



2014 Employee Benefit Summary

EFFECTIVE JANUARY 1, 2014

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





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*

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

Montgomery County Public Schools

2014 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, 2014. This summary includes information about eligibility for MCPS benefits, a list of benefit costs, important contact information, and instructions for accessing enrollment forms online.

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. Information available on the website includes summary plan and evidence of coverage documents. Provider handbooks are available from ERSC. ERSC staff members are available to assist you Monday through Friday. You may contact ERSC directly at:

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 within 60 days following employment or wait for a future Open Enrollment, typically held in October, with coverage effective January 1 of the following year. You must complete MCPS Form 455-20: *Employee Benefit Plan Enrollment*, to join the employee benefit plan. This enrollment form also is used to make changes during the annual Open Enrollment for active employees, changes due to a qualifying event, and changes for employees returning from leave. This form also is used to designate and change beneficiaries for basic employee term life insurance.

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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.

If you are covered under your parent's MCPS employee benefit plan and are subsequently employed by MCPS in a benefits-eligible position, you cannot continue coverage as a dependent on your parent's benefit plan. If you fail to elect your own benefits coverage in the time allotted for new employees, MCPS will automatically unenroll you from your parent's benefit plan. MCPS then will enroll you in the same benefits coverage you previously held.

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 coverage in which you are enrolled.

Eligible dependents include your—

- spouse,
- qualified same sex domestic partner, and
- eligible children meeting the following age requirements:
 - until the end of the month in which they turn 26 for medical and prescription coverage
 - until September 30 following their 23rd birthday for dental, vision, and dependent life insurance coverage

The documentation you submit to show eligibility of a spouse, qualified same sex domestic partner, 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)

Qualified Same Sex Domestic Partner:

- Social Security number and
- signed and notarized MCPS affidavit (available on ERSC website) plus additional documentation as required by the affidavit

Newborn or Biological Children:

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

Children of same sex domestic partner:

- Social Security number and
- valid birth certificate or valid birth registration and one of the following—
 - official adoption documents
 - shared or joint custody agreement (court validated)

Stepchildren:

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

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)

Continuation of Coverage for 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, vision, and 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 mental retardation or physical handicap, or he or she became disabled, and
- the disability occurred before he or she reached age 19.

Coverage will continue as long as the disabled child is incapacitated and dependent unless coverage is otherwise terminated in accordance with the terms of the plan. 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 provider examines the child. The plan administrator may ask for proof that the child continues to meet these conditions of incapacity and dependency. 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 September 30 following his/her 23rd birthday for dental, vision, and life insurance. Medical and prescription coverage will end at the end of the month in which he/she turns age 26.

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

It is your responsibility to notify MCPS of the child's incapacity and dependency to be considered for continuous coverage. Forms for incapacitated/disabled dependent children are

available from ERSC. 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 within 60 days of initial employment or wait until a future Open Enrollment. Coverage begins on the first day of the month following the month that you enroll, provided ERSC receives your enrollment form by the 20th day of the month. If the 20th of the month falls on a weekend or holiday, the deadline to submit your enrollment form is the last business day before the 20th.

If ERSC receives your enrollment form after the 20th day of the month, your benefits coverage begins on the first day of the second month following receipt of your enrollment form. 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 enrollment form:	Your coverage will begin on:
On or before January 20	February 1
Between January 21 and February 18	March 1
On February 22	April 1

Special Rule for 10-Month Employees

If you are a 10-month employee reporting at the beginning of a school year, your coverage begins October 1 if ERSC receives your enrollment form by September 20. If ERSC receives your enrollment form between September 21 and September 30, your coverage begins November 1. You must enroll within 60 days of initial employment.

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

When you enroll a dependent in your plan, you are required to complete MCPS Form 455-20: *Employee Benefit Plan Enrollment*, and to provide supporting documentation.

Refer to the chart below for information about important deadlines and documentation you are required to submit.

ENROLLING NEW DEPENDENTS

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

Qualifying Event	Forms Required	Deadline to Add
Newborn/adopted child	MCPS Form 455-20 Social Security number* Birth certificate/registration* or Legal court documentation	60 days from the date of birth or adoption
Legal guardianship/custody	MCPS Form 455-20 Social Security number* Legal court documentation	60 days from the court award of legal guardianship
Spouse	MCPS Form 455-20 Social Security number Marriage certificate	60 days from the date of marriage

** 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 a Social Security number and birth certificate or birth registration in a timely manner will result in termination of coverage.*

Coverage for your new 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.

or holiday), coverage for your new dependent will begin on the first day of the following month. If ERSC receives the forms after the 20th of the month, coverage for your new dependent will start on the first day of the second month.

