing	100%	80%	100%
Basic (Class II) Space Maintainers Molar Root Canal Therapy Osseous Surgery (periodontal surgery) General Anesthesia	100%	80%	75%
Major (Class III) Inlays, Onlays, and Crowns Full and Partial Dentures Bridge Pontics, and Abutments	50%	40% Maximum eligible charge per service: $400	75%
Major (Class III) Surgical Removal of Impacted Teeth	100%	80% Maximum eligible charge per service: $400	75%
Orthodontics (Class IV)** Orthodontic Appliances and Treatment (one lifetime treatment per covered dependent child only if treatment begins prior to age 20 while covered under the MCPS plan)	50%, up to $1,000 lifetime maximum	30%, up to $1,000 lifetime maximum	50%, no lifetime maximum
Dental Implants	50%	N/A	N/A

**The $2,000 maximum annual benefit is a combined total benefit from in-network and/or out-of-network benefit total.*
*** The $1,000 maximum lifetime benefit is a combined total benefit from in-network and/or out-of-network benefit total.*

Vision Coverage

If you are eligible for benefits, you may choose to enroll in vision coverage offered by Davis Vision (provided through CareFirst). Kaiser Permanente medical plan members are automatically enrolled in the Kaiser Permanente vision plan, but have the option of also enrolling in the Davis Vision plan.

Davis Vision Plan

As a participant in the Davis Vision plan, you have access to care through either our network of independent, private practice doctors (optometrists and ophthalmologists) or select retail partners for vision services. When you use a Davis Vision provider, the benefit below is deducted from eligible expenses at the time the services are rendered. There is no need to file a claim.

Service	Maximum Benefit	Limits
Exams: Optometrist Ophthalmologist	 $50 $66	One exam during any consecutive 18-month period
Frames: Frames only	 $40	One set of frames during any consecutive 18-month period (in lieu of contact lenses)
Lenses only, per pair: Single vision Bifocal Trifocal Lenticular **Contact Lenses:** Medically Necessary** Standard or Disposable	 $40 $70 $90 $240 $230 $80	Two lenses during any consecutive 18-month period (in lieu of contact lenses) In lieu of lenses & frames

**Contact lenses are covered up to $230 only if they are prescribed after cataract surgery or when needed to restore the visual acuity of the person's healthier eye to 20/70 or better, and if this cannot be accomplished with regular glasses. Otherwise, they are covered at $80 in lieu of glasses.

This coverage does not provide benefits for the following:

- More than one eye examination, including refraction, and two lenses per person during any consecutive 18-month period.
- More than one set of frames per person during any consecutive 18-month period.
- Services and materials in connection with special procedures, such as orthoptics and vision training, or in connection with medical or surgical treatment of the eye.
- Sunglasses, plain or prescription.
- Replacement of lost, stolen, or broken lenses or frames furnished under this benefit.
- Eye examinations required by an employer as a condition of employment, where the employer is required to provide by virtue of a labor agreement or a government body.
- Any eye care to the extent that benefits are payable for the service or supply under any other coverage of the plan, such as infections of the eye and eye surgery that are covered under your medical plan.

Value Added Features—Replacement contacts (after initial benefit) through *www.DavisVisionContacts.com* mail order contact lens replacement service ensures easy and convenient online purchasing and quick shipping direct to your door.

The vision plan enables participants to purchase lens option services at discount prices. The plan also provides LASIK surgery discounts of up to 25 percent off the provider's usual and customary fees, or 5 percent off advertised specials, whichever is lower. For additional information on LASIK surgery, please call 800-783-5602 for a list of participating Davis Vision providers.

Out-of-Network Vision Services—Please be aware that non-Davis Vision providers will expect the entire payment up-front. You may then seek reimbursement by submitting a claim form to Davis Vision. Refer to the benefits chart at left for reimbursement amounts.

Need More Information?—Visit *www.carefirst.com/mcps* to access the Davis Vision website or call 1-800-783-5602. Hours of operation are—

- Monday–Friday, 8:00 a.m.–8:00 p.m.
- Saturday, 9:00 a.m.–4:00 p.m.

Kaiser Vision Plan

In addition to medical and prescription coverage, Kaiser Permanente offers a vision program included in the plan premium. For details about this vision plan, visit *www.montgomeryschoolsmd.org/departments/ersc/employees/benefits/health/medical/kaiser.aspx* and click on the Evidence of Coverage link. You will find the vision plan information on page 118. The in-network-only benefits are as follows:

The in-network-only benefits are as follows:

KAISER PERMANENTE VISION PLAN	COPAYS
Exams: Optometrist Ophthalmologist	$10 per visit $15 per visit
Lenses and frames: (Limited to a select group)	$75 discount off retail price combined for lenses and frames purchased at KP Optical
Contact lenses: (Limited to a select group)	$25 discount off retail price for contact lenses purchased at KP Optical
Medically necessary contact lenses: (Limited to a select group)	No charge, limited to two pair per eye, per year
Low vision aids: (Unlimited low vision aids from available supply)	No charge

Vision benefits are provided by Vision Essentials. There are 18 Vision Essential locations in the MCPS service area. For more information and a list of the Vision Essentials locations near you, visit *kp2020.org*.

Prescription Drug Coverage

Two prescription drug plans are offered to MCPS employees. Eligibility for a plan depends on which medical plan you choose. If you enroll in a Cigna medical plan, or if you decline medical coverage, you are eligible to enroll in the CVS/Caremark prescription drug plan.

If you enroll in the Kaiser Permanente HMO, you must enroll in the Kaiser Permanente prescription drug plan to receive a prescription drug benefit.

CVS/Caremark Prescription Plan

The CVS/Caremark prescription plan provides benefits for short-term medications to be filled at participating retail pharmacies using the CVS/Caremark prescription drug card. Short-term medications are medicines prescribed for short-term illnesses such as a cold, flu, or infection, generally requiring no more than a 30-day supply.

Filling prescriptions for long-term maintenance medications works differently. Long-term maintenance medications generally are used to treat long-term chronic conditions such as high blood pressure, arthritis, coronary artery disease, and diabetes.

To avoid paying penalty fees, you must fill your long-term maintenance medications in 90-day increments. You are allowed one initial fill and one refill at any participating retail pharmacy. After that, you only may fill your 90-day supply of long-term maintenance medications at a CVS pharmacy or through the CVS/Caremark Mail Service pharmacy. Some long-term medications will be subject to the specialty drug guideline management program or the generic drug step therapy program. Refer to the sections "Specialty Drug Coverage" and "Generic Drug Step Therapy" for information about each program.

The plan has a three-tier copay structure and provides financial incentives for using generic

drugs, using preferred brand name drugs, and purchasing maintenance medications through CVS/Caremark's Mail Service and CVS retail pharmacies. These copay structures will only apply to those drugs not subject to the specialty drug guidelines or generic drug step therapy.

Refer to the chart below for more information:

	Retail (up to 30-day supply)	CVS/Caremark Mail Service Pharmacy or CVS retail pharmacy (up to 90-day supply)
Generic	$10 copay One refill allowed for maintenance medications	$10 copay
Preferred Brand Name (no generic equivalent)*	$25 copay One refill allowed for maintenance medications	$25 copay
Non-Preferred Brand Name**	$40 copay One refill allowed for maintenance medications	$40 copay***

*Detailed information is available on the CVS/Caremark website.
**If you purchase a brand name drug when a generic equivalent exists, you pay the generic drug copay plus the difference between the non-preferred brand name drug and generic drug cost. Example: Generic drug cost is $100, Non-Preferred Brand Name drug cost is $200, and your copay is $110.
***There is no penalty for purchasing a brand name drug that has a generic equivalent if a letter of medical necessity is filed. See details on following page.

Please Note

You can purchase your 90-day supply of maintenance medication at a CVS pharmacy for the same copay as the CVS/Caremark Mail Service pharmacy.

If you choose *not* to purchase a maintenance medication at a CVS pharmacy or through CVS/Caremark Mail Service after two fills at another retail pharmacy, you will pay the corresponding copay, plus the difference between the mail order and retail prescription cost.

To take advantage of the lowest copay, choose generic drugs when available. Plan participants who choose to purchase a brand name drug when a generic equivalent exists will be required to pay the generic drug copay plus the difference between the cost of the brand name drug and its generic equivalent.

When your doctor certifies in a letter (along with your prescription) that it is medically necessary to prescribe a brand name drug and not its generic equivalent, if it meets the FDA-approved diagnosis criteria, you will be charged the brand name copay, without penalty, for mail order only.

The letter of medical necessity must be written on the doctor's official letterhead (not written on the prescription) and must contain details of the medical reason accompanied by the prescription. Simply stating that in his/her medical opinion brand name drugs are better than generic drugs is not sufficient medical documentation. CVS/Caremark will require yearly updates of medical necessity.

The letter of medical necessity and prescription should be sent to:

CVS/Caremark, Inc.
Department of Appeals, MC109
P.O. Box 52084
Phoenix, AZ 85072-2084

CVS/Caremark also can be reached by fax at 1-866-689-3092.

The plan provides two options for the purchase of brand name drugs that do not have a generic equivalent:

- $25 copay for any preferred brand name drug that appears on CVS/Caremark's Primary Drug list (updated quarterly) or
- $40 copay for non-preferred brand name drugs that do not appear on CVS/Caremark's Primary Drug list

Coverage for over-the-counter drugs, cosmetic drugs, experimental drugs, and vitamins is excluded under the MCPS plan. While not all drugs are covered, those that are not may be filled at 100 percent of the discounted cost.

The following medications have prior authorization requirements, corresponding programs, or quantity limits:

- Anabolic steroids, some treatments for acne, Botox, growth hormones, and medication to treat fungal infections all require prior authorization.
- Smoking cessation drugs and weight loss medications require corresponding programs.
- Drugs for erectile dysfunction have a quantity limit of six doses per month.

Your doctor will need to contact the prior authorization staff with your diagnosis. If you meet the criteria, your prescription will be approved. The prior authorization phone number is 1-800-626-3046. The prior authorization will be valid through the life of the prescription (maximum of one year).

Specialty Drug Coverage—Drugs used to treat certain conditions are considered specialty drugs. These conditions may include multiple sclerosis, oncology, allergic asthma, human growth hormone, Hepatitis C, psoriasis, rheumatoid arthritis and respiratory syncytial virus, but other conditions may be included as well. In an effort to maximize your access to these drugs as well as the cost-effectiveness to both you and MCPS, these drugs are subject to the Specialty Guideline Management Program. Under this program, you still have access to the specialty drugs prescribed by your physician. However, you must go through the proper process in order to obtain these medications. To initiate this process, your physician will have to coordinate with CVS/Caremark in order for these prescriptions to be filled.

For additional information or to see if your medication is in this category, call the toll-free number on the back of your CVS/Caremark ID card or visit *www.caremark.com*.

Generic Drug Step Therapy—CVS/Caremark administers a generic drug step therapy program as part of its prescription plan to assist you and MCPS in managing prescription costs. Brand-name drugs that are used to treat certain conditions, including, but not limited to, high blood pressure and high cholesterol, are subject to the generic first step therapy requirements.

Be sure to ask your physician whether or not the drug being prescribed is affected by the generic drug step therapy program. CVS/Caremark maintains a list of all affected drug classes on their website at *www.caremark.com*.

Primary Preferred Drug List—For drugs that are not subject to the specialty guideline management program or the generic drug step therapy program, CVS/Caremark offers a Primary Preferred Drug List. The Primary Preferred Drug list is a list of preferred brand-name medications that have been carefully reviewed and selected by the CVS/Caremark National Pharmacy and Therapeutics Committee of practicing doctors and clinical pharmacists for their safety, quality, and effectiveness. You can help control the amount you pay for prescriptions by asking your doctor to prescribe medications on the Primary Preferred Drug list. The medicines on the Primary Preferred Drug list are not equivalents of non-preferred brand-name medicines, but are medicines in the same therapeutic category used to treat the same condition.