If ERSC receives all required forms by the 20th of the month (or the last business day before the 20th of the month if the 20th falls on a weekend

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 for coverage.

CHANGES IN COVERAGE

In general, you are not permitted to make changes to your coverage during the plan year. Changes are permitted only during the annual Open Enrollment or if you experience a qualifying life or work event during the year.

Qualifying life or work events include:

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

Changes due to qualifying life or work events may be made during the plan year, as described in the section **Enrolling New Dependents**. If you experience a qualifying life or work event, you have 60 days from the date of the qualifying event to submit the necessary enrollment forms to ERSC. You must use MCPS Form 455-20: *Employee Benefit Plan Enrollment*, to change your benefit plan enrollment, and you must attach all necessary documentation to the enrollment form at the time you submit your form. If you fail to submit all required information with MCPS Form 455-20, your form will be rejected and returned to you.

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

It is your responsibility to notify ERSC of all changes.

You may drop a dependent or cancel your entire coverage at any time by completing MCPS Form 455-20: *Employee Benefit Plan Enrollment*. However, you may not cancel individual components of your benefit plan. If you choose to cancel coverage, you must cancel the entire employee benefit plan—with the exception of life insurance coverage(s). It is recommended that you notify ERSC promptly because removing a dependent could change your coverage level and reduce your cost.

If ERSC receives all required forms by the 20th of the month (or the last business day before the 20th of the month if the 20th falls on a weekend or holiday), changes to 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.

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 ePaystub.

- 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 your health coverage costs for 2014.

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.

Benefits coverage for a dependent child automatically ends at the end of the month in

which he/she turns age 26 for medical and prescription plans. Benefits coverage for a dependent child's dental, vision, and dependent life insurance plans automatically ends on September 30 following the dependent child's 23rd birthday. You must complete MCPS Form 455-20: *Employee Benefit Plan Enrollment*, to remove your dependent from benefits coverage if your child becomes benefits-eligible on his/her own with MCPS.

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, your coverage continues through September 30 because you have prepaid for benefits through the summer.

CONTINUATION OF BENEFITS

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 in the appropriate box on MCPS Form 455-20: *Employee Benefit Plan Enrollment*. 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 return to work at a later date, you must contact ERSC and provide a completed MCPS Form 455-20: *Employee Benefit Plan Enrollment*, within 60 days of returning to active work status if you wish to reenroll for benefits coverage. You must reenroll 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 by completing MCPS Form 455-20: *Employee Benefit Plan Enrollment*, and providing the appropriate documentation.

You cannot continue your participation in the flexible spending accounts (FSAs) while on leave. Your FSAs are cancelled at the end of the month your leave begins, 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.

Please note: Returning from leave is not a qualifying event to change your election amount.

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 any dependents age 19 or older must provide evidence of insurability and be approved by the Prudential Life Insurance Company. ERSC staff will initiate the evidence of insurability process after receiving your enrollment forms, which are available on the ERSC website.

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. Your dependents must contact the medical plan for authorization before receiving out-of-area medical care and the plan may deny out-of-area care. Refer to the applicable HMO summary plan document for details.

If you are enrolled in the CareFirst BlueChoice HMO, you have access to the Away From Home

Care (AFHC) Program that provides benefits for participants residing outside of the HMO home service area for 90 days or more. Some areas of the country do not participate in the AFHC Program. Members must reapply to the Program every year. To take advantage of the AFHC Program or to reapply, you should contact CareFirst BlueChoice at 1-888-452-6403 for more information and enrollment procedures.

If you are enrolled in the CareFirst BlueChoice Open Point-of-Service (POS) plan, you have access to a regional network of doctors and facilities. In the event that you and/or your dependents seek care where CareFirst BlueChoice does not have participating doctors or facilities, the plan provides out-of-network benefits.