Remember, not every drug listed on the Primary Preferred Drug list is covered by MCPS. CVS/Caremark updates the Primary Preferred Drug list periodically, so you may need to work with your doctor and Caremark to determine which covered drug you will need to use in the future. The complete list is available on the CVS/Caremark website at *www.caremark.com*.

Compound Drug Preauthorization—Any compound drug medication costing $300 or more requires the doctor/pharmacist to receive pre-authorization from Caremark before the prescription is dispensed.

Morphine Milligram Equivalent (MME) Based Limits—In response to the opioid epidemic in the United States, CVS Caremark has adopted use of the Morphine Milligram Equivalent. MME is a calculation that converts

all opioids to the same units—a morphine equivalent dose—so that the total amount of opioids prescribed can be limited. The limits are based on guidelines recently published by the Centers for Disease Control (CDC). If a written prescription exceeds the allowed limits, physicians will need to contact CVS Health Prior Authorization department at 1-800-294-5979.

CVS Retail Pharmacy or CVS/Caremark Mail Service Pharmacy—If you are taking a maintenance medication, you are allowed an initial fill and one refill up to a 30-day supply at a retail pharmacy at the applicable copay. Thereafter, you either must use the CVS/Caremark Mail Service Pharmacy or fill your maintenance medication prescription at any CVS pharmacy. If you choose to purchase a maintenance medication at a retail pharmacy other than a CVS pharmacy after a second fill, you will be required to pay the retail copay plus the difference between the mail order and retail cost of the drug.

To receive a 90-day supply of medication at a CVS pharmacy, ask your doctor for a prescription for up to a 90-day supply of medication, plus refills as appropriate (three refills maximum), and submit directly to the CVS pharmacist.

To participate in the CVS/Caremark Mail Service pharmacy, ask your doctor for a prescription for up to a 90-day supply of medication, plus refills as appropriate (three refills maximum). Complete a Patient Profile/Order Form, available from ERSC and on the ERSC website, and mail the form, along with the original prescription, to CVS/Caremark. Keep a copy of the prescription for your records and allow a minimum of 10 to 14 business days for delivery. You can also order medications online at *www.caremark.com*.

If you wish to change your current long-term prescription from CVS/Caremark Mail Service to a CVS pharmacy, you must call Customer Care at 1-800-378-7558.

CVS/Caremark's website provides information on how to use the mail order benefit, forms you can download (mail order claim, etc.), and a feature to request refills once you are registered. You also may obtain forms from ERSC and on the ERSC website. You may choose to refill your prescriptions using CVS/Caremark's automated telephone service at 1-800-378-7558.

If you fill a prescription at a non-participating pharmacy, you must pay the full cost of the prescription and may file a paper claim for partial reimbursement. Reimbursement is limited to the network price (an amount that is normally less than the retail price) of the drug minus the appropriate copay. Most major pharmacies participate in the CVS/Caremark network.

Please ask your pharmacist or refer to the CVS/Caremark website to determine if your pharmacy participates with CVS/Caremark.

Diabetic Supplies—CVS/Caremark will cover diabetic supplies, including test strips, lancets, swabs, and meters. The medical plans will cover Insulin Pumps and supplies associated with the pumps under durable medical equipment provisions. Supplies are limited up to the following:

- 200 strips every 30 days
- 200 lancets every 30 days
- 200 alcohol swabs every 30 days
- Lancet device limit of 1 per 180 days

You can receive up to 600 strips, swabs, and lancets every 90 days either through a CVS pharmacy or through the CVS/Caremark Mail Service pharmacy. Diabetic supplies are considered a maintenance drug and, therefore, follow maintenance drug requirements.

Kaiser Permanente Prescription Plan

If you are enrolled in the Kaiser Permanente HMO and elect to receive prescription drug coverage, you will receive your coverage through Kaiser Permanente.

The Kaiser plan pays for prescriptions you fill at either Kaiser Medical Center pharmacies, participating Kaiser network pharmacies, or through Kaiser mail order pharmacy.

Short-term medications are those prescribed for illnesses such as colds, flu, and ear/sinus infections. You can obtain up to a 60-day supply at a Kaiser Medical Center pharmacy or a Kaiser participating network pharmacy.

Long-term maintenance medications and prescriptions taken for chronic illnesses may be obtained up to a 90-day supply via Kaiser's mail order program. Long-term maintenance medications are those prescribed for high blood pressure, arthritis, heart conditions, and diabetes.

The Kaiser plan does not pay benefits for over-the-counter cosmetics, experimental drugs, or vitamins. Prescriptions written by a dentist will be covered when written either for antibiotics or pain medications. For prescriptions that do not meet these conditions, you must contact your Kaiser physician; otherwise, you will not receive benefits for these prescriptions.

Refer to the chart below for more information about your costs for prescriptions under the plan.

	Kaiser Medical Center Pharmacy (up to 60-day supply)	Kaiser Network Pharmacy (up to 60-day supply)	Mail Order (up to 90-day supply)
Kaiser Generic	$10 copay	$15 copay	$10 copay
Kaiser Brand Name (only when no generic equivalent is available)	$10 copay	$15 copay	$10 copay

Retail Pharmacy—You can receive benefits for prescriptions you fill at any participating Kaiser Medical Center Pharmacy or any participating Kaiser network pharmacy. Simply present your Kaiser member ID card when you fill your prescription. When you fill your prescription at a Kaiser Medical Center Pharmacy, you pay the $10 copay for up to a 60-day supply for a generic drug or the $10 copay for up to a 60-day supply of a brand name drug when there is not a generic available. When you fill your prescription at a participating Kaiser network pharmacy, you can receive up to a 60-day supply of a generic drug for a copay of $15 or up to a 60-day supply of a brand name drug for a $15 copay when there is not a generic available. Major and independent pharmacies participate with Kaiser. Please visit Kaiser's website at *www.kp.org* for a complete list. The quantity limitation for medications obtained on the retail level is up to a 60-day supply.