If you are enrolled in a Cigna Open Access Plus (POS) plan or the Cigna Open Access Plus In Network (HMO) plan, you have access to a national network of doctors and facilities. In the event that you and/or your dependents seek care, the plans provide in-network benefits. Out-of-network benefits are available only to Cigna Open Access Plus (POS) plan members. Please consult the POS Plan chart for further details.

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 follows the biological parent.

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.

Accessing Benefits Forms

Forms to enroll in benefits, make changes, and file claims are available online. Most forms are available in Adobe Portable Document Format (PDF) and require Adobe Reader 8 or higher to download.

Employees can access benefits forms on the MCPS and ERSC websites by:

- Searching the MCPS website
- Searching the MCPS Forms Directory
- Using the ERSC Forms page
- Clicking on direct links

SEARCHING THE MCPS WEBSITE

The MCPS website offers a search box in the upper right corner of every MCPS web page. Enter a form name, number, or appropriate keyword in this search box, and you will see a list of results to match your search. Navigate to the form you need from the search results.

SEARCHING THE MCPS FORMS DIRECTORY

All MCPS forms are available on the MCPS Forms Directory web page at www.montgomeryschoolsmd.org/departments/forms/. Enter a form name, number, or appropriate keyword in the search box on this page. You then will see a list of results that match your search. Navigate to the form you need from the search results.

USING THE ERSC FORMS WEB PAGE

Some benefits forms are provided courtesy of your insurance provider or other benefits vendor. For your convenience, ERSC maintains a Forms web page where links to all benefits forms are compiled. You can browse for forms by benefit type. For example, a Cigna claim form would be

located in the “Health Benefits” section under “Medical Forms.”

DIRECT LINKS

The following are direct links to your benefit enrollment forms. Additional forms can be found on the MCPS and ERSC websites using the search methods described.

- MCPS Form 455-20: *Employee Benefit Plan Enrollment*—
www.montgomeryschoolsmd.org/departments/forms/455-20.shtm
- MCPS Form 450-3: *Flexible Spending Account Calendar Year 2014 Election*
- MCPS Form 450-1: *Optional Employee Term Life Insurance: Enrollment/Cancellation*—
www.montgomeryschoolsmd.org/departments/forms/450-1.shtm
- MCPS Form 450-2: *Optional Dependent Life Insurance: Enrollment/Cancellation*—
www.montgomeryschoolsmd.org/departments/forms/450-2.shtm

SUBMITTING BENEFITS FORMS

All forms must be submitted to ERSC. Forms can be submitted in the following ways:

- E-mail: 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 a form via e-mail, please note that you must submit an electronically signed Adobe PDF file. You also may scan a copy of your form with your original signature and attach it to an e-mail.

Your Benefits at a Glance

The chart below is a brief overview of your benefit options for 2014. 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	<ul style="list-style-type: none"> CareFirst BlueChoice—Open POS Cigna Open Access Plus—Open (POS) Cigna Open Access Plus—Closed (POS) <p>(open to employees hired before January 1, 1994 only)</p>
Health Maintenance Organizations (HMO) Health Plans	<ul style="list-style-type: none"> CareFirst BlueChoice HMO Cigna Open Access Plus In Network (HMO) Kaiser Permanente HMO
Prescription Drug	<ul style="list-style-type: none"> CVS Caremark Prescription Drug (not available to Kaiser Permanente plan participants) Kaiser Permanente Prescription Drug (only available to Kaiser Permanente plan participants)
Dental	<ul style="list-style-type: none"> Aetna Dental Preferred Provider Organization (PPO) Aetna Dental Maintenance Organization (DMO)
Vision	<ul style="list-style-type: none"> National Vision Administrators, LLC
Protecting Your Income	
Flexible Spending Accounts	<ul style="list-style-type: none"> Medical spending account (up to \$2,500/year—MCPS matches the first \$100 you contribute) Dependent care account (up to \$5,000/year or \$2,500/year if married, filing separately)
Basic Term Life Insurance	<ul style="list-style-type: none"> Employee (90 percent paid by MCPS)—2 times annual salary Dependent (paid by MCPS)—\$2,000/spouse, \$1,000/each eligible dependent child
Optional Life Insurance	<ul style="list-style-type: none"> Employee—1 times annual salary (paid by employee) Dependent—\$10,000/spouse or each eligible dependent child (paid by employee)
Long-Term Care Insurance	Elect coverage through Prudential Life Insurance Company of America (paid by employee)
Protecting Your Future	
Defined Contribution Plans	
403(b) Tax Shelter Savings Plan	Elect a percentage or flat amount of your salary to contribute to each account, up to annual IRS limits (available at www.mcps.yourplan.info/)
457(b) Deferred Compensation Plan	
Defined Benefit Pension Plans	By completing the appropriate forms, you are enrolled in state and/or county-sponsored pension plans.