Mail Order Service—You can use the mail order program to fill up to a 90-day supply of maintenance medications with the $10 copay for generic drugs or the $10 copay for brand name drugs when there is not a generic available. There is no cost for shipping. Refills can be made online or through your Kaiser Permanente app. You must be registered on *kp.org*. Download and use the app, or order online. To participate in the mail order program, ask your doctor for a written prescription for up to a 90-day supply of medication, plus refills as appropriate. You should fill new maintenance prescriptions at your Kaiser Medical Center Pharmacy for the first fill so that you have the opportunity to consult with a pharmacist. Allow seven business days for delivery.

Insulin has the same coverage as other prescription medications.

Life Insurance

EMPLOYEE LIFE INSURANCE

Basic Employee Term Life Insurance

New employees who are eligible for benefits automatically receive basic employee term life insurance effective the first day of the month following their hire date.* Term life insurance has no cash value.

If you do not wish to participate in the basic term life insurance program, you must decline life insurance coverage when you enroll in benefits online using the BES.

Once you decline coverage, you may enroll only during the annual Open Enrollment by providing evidence of insurability and receiving approval from the insurer.

The amount of basic term life insurance you receive is determined by rounding your annual salary to the closest thousand dollars and multiplying by two. Overtime, stipends, and non-guaranteed supplemental earnings are not included in this calculation.

For Example
An employee with a salary of $52,300 would have $104,000 of employee basic term life insurance coverage ($52,000 times 2).

You and MCPS share the cost of your basic term life insurance coverage. You pay 17 percent of the cost for coverage and MCPS pays 83 percent. MCPS pays 100 percent of the cost for basic dependent term life insurance.

Please remember to update your beneficiary information as your personal situations change. You can make beneficiary updates online during Open Enrollment, or during the plan year by completing the MCPS Form 455-20 *Employee Benefit Plan Enrollment*. (Note: The enrollment form does not update your beneficiaries for retirement/pension plans or 403(b) or 457(b) defined contribution plans.)

Accelerated Death Benefit—Your employee life insurance plans offer an accelerated death benefit. This benefit does not apply to dependent life insurance plans. The accelerated death benefit provides a payment of up to 80 percent of your employee life insurance benefit if your life expectancy is 12 months or less, and the payment can be used for any purpose. Any remaining life insurance benefits will be paid to your beneficiary(ies) after your death.

To apply for this benefit, you and the attending physician must complete and submit the two accelerated death benefit claim forms, which are available on the ERSC website. Please read the instructions carefully and forward the completed forms to ERSC.

**For 10-month employees reporting for the school year in August, coverage begins October 1.*

Optional Employee Term Life Insurance

If you are enrolled in basic employee term life insurance, you also may choose to purchase additional life insurance equal to one times your annual salary (rounded down to the nearest thousand). Employee cost for optional life insurance coverage is outlined in the life insurance rate chart which appears later in this document.

The cost of optional employee life insurance is based on your age, and you pay the full cost of coverage through payroll deduction. New employees are not required to submit evidence of insurability when selecting coverage, provided they enroll within 60 days of employment via the online BES.

If you did not elect coverage during your initial period of eligibility, you are required to provide evidence of insurability and be approved for coverage by the insurer when you enroll during the next annual Open Enrollment.

DEPENDENT TERM LIFE INSURANCE

Benefits-eligible employees who are enrolled in basic employee term life insurance also may choose two levels of life insurance for their eligible dependents: basic dependent life insurance and optional dependent life insurance. You are always the beneficiary for dependent life insurance.

If your spouse also is employed by MCPS, neither of you may elect dependent life insurance for his/her spouse.

Children no longer are eligible for dependent basic and/or optional life insurance as of September 30 following their 23rd birthday. Employees must notify ERSC when a child reaches age 23 so that they may be removed from this coverage and deductions reduced appropriately.

Under IRS regulations, you are taxed on the value of the employer-paid portion of premiums for all coverage in excess of $50,000. This taxable imputed income appears on your *e*Paystub as EXS Life.

Basic Dependent Term Life Insurance

If you are enrolled in basic employee term life insurance, you automatically receive dependent life insurance coverage for your spouse and any eligible dependent children at no additional cost as follows:

- $2,000 for your eligible spouse, and
- $1,000 for each eligible dependent child.

Optional Dependent Term Life Insurance

If you are enrolled for basic dependent life insurance, you may choose to purchase additional dependent life insurance in the amount of $10,000 for each eligible dependent. The cost of coverage is based on a flat rate, regardless of the number of dependents you enroll. You pay for the full cost of this coverage.

This coverage includes your spouse and any eligible dependent child. If your spouse also is employed by MCPS, you may not elect dependent life insurance for him/her.

Otherwise, you must wait until the next annual Open Enrollment to enroll your dependents. Dependents age 19 or older will be required to provide evidence of insurability and be approved for coverage by the insurer.

If you have a qualifying event, such as marriage or birth of a child, you must complete MCPS Form 450-2 *Optional Employee Term Life Insurance Enrollment/Cancellation*, within 60 days of the event to enroll your dependents in optional dependent life, or elect to enroll in the Optional Dependent Life coverage through the Benefit Enrollment System.

In the event of the death of an eligible dependent, employees should notify ERSC by email or phone. Claim forms will then be provided in order to process the claim with the life insurance vendor.

Flexible Spending Accounts

Flexible Spending Accounts (FSAs) provide you with a tax-saving opportunity. The *plan year* begins January 1 of the current year and continues through March 15 of the following year. The *plan year* determines the period of time you may incur expenses. The *calendar year* begins January 1 of the current year and continues through December 31 of the current year. The *calendar year* determines the period of time you make contributions. Under the FSA plan, you may set aside a portion of your salary before taxes are deducted to pay for anticipated, qualifying expenses such as day care for a child under age 13 or medical expenses not covered by an insurance plan. You have two FSA plan options:

- Dependent Care Account—Set aside up to a combined family maximum of $5,000/year, or $2,500/year if filing separately, from your salary to pay for qualified dependent care

expenses. Qualified dependent care expenses are expenses incurred for the care of children under age 13 or disabled dependents while you are working, disabled, or attending school. Qualified expenses include day care, nursery school, summer day camps, and in-home care.

- Medical Spending Account—Set aside up to $2,850 from your salary per calendar year to pay for qualified medical expenses. Qualified expenses include deductibles, copayments, expenses in excess of plan limits, and qualified costs not covered by any benefit plan. Cosmetic procedures are not qualified expenses under a medical spending account.

Benefit Strategies administers MCPS flexible spending accounts. Visit the Benefit Strategies website at *https://benstrat.navigatorsuite.com* for a complete listing of eligible expenses for dependent care and medical spending accounts.

You are eligible to enroll in the FSA plan if you are a permanent employee working at least 20 hours a week, even if you do not participate in health coverage through MCPS.

When you are newly hired, you have 60 days from your date of hire to enroll in the FSA plan via the BES. After that time, you may only enroll for the FSA plan online during the annual Open Enrollment, unless you have a qualifying event. If you experience a qualifying event, you have 60 days from the date of the event to enroll in the FSA plan using the BES. Qualifying events include marriage or divorce, addition or loss of a dependent, spouse becomes eligible for or loses medical coverage, spouse loses full-time employment or you return from leave.

You may enroll in one or both accounts subject to a $100 annual minimum per account. Elections are made one year at a time and do not carry forward from year-to-year. If you wish to participate, you must make a new FSA election each year during Open Enrollment.

You decide how much to contribute to your FSA plan on a calendar year basis. The amount you specify will be withheld from your paycheck in equal amounts on a pretax basis. When you incur a qualified expense for dependent care, you file a claim for reimbursement from your FSA plan through Benefit Strategies. Then, you are reimbursed from your FSA plan with pretax dollars.

When you contribute to a medical and/or dependent care FSA, **you will receive a Visa debit card that is good for three consecutive years if you reenroll each calendar year**. Using the Visa debit card provides immediate access to the funds in your FSA. You can use the debit card to cover the costs of certain eligible health and dependent care services so you do not have to file a claim for reimbursement.

Be sure to visit the following website to create an account with Benefit Strategies so you can submit claims and track expenses: *https://benstrat.navigatorsuite.com*

Important Reminder to Visa Debit Card Users

All expenditures are subject to audit. It is important to retain all receipts.

You are not required to use the Visa debit card for reimbursement of eligible expenses. If you prefer, you can submit a paper claim along with receipts for eligible expenses directly to Benefit Strategies for reimbursement.

When submitting for reimbursement using a claim form, mail or fax the form, Explanation of Benefits (EOB), billing statement showing the service provided, and receipt(s), to Benefit Strategies. You will be reimbursed for all eligible expenses not covered by your health plan. You can sign up for direct deposit at *https://benstrat.navigatorsuite.com*.

There are separate reimbursement forms for the medical and dependent care accounts. Reimbursement forms are available on the ERSC website. IRS regulations do not permit FSA election changes during the year unless a qualifying event such as marriage, divorce,

addition or loss of a dependent, or change of employment status occurs.

IRS regulations impose a "use or lose" rule due to the tax advantages of the FSA plan. This rule requires that any money not used by the end of the plan year is forfeited. In addition, you are not permitted to transfer funds from one account to the other. It is very important to fully understand the program and carefully estimate qualifying expenses before enrolling.

An IRS regulation provides plan participants enrolled in the medical and dependent care FSA with an additional two and one-half months to incur claims for the plan year. Qualifying medical and/or dependent care expenses incurred from January 1, 2023, through March 15, 2024, may be reimbursed from funds set aside for the 2032 calendar year.

If there is a balance in the 2023 plan year account, qualifying expenses incurred between January 1, 204, and March 15, 2024, may be reimbursed from either the 2023 or 2024 plan year account (but not from both plan years). All claim requests for reimbursement of expenses incurred during the 2023 plan year must be submitted and received by Benefit Strategies no later than April 30, 2024.

To be considered, appeals for FSA accounts must be received within 90 days following April 30—the claim filing deadline.

You cannot continue your participation in the flexible spending accounts (FSAs) while on leave. Your FSAs are cancelled as of the last deduction taken once you are on leave. You must reenroll within 60 days of returning from leave. You can incur expenses up to the date your leave begins and have until April 30 following the plan year to submit claims for reimbursement.
Please note: Returning from leave is not a qualifying event to change your election amount.

Employees who begin leave, terminate employment, or retire will be reimbursed for qualified expenses incurred prior to beginning leave and/or separation of employment with MCPS, and they must submit claim receipts for reimbursement by April 30 following the plan year. Expenses incurred after you begin leave, terminate employment, or retire are not qualified expenses.

Additional information, estimation worksheets, and reimbursement forms are available on the ERSC website.

403(b) Tax Shelter Savings and 457(b) Deferred Compensation Plans

(Defined Contribution Plans)

MCPS offers two voluntary defined contribution plans to all employees:

- 403(b) Tax Sheltered Savings Plan
- 457(b) Deferred Compensation Plan

The plans offer a means to supplement your retirement savings while reducing current taxable income. You can choose to participate in the 403(b) plan, the 457(b) plan, or both plans. You decide how much of your salary to contribute to an account in your name administered by Fidelity Investments. Contributions from your salary are made on a pretax basis through payroll deductions. The contributions are then invested in investment options that you have selected from the MCPS investment menu. You will pay income taxes on your contributions and any investment earnings when you withdraw money from your account.

You may begin participating in the Fidelity 403(b) and/or 457(b) plan(s) at any time. You can also change or stop the amount you are contributing to your 403(b)/457(b) account(s) at any time. To start an account or to modify your contribution, log in to *www.netbenefit.com/mcps* or contact Fidelity at 1-800-343-0860. Please allow one to two pay periods for your changes to be effective. If you have any questions about

your 403(b) and/or 457(b) plan(s), please contact Fidelity at 1-800-343-0860.