Medical Coverage

You may choose one of the following medical plan options:

Point-of-Service (POS) options:

- CareFirst BlueChoice POS
- Cigna Open Access Plus—Open (POS)
- Cigna Open Access Plus—Closed (POS) **(available to employees hired before January 1, 1994, only)**

Health Maintenance Organization (HMO) options:

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

POINT-OF-SERVICE PLANS

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.

CareFirst BlueChoice Open POS

MCPS offers this POS plan to employees and their eligible dependents through CareFirst BlueChoice.

When you enroll in the CareFirst BlueChoice Open POS plan, you must select a primary care physician (PCP) who will direct your care. You can contact CareFirst BlueChoice directly to select a PCP from a list of participating doctors in the BlueChoice provider directory by phone at 1-800-545-6199 or online at www.carefirst.com. You may change your PCP once you are enrolled in the plan by registering through the CareFirst BlueChoice website at www.carefirst.com.

This plan offers open access that allows you to see any in-network physician or specialist without a referral. If you receive care from an in-network specialist, benefits will be paid according to the in-network schedule of benefits outlined later in this document. If you choose to go out-of-network for medical care, you will receive benefits under the out-of-network schedule of benefits.

A percentage of out-of-network benefits are paid after you meet an annual deductible of \$300 for individual coverage or \$600 for family coverage. Benefits are generally paid at 80 percent of Allowed Benefit, depending on the type of service provided. The plan pays 100 percent of Allowed Benefit after you reach a \$1,000 out-of-pocket maximum per person. The out-of-pocket maximum excludes the deductible and the cost of services above the Allowed Benefit. Some services, such as preventive care, are not covered out-of-network and are covered only when performed by an in-network physician.

You decide whether to stay in-network or use an out-of-network physician each time you receive medical care. Out-of-pocket expenses will vary depending on the types of services rendered. Away From Home Care* may be of interest to you or your covered family members out of the service area for an extended period of time.

Diabetic supplies are covered under your prescription drug benefit administered by CVS Caremark.

**Away From Home Care (AFHC) is an out-of-area program that provides benefits for CareFirst BlueChoice plan participants residing outside of their home network service area for 90 days or more. Some areas of the country do not participate in the AFHC program. Members must reapply to the program every year. To take advantage of the AFHC program or to reapply, members should contact CareFirst BlueChoice at 1-800-452-6403 for more information and enrollment procedures.*

Cigna Open Access Plus—Open (POS)

MCPS offers this POS plan to employees and their eligible dependents through Cigna.

Cigna Open Access Plus is designed to provide the highest quality healthcare while maintaining your freedom to choose from a wide selection of personal physicians. You have the option to choose a primary care physician (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 for these plans 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 Open Access Plus network, your benefit coverage will be a greater level than opting to receive services outside the network.

Cigna Open Access Plus 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 pre-admission 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.

Cigna Open Access Plus—Closed (POS)

This option is open to employees hired before January 1, 1994, only.

Details about this plan can be found in the Evidence of Coverage document on the ERSC website.

HEALTH MAINTENANCE ORGANIZATIONS

A health maintenance organization (HMO) plan offers a full range of services provided or authorized 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.

CareFirst BlueChoice HMO

CareFirst BlueChoice is an individual practice HMO where you select a PCP from a list of participating doctors in the CareFirst BlueChoice provider directory or online at www.carefirst.com. Your PCP will provide medical care and may refer you to a network specialist, as necessary. However, the plan is an open access plan, and referrals are not necessary to see an in-network specialist. Referrals are necessary for certain coverage such as laboratory and X-ray services. Each covered family member may select a different PCP. You must select your PCP prior to your first appointment by contacting CareFirst BlueChoice directly online or by phone at 1-800-545-6199.