The rules and regulations of the plans are governed by IRS rules and the plan documents. For example, the total amount you may contribute in a calendar year is determined by limits set by the IRS. Please keep in mind the funds in your 403(b) and/or 457(b) accounts are intended for retirement, and you may not have penalty-free access to the funds until you meet one of the withdrawal requirements such as a certain age or separation of service. You may visit *www.irs.gov* and *www.netbenefits.com/mcps* for more information.

Applying for Distribution of Funds from 403(b) and/or 457(b) Accounts After Retirement

Participants enrolled in a 403(b) plan may begin withdrawals at age 59½ while still employed. If you have a 403(b), IRS penalties will apply if you separate from service and make withdrawals before age 59 ½. There are exceptions. Consult *www.irs.gov* for further information.

If you have a 457(b), you may begin penalty-free withdrawals at age 59½ while still employed or upon separation from service at any age. If 403(b) and/or 457(b) plan participants separate from service and then become re-employed by MCPS in any capacity, penalty-free withdrawals are not permitted if they are under age 59½.

403(b) and/or 457(b) benefits are taxable in the year of withdrawal. The IRS generally requires that you start taking withdrawals, Required Minimum Distributions (RMDs), from your 403(b) and/or 457(b) account(s) when you reach age 73 (72 if you turned 72 in 2022 or earlier; 70½ if you turned 70½ in 2019 or earlier) or retire. To request your withdrawal from Fidelity Investments, contact a Fidelity representative at 1-800-343-0860. If you have questions about the withdrawal process at another vendor, please contact that vendor directly. Contact information for previous vendors is available at *www.netbenefits.com/mcps*.

Important

As a plan participant, you are responsible for the review and selection of any and all investment options. You must review them carefully before making any investment decisions. Neither MCPS nor any of its employees has any liability or responsibility for investment options that you select.

Well Aware: Employee Wellness Program

MCPS offers the Well Aware employee wellness program to all benefits-eligible employees free of charge. Well Aware's mission is to establish a work environment that promotes healthy lifestyles, decreases the risk of disease, enhances quality of life, and recognizes employee health and wellness as a cultural priority in the long-term success of MCPS as a whole. This program encourages strengthening health and well-being through convenient access to educational opportunities, wellness activities, behavioral change programs, and awareness events.

Well Aware supports employees in their efforts to lead healthy lifestyles by providing discounts on health and wellbeing services, a smoking cessation program, activity challenges, and educational outreach. To learn more about Well Aware and to view a calendar of upcoming wellness events, visit the Well Aware web page by searching for "staff wellness" from any MCPS web page or go to *https://www2.montgomeryschoolsmd.org/staff/wellness/*.

Retirement Benefits

SOCIAL SECURITY

As an MCPS employee, you pay Social Security and Medicare taxes on your earnings and are eligible to qualify for benefits under the Social Security program. If you earn 40 credits (10 years of work) under the program, you will qualify for a future Social Security retirement benefit.

"Social Security: Understanding the Benefits" (Publication No. 05-10024) provides a summary of the Social Security program and includes instructions on estimating your Social Security retirement benefit. The summary is available free of charge from the Social Security Administration by calling 1-800-772-1213 or by visiting their website at *www.ssa.gov/*.

PENSION PLANS

MCPS offers comprehensive retirement benefits, including pension plans, to its retired employees. For details, please see *Understanding Your Retirement*, which is available online at *www.montgomeryschoolsmd.org/uploadedFiles/departments/ersc/employees/retirement-planning/understanding_your_retirement.pdf*.

POSTRETIREMENT HEALTH BENEFITS

MCPS employees who meet eligibility requirements may obtain health insurance benefits in retirement. Eligibility rules and cost share details are included in the *Retiree Benefit Summary* available at *www.montgomeryschoolsmd.org/uploadedFiles/retiree_benefit_summary_current.pdf*.

WELLNESS INITIATIVES

When you retire, any Wellness Initiatives program credits you earned as an active employee will not carry over into retirement. A retiring employee needs to complete their biometric health screening and health risk assessment again, as a retiree, to receive the credits for the following benefit plan year.

Ten-month employees who retire on July 1 and whose retiree benefits do not begin until October 1 will have from October 1 of the current year until the Friday before Open Enrollment begins that year to complete their biometric health screening and health risk assessment as a retiree.

Wellness Initiatives credits no longer apply if the retiring employee is Medicare-eligible at the time of retirement.

Active Employee Cost - Calendar Year 2023

Healthcare Costs

Completed Neither Health Risk Assessment nor Biometric Health Screening

Base Employee Cost Share*

Effective January 1, 2023

Medical Plans	Coverage Level	Employee Percentage	Biweekly 10-Month Employee	Biweekly 12-Month Employee
Point of Service Plans				
Cigna POS	Individual	17%	64.81	49.85
	Individual + Spouse	17%	129.61	99.70
	Individual + Child	17%	129.61	99.70
	Family (Individual + Spouse + Child(ren))	17%	176.35	135.65
	Family (Individual + Children)	17%	176.35	135.65
Health Maintenance Organization Plans				
Cigna HMO	Individual	12%	33.14	25.50
	Individual + Spouse	12%	62.30	47.92
	Individual + Child	12%	62.30	47.92
	Family (Individual + Spouse + Child(ren))	12%	102.07	78.51
	Family (Individual + Children)	12%	102.07	78.51
Kaiser Permanente HMO	Individual	12%	43.90	33.77
	Individual + Spouse	12%	87.62	67.40
	Individual + Child	12%	87.62	67.40
	Family (Individual + Spouse + Child(ren))	12%	126.96	97.66
	Family (Individual + Children)	12%	126.96	97.66

Supplemental Plans	Coverage Level	Employee Percentage	Biweekly 10-Month Employee	Biweekly 12-Month Employee
Caremark Prescription	Individual	17%	17.96	13.82
	Individual + Spouse	17%	35.89	27.61
	Individual + Child	17%	35.89	27.61
	Family (Individual + Spouse + Child(ren))	17%	44.29	34.07
	Family (Individual + Children)	17%	44.29	34.07
Kaiser Permanente Prescription	Individual	17%	8.03	6.18
	Individual + Spouse	17%	15.89	12.23
	Individual + Child	17%	15.89	12.23
	Family (Individual + Spouse + Child(ren))	17%	22.97	17.67
	Family (Individual + Children)	17%	22.97	17.67
CareFirst Dental PPO	Individual	17%	3.55	2.73
	Individual + Spouse	17%	7.10	5.46
	Individual + Child	17%	7.10	5.46
	Family (Individual + Spouse + Child(ren))	17%	10.43	8.03
	Family (Individual + Children)	17%	10.43	8.03
Aetna Dental DMO	Individual	17%	2.20	1.69
	Individual + Spouse	17%	4.40	3.38
	Individual + Child	17%	4.40	3.38
	Family (Individual + Spouse + Child(ren))	17%	6.46	4.97
	Family (Individual + Children)	17%	6.46	4.97
Davis Vision	Individual	17%	0.19	0.14
	Individual + Spouse	17%	0.34	0.26
	Individual + Child	17%	0.34	0.26
	Family (Individual + Spouse + Child(ren))	17%	0.43	0.33
	Family (Individual + Children)	17%	0.43	0.33

*Your rates may vary based on your participation in the Wellness Initiatives program. Visit the Employee Benefits web page to see all of the rate combinatic **Employee Benefits web page**

Employee Life Insurance 100% rate = $.068 per thousand of insurance per month
Based on two times current salary rounded to the nearest $1,000

Active Employee Cost - Calendar Year 2023

LEAVE RATE SCHEDULE

100% ACTIVE EMPLOYEE RATE

Effective January 1, 2023

		Component Cost	
		MONTHLY	ANNUAL
Cigna POS	Individual	635.34	7,624.08
	Individual + Spouse	1,270.64	15,247.68
	Individual + Child	1,270.64	15,247.68
	Family (Individual + Spouse + Child(ren))	1,728.87	20,746.44
	Family (Individual + Children)	1,728.87	20,746.44
Cigna HMO	Individual	460.37	5,524.44
	Individual + Spouse	865.28	10,383.36
	Individual + Child	865.28	10,383.36
	Family (Individual + Spouse + Child(ren))	1,417.62	17,011.44
	Family (Individual + Children)	1,417.62	17,011.44
Kaiser Permanente HMO	Individual	609.76	7,317.12
	Individual + Spouse	1,216.91	14,602.92
	Individual + Child	1,216.91	14,602.92
	Family (Individual + Spouse + Child(ren))	1,763.32	21,159.84
	Family (Individual + Children)	1,763.32	21,159.84
Caremark Prescription	Individual	176.12	2,113.44
	Individual + Spouse	351.87	4,222.44
	Individual + Child	351.87	4,222.44
	Family (Individual + Spouse + Child(ren))	434.22	5,210.64
	Family (Individual + Children)	434.22	5,210.64
Kaiser Permanente Prescription	Individual	78.69	944.28
	Individual + Spouse	155.78	1,869.36
	Individual + Child	155.78	1,869.36
	Family (Individual + Spouse + Child(ren))	225.16	2,701.92
	Family (Individual + Children)	225.16	2,701.92
CareFirst PPO Dental	Individual	34.80	417.60
	Individual + Spouse	69.64	835.68
	Individual + Child	69.64	835.68
	Family (Individual + Spouse + Child(ren))	102.30	1,227.60
	Family (Individual + Children)	102.30	1,227.60
Aetna DMO Dental	Individual	21.55	258.60
	Individual + Spouse	43.12	517.44
	Individual + Child	43.12	517.44
	Family (Individual + Spouse + Child(ren))	63.28	759.36
	Family (Individual + Children)	63.28	759.36
Davis Vision	Individual	1.85	22.20
	Individual + Spouse	3.40	40.80
	Individual + Child	3.40	40.80
	Family (Individual + Spouse + Child(ren))	4.31	51.72
	Family (Individual + Children)	4.31	51.72

Active Employee Cost - Calendar Year 2023

Optional Term Life Insurance (Employee and Dependent)

Effective January 1, 2023

Optional Employee Term Life Insurance		
Eligible employees enrolled for basic term life insurance are entitled to purchase additonal one times their salary (rounded down to the nearest thousand) in life insurance. The cost of optional life insurance is based on age and is paid entirely by the employee through payroll deductions.		
Age Bracket	**Bi-weekly Employee Deductions (per thousand of coverage)**	
	10-month	**12-month**
Under 25	0.014	0.011
25 - 29	0.017	0.013
30 - 34	0.019	0.015
35 - 39	0.023	0.018
40 - 44	0.026	0.020
45 - 49	0.040	0.031
50 - 54	0.057	0.044
55 - 59	0.111	0.085
60 - 64	0.168	0.129
65 - 69	0.325	0.250
70 and over	0.530	0.408
SAMPLE CALCULATION: Optional Term Life Insurance Coverage rates for a 37 year-old, 10-month employee who earns $46,000 a year.		
Coverage Amount (one times the annual salary)		$46,000.00
Thousands of Coverage		46
Bi-weekly Cost = 46 x .023		$1.06

Optional Dependent Term Life Insurance	
You must be enrolled in Basic Employee Term Life coverage to elect Optional Dependent Term Life coverage. Coverage for qualified dependent children will continue until September 30 following their 23rd birthday.	
Coverage Amount for each qualified dependent spouse and/or dependent child(ren)	$10,000.00
Bi-weekly payroll deduction for 12-month employees	$1.15
Bi-weekly payroll deduction for 10-month employees	$1.50

Websites and Telephone Numbers

Employee and Retiree Service Center
301-517-8100
www.montgomeryschoolsmd.org/departments/ersc