Diabetic supplies are covered under the prescription drug benefit administered by CVS/Caremark. Specialty care benefits are covered as follows:

- Chiropractic Manipulation: 20 visits/year, \$20 co-pay/visit
- Diabetic Education/Training: \$20 co-pay (benefits are paid at 100 percent of the allowed amount)
- Physical, Speech, and Occupational Therapy: 30 visits/year, \$20 co-pay/visit
- Away From Home Care*

**Away From Home Care (AFHC) is an out-of-area program that provides benefits for CareFirst BlueChoice plan participants residing outside of their home network service area for 90 days or more. Some areas of the country do not participate in the AFHC program. Members must reapply to the program every year. To take advantage of the AFHC program or to reapply, members should contact CareFirst BlueChoice at 1-888-452-6403 for more information and enrollment procedures.*

Cigna Open Access Plus In Network (HMO)

The Cigna Open Access Plus In Network 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 choose a primary care physician (PCP) to coordinate your care, and pay only a co-payment for most services. You do not have to complete a claim form.

Diabetic supplies are covered under the prescription drug benefit administered by CVS Caremark. Specialty care benefits are covered as follows:

- Chiropractic Manipulation: 20 visits/year, \$15 co-pay/visit
- Diabetic Education/Training: \$15 co-pay (benefits are paid at 100 percent of the allowed amount)
- Physical, Speech, and Occupational Therapy: 30 visits/year, \$15 co-pay/visit

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 is a center-based HMO with approximately 30 medical centers in the MCPS service area. You may receive information about locations at www.kp.org or from the provider directory. 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.

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 co-pays 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 co-pays outlined in the HMO and POS comparison charts on the following pages. Out-of-network coverage remains unchanged, and co-pays are listed in the POS comparison chart later in this document.

Preventive Services Covered with Zero Co-Pay for Adults (regardless of your medical plan choice)

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: <ul style="list-style-type: none"> • 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

Preventive Services Covered with Zero Co-Pay for Women (regardless of your medical plan choice)

Preventive Service Covered	Who is Eligible, Additional Details
Annual well-women 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: <ul style="list-style-type: none"> • 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 	all women
(OTC) Over the Counter (P) Prescription Required	
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 Papilloma Virus (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

*Note: 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 Co-Pay for Children (regardless of your medical plan choice)

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: <ul style="list-style-type: none"> • 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

Health Maintenance Organization (HMO) Plans	Kaiser Permanente HMO	Cigna Open Access Plus In Network Select (HMO)	CareFirst BlueChoice HMO
Annual Deductible	None	None	None
Preventive Care			
Routine Physical Exam	Covered in full	\$10 co-pay*	\$10 co-pay*
Well Baby/Child Care	Covered in full (under age 5)	\$10 co-pay*	\$10 co-pay*
Childhood Immunizations	Covered in full (under age 5)	\$10 co-pay*	\$10 co-pay*
Physician Services			
Physician Office Visit	\$10 co-pay	\$10 co-pay	\$10 co-pay
Specialist Office Visit	\$15 co-pay	\$15 co-pay	\$15 co-pay
Lab Work and X-rays	Covered in full	Covered in full	Covered in full
Allergy Shots	\$10 co-pay	\$10 PCP co-pay \$15 specialist co-pay	\$10 co-pay (\$20 co-pay for specialist)
Maternity Care			
Prenatal and Postnatal Care	\$10 co-pay, no charge once pregnancy is confirmed*	\$10 PCP co-pay; no charge once pregnancy is confirmed*	\$20 co-pay; no charge once pregnancy is confirmed*
Physician Services	Covered in full	Covered in full	Covered in full
Hospital Services	Covered in full	Covered in full	Covered in full
Emergency Services (when medically necessary)			
Urgent Care Centers	\$15 co-pay	\$20 co-pay	\$15 co-pay
Emergency Room	\$100 co-pay (waived if admitted)	\$100 per visit (co-pay waived if admitted)	\$100 co-pay (waived if admitted)
Emergency Physician Services	Covered in full	Covered in full	Covered in full
Emergency Ambulance	Covered in full if authorized	Covered in full	Covered in full
Hospital Services—Inpatient			
Semi-Private Room	Covered in full	Covered in full	Covered in full
Professional Services	Covered in full	Covered in full	Covered in full
Surgical Procedures	\$15 co-pay	Covered in full	Covered in full
Specialty Care/ Consultation	Covered in full	Covered in full	Covered in full
Anesthesia	Covered in full	Covered in full	Covered in full
Radiology and Drugs	Covered in full	Covered in full	Covered in full
Intensive Care	Covered in full	Covered in full	Covered in full
Coronary Care	Covered in full	Covered in full	Covered in full
Hospital Services—Outpatient			
Surgical Procedures	\$15 co-pay	\$25 per facility visit co-pay	Covered in full
Professional Fees	Covered in full	Covered in full	\$20 co-pay
Mental Health/Substance Abuse Services			
Inpatient Days	Covered in full	Covered in full	Covered in full
Outpatient Visits	\$10 co-pay	\$10 co-pay	\$10 co-pay
Other Services			
Catastrophic Illness	Covered in full	Covered in full	Covered in full
Durable Medical Equipment	Covered in full	You pay 25%**	You pay 25%*
Home Health Care	Covered in full	Covered in full up to 60 visits	Covered in full
Hospice Care	Covered in full	Covered in full	Covered in full
Skilled Nursing Care	Covered in full up to 100 days per contract year	Covered in full up to 60 days	Covered in full