MCPS Help Desk (to reset MCPS ID/password)
301-517-5800

Office of Human Resources and Development
301-279-3204
www.montgomeryschoolsmd.org/departments/personnel

Aetna Dental Plan (DMO)
1-800-843-3661
www.aetna.com

American Fidelity
1-800-662-1113
https://americanfidelity.com/

Benefit Strategies COBRA
1-888-401-3539
www.benstrat.com

Benefit Strategies Flexible Spending Accounts
1-888-401-3539
https://benstrat.navigatorsuite.com

Cigna Open Access Plus POS Plan
Cigna Open Access Plus In-Network HMO Plan
Cigna Indemnity Plan
1-800-Cigna24
www.MyCigna.com

CareFirst Preferred Dental (PPO)
In-network: 1-888-755-2657
www.carefirst.com/mcps

CVS Caremark Prescription Plan
1-800-378-7558
www.caremark.com

Davis Vision/Blue Vision Plus
(provided through CareFirst)
1-800-783-5602
www.carefirst.com/mcps

Kaiser Permanente HMO and Prescription Plans
1-800-777-7902
www.kp.org

Maryland State Retirement Agency
1-800-492-5909
https://sra.maryland.gov/

Maryland State Retirement Agency—Local Member Services
410-625-5555

MCAAP (Administrators Union)
301-762-8174

MCBOA (Non-certified Supervisors Union)
301-762-8174

MCEA (Teachers Union)
301-294-6232
www.mceanea.org

MCPS 403(b)/457(b) Plans
Fidelity Investments
1-800-343-0860
www.netbenefits.com/mcps

MetLife
1-800-638-6420
www.metlife.com/mybenefits

SEIU Local 500
301-740-7100
www.seiu500.org

MCPS NONDISCRIMINATION STATEMENT

Montgomery County Public Schools (MCPS) prohibits illegal discrimination based on race, ethnicity, color, ancestry, national origin, nationality, religion, immigration status, sex, gender, gender identity, gender expression, sexual orientation, family structure/parental status, marital status, age, ability (cognitive, social/emotional, and physical), poverty and socioeconomic status, language, or other legally or constitutionally protected attributes or affiliations. Discrimination undermines our community's long-standing efforts to create, foster, and promote equity, inclusion, and acceptance for all. The Board prohibits the use of language and/or the display of images and symbols that promote hate and can be reasonably expected to cause substantial disruption to school or district operations or activities. For more information, please review Montgomery County Board of Education Policy ACA, *Nondiscrimination, Equity, and Cultural Proficiency*. This Policy affirms the Board's belief that each and every student matters, and in particular, that educational outcomes should never be predictable by any individual's actual or perceived personal characteristics. The Policy also recognizes that equity requires proactive steps to identify and redress implicit biases, practices that have an unjustified disparate impact, and structural and institutional barriers that impede equality of educational or employment opportunities. MCPS also provides equal access to the Boy/Girl Scouts and other designated youth groups.**

For inquiries or complaints about discrimination against MCPS students*	**For inquiries or complaints about discrimination against MCPS staff***
Director of Student Welfare and Compliance Office of District Operations Student Welfare and Compliance 850 Hungerford Drive, Room 55, Rockville, MD 20850 240-740-3215 SWC@mcpsmd.org	Human Resource Compliance Officer Office of Human Resources and Development Department of Compliance and Investigations 45 West Gude Drive, Suite 2100, Rockville, MD 20850 240-740-2888 DCI@mcpsmd.org
For student requests for accommodations under *Section 504 of the Rehabilitation Act of 1973*	**For staff requests for accommodations under the *Americans with Disabilities Act***
Section 504 Coordinator Office of Academic Officer Resolution and Compliance Unit 850 Hungerford Drive, Room 208, Rockville, MD 20850 240-740-3230 RACU@mcpsmd.org	ADA Compliance Coordinator Office of Human Resources and Development Department of Compliance and Investigations 45 West Gude Drive, Suite 2100, Rockville, MD 20850 240-740-2888 DCI@mcpsmd.org
For inquiries or complaints about sex discrimination under Title IX, including sexual harassment, against students or staff*	
Title IX Coordinator Office of District Operations Student Welfare and Compliance 850 Hungerford Drive, Room 55, Rockville, MD 20850 240-740-3215 TitleIX@mcpsmd.org	

**Discrimination complaints may be filed with other agencies, such as the following: U.S. Equal Employment Opportunity Commission (EEOC), Baltimore Field Office, GH Fallon Federal Building, 31 Hopkins Plaza, Suite 1432, Baltimore, MD 21201, 1-800-669-4000, 1-800-669-6820 (TTY); Maryland Commission on Civil Rights (MCCR), William Donald Schaefer Tower, 6 Saint Paul Street, Suite 900, Baltimore, MD 21202, 410-767-8600, 1-800-637-6247, mccr@maryland.gov; or U.S. Department of Education, Office for Civil Rights (OCR), The Wanamaker Building, 100 Penn Square East, Suite 515, Philadelphia, PA 19107, 1-800-421-3481, 1-800-877-8339 (TDD), OCR@ed.gov, or www2.ed.gov/about/offices/list/ocr/complaintintro.html.*

***This notification complies with the federal Elementary and Secondary Education Act, as amended.*

This document is available, upon request, in languages other than English and in an alternate format under the *Americans with Disabilities Act*, by contacting the MCPS Office of Communications at 240-740-2837, 1-800-735-2258 (Maryland Relay), or PIO@mcpsmd.org. Individuals who need sign language interpretation or cued speech transliteration may contact the MCPS Office of Interpreting Services at 240-740-1800, 301-637-2958 (VP) mcpsinterpretingservices@mcpsmd.org, or MCPSInterpretingServices@mcpsmd.org.

Maryland's Largest School District

MONTGOMERY COUNTY PUBLIC SCHOOLS

Published by the Department of Materials Management for the Employee and Retiree Service Center
0197.23 • Editorial, Graphics & Publishing Services • 9.22 •1,500