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

**Does not include diabetic supplies such as lancets, glucose strips, etc. See CVS Caremark Prescription for details.

Open Point of Service (POS) Plans	CareFirst BlueChoice POS		Cigna Open Access Plus (POS)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible	None	\$300 individual, \$600 family	None	\$300 individual, \$600 family
Preventive Care				
Routine Physical Exam	\$15 co-pay*	Not covered	\$15 co-pay	Not covered
Well Baby/Child Care	\$15 co-pay*	80%, no deductible	\$15 co-pay	80% after deductible
Childhood Immunizations	Covered in full	80%, no deductible	Covered in full	80%, no deductible
Physician Services				
Physician Office Visit	\$15 co-pay	80% after deductible	\$15 co-pay	80% after deductible
Specialist Office Visit	\$20 co-pay	80% after deductible	\$20 co-pay	80% after deductible
Lab Work and X-rays	Covered in full	Diagnostic: 80% after deductible Routine: not covered	Covered in full	Diagnostic: 80% after deductible Routine: not covered
Allergy Evaluations	\$15 co-pay each visit	80% after deductible	\$15 PCP or \$20 specialist co-pay	80% after deductible
Allergy Shots	Covered in full	80% after deductible	Covered in full	80% after deductible
Maternity Care				
Prenatal and Postnatal Care	\$20 co-pay first visit, covered in full after*	80% after deductible	\$15 co-pay first visit, covered in full after*	80% after deductible
Physician Services	Covered in full	80% after deductible	Covered in full	80% after deductible
Hospital Services	Covered in full	80% after deductible	Covered in full	80% after deductible
Emergency Services (when medically necessary)				
Urgent Care Centers	\$15 co-pay	80% no deductible	\$15 per visit	80% no deductible
Emergency Room	\$100 co-pay, waived if admitted	\$100 co-pay, waived if admitted	\$100 per visit (co-pay waived if admitted)	\$100 per visit (co-pay waived if admitted)
Emergency Physician Services	Covered in full	Covered in full	Covered in full	Covered in full
Emergency Ambulance	Covered in full	Covered in full	Covered in full	Covered in full
Hospital Services—Inpatient				
Semi-Private Room	Covered in full	80% after deductible up to 180 days	Covered in full	80% after deductible up to 180 days
Professional Services	Covered in full	80% after deductible	Covered in full	80% after deductible
Surgical Procedures	Covered in full	80% after deductible	Covered in full	80% after deductible
Specialty Care/ Consultation	Covered in full	80% after deductible	Covered in full	80% after deductible
Anesthesia	Covered in full	80% after deductible	Covered in full	80% after deductible
Radiology and Drugs	Covered in full	80% after deductible	Covered in full	80% after deductible
Intensive Care	Covered in full	80% after deductible	Covered in full	80% after deductible
Coronary Care	Covered in full	80% after deductible	Covered in full	80% after deductible
Hospital Services – Outpatient				
Surgical Procedures	\$20 co-pay	80% after deductible	\$20 co-pay	80% after deductible
Professional Fees	Covered in full	80% after deductible	Covered in full	80% after deductible
Mental Health/Substance Abuse Services				
Inpatient Days	Covered in full	80% after deductible (up to 180 days)	Covered in full	80% after deductible up to 180 days
Outpatient Visits	\$20 co-pay	80% after deductible	\$15 co-pay	80% after deductible
Other Services				
Catastrophic Illness	Covered in full	Covered in full after \$1,000 out-of-pocket expenses (excludes deductible)	Covered in full	Covered in full after \$1,000 out-of-pocket expenses (excludes deductible)
Durable Medical Equip.**	Covered in full	80% after deductible	Covered in full	80% after deductible
Home Health Care/ Skilled Nursing Care	Covered in full	80% after deductible	Covered in full	80% after deductible
	(up to 90 visits in- and out-of-network)		(up to 60 visits in- and out-of-network)	
Hospice Care	Covered in full	80% after deductible	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. See CVS Caremark Prescription for details.

Please Note: All percentages shown for out-of-network service are up to the usual, customary, and reasonable (UCR) charge or eligible expenses, as determined by Cigna Open Access Plus, or allowed benefit, as determined by CareFirst BlueChoice. The description of benefits and services is only a summary. For complete information, please refer to the evidence of coverage on the ERSC website.

Other Benefit Plan Coverage

In addition to medical coverage, you also may choose dental, vision, and prescription drug coverage when you enroll (refer to the appropriate section in this document for additional information). Rates for the 2014 plan year are included in this document.

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)]. Forms are available on the ERSC website. To change your defined contribution plan beneficiaries, contact your vendor directly.

Important Notice

New employees eligible for benefits automatically are enrolled in the basic term life insurance plan. You will need to designate a beneficiary for basic life insurance using MCPS Form 455-20: *Employee Benefit Plan Enrollment*. If you wish to decline basic term life insurance coverage, you must complete Section V of MCPS Form 455-20 and elect "decline" life insurance coverage. See the Life Insurance section of this document for additional details on this benefit, as well as Optional Employee Life and Optional Dependent Life Insurance. You may update your life insurance beneficiaries at any time. It is important that you update beneficiary designations as your circumstances change.

Dental Coverage

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

- Aetna Dental Preferred Provider Organization (PPO) or
- Aetna Dental Maintenance Organization (DMO).

You may change dental plans only during Open Enrollment.

DENTAL PREFERRED PROVIDER ORGANIZATION (PPO)

If you enroll in the Aetna Dental PPO, you have the freedom to select the dentist of your choice. You can access provider information by calling 1-800-282-0555 or visiting Aetna's website at www.aetna.com/docfind. Generally, 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, co-pays, 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. There is no orthodontic coverage for retirees or their dependents. 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).

You must submit an Aetna dental claim form for reimbursement for PPO claims incurred with a non-participating provider. The claim form is available on the ERSC website. The annual maximum benefit per covered participant is \$2,000.

Refer to the dental benefits chart for more information about your dental benefits.

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. There is no orthodontic coverage for retirees or their dependents. 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 following chart for more information about your dental options.

Dental Benefits	Aetna 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	None	None	None
Class II	\$50	\$100	None
Class III	\$50	\$100	None
Diagnostic (Class I)	100%	80%	100%
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	Oral Hygiene Instruction not covered	Oral Hygiene Instruction not covered	
Basic (Class II)	100%	80%	100%
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			
Basic (Class II)	100%	80%	75%
Space Maintainers			
Molar Root Canal Therapy			
Osseous Surgery (periodontal surgery)			
General Anesthesia			
Major (Class III)	50%	40%	75%
Inlays, Onlays, and Crowns		Maximum eligible charge per service: \$400	
Full and Partial Dentures			
Bridge Pontics, and Abutments			
Major (Class III)	100%	80%	75%
Surgical Removal of Impacted Teeth		Maximum eligible charge per service: \$400	
Orthodontics (Class IV)	50%, up to \$1,000 lifetime maximum	30%, up to \$1,000 lifetime maximum	50%, no lifetime maximum
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)			

Vision Coverage

If you are eligible for benefits, you may choose to enroll for vision coverage offered through the National Vision Administrators, L.L.C. (NVA).

As a participant in the plan, you may use any licensed doctor, optometrist, or ophthalmologist for vision services and file a claim for a partial reimbursement with NVA. You will be reimbursed as follows:

Service	Maximum Benefit	Limits
Exams: Optometrist Ophthalmologist	\$25 \$33	One exam during any consecutive 18-month period
Frames: Frames only	\$20	One set of frames during any consecutive 18-month period (In lieu of contact lenses)
Lenses only, per pair: Single vision Bifocal Trifocal Lenticular	\$20 \$35 \$45 \$120	Two lenses during any consecutive 18-month period (in lieu of contact lenses)
Contact Lenses: Medically Necessary** Standard or Disposable	\$230 \$40	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 \$40 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.

OPTI-VISION PROGRAM

MCPS also has selected NVA to offer a discount vision care program that includes eye examinations, eyeglasses, and supplies at discount prices under the Opti-Vision Program. This extended discount benefit is available throughout the plan year when you need additional coverage for benefits that are limited to the 18-month reimbursement period.

The discount vision plan enables participants to purchase glasses, standard or disposable contact lenses, frames, and related services at discount prices. The plan also provides discount LASIK surgery at more than 100 locations across the United States. Vision plan participants can schedule a complimentary evaluation.

For additional information on LASIK surgery, please call 1-877-295-8599 or visit www.e-nva.com. Your out-of-pocket expenses are reduced when using an NVA network provider. In addition, there is a mail order program available to plan participants where you can obtain contact lenses, including disposable lenses, at a discounted rate. A list of participating providers is available at www.e-nva.com.

When you enroll in the plan, you will receive a vision plan ID card, a plan description, a provider directory, and claim forms. Please

review the specific information on the ERSC website for details of the NVA Opti-Vision discount program.

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 or CareFirst BlueChoice 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 co-pay 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 co-pay 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 co-pay One refill allowed for maintenance medications	\$5 co-pay
Preferred Brand Name (no generic equivalent)*	\$20 co-pay One refill allowed for maintenance medications	\$20 co-pay
Non-Preferred Brand Name**	\$35 co-pay One refill allowed for maintenance medications	\$35 co-pay***

*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 co-pay 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 co-pay is \$105.

***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 co-pay 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 co-pay, plus the difference between the mail order and retail prescription cost.

To take advantage of the lowest co-pay, 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 co-pay 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 co-pay, 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:

- \$20 co-pay for any preferred brand name drug that appears on CVS Caremark's Primary Drug list (updated quarterly) or
- \$35 co-pay 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 implemented 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.

If you take a prescription drug that is affected by this program and have not contacted your physician, please do so promptly. 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.

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 co-pay. 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 co-pay 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 co-pay. 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 co-pay	\$15 co-pay	\$10 co-pay
Kaiser Brand Name (only when no generic equivalent is available)	\$10 co-pay	\$15 co-pay	\$10 co-pay

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 co-pay for up to a 60-day supply for a generic drug or the \$10 co-pay 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 co-pay of \$15 or up to a 60-day supply of a brand name drug for a \$15 co-pay 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 co-pay for generic drugs or the \$10 co-pay for brand name drugs when there is not a generic available. 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 is covered the same 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.* Employee cost for life insurance coverage is outlined in the life insurance rate chart which appears later in this document.

If you do not wish to participate in the basic term life insurance program, you must decline life insurance coverage using MCPS Form 455-20: *Employee Benefit Plan Enrollment*.

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

Once you decline coverage, you may enroll only during the annual Open Enrollment by providing evidence of insurability and receiving approval from the insurer. ERSC will initiate the process of providing evidence of insurability upon receipt of your enrollment forms.

The amount of basic life insurance you receive is determined by rounding your annual salary to the next lowest 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 life insurance coverage. You pay 10 percent of the cost for coverage and MCPS pays 90 percent. MCPS pays 100 percent of the cost for basic dependent life insurance.

Please remember to update your beneficiary information as your personal situations change. You can make beneficiary updates by completing the MCPS Form 455-20: *Employee Benefit Plan Enrollment*. (Note: The enrollment form does not update your beneficiaries for retirement/pension plans, 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 75 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 must submit an Accelerated Benefit Option Claim Form, available on the ERSC website. Please read the instructions carefully; forward the portion for completion by your employer to ERSC.

Optional Employee Life Insurance

If you are enrolled for basic employee life insurance, you also may choose to purchase

additional life insurance equal to one times your annual salary (rounded down to the nearest thousand).

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 by completing the MCPS Form 450-1: *Optional Employee Term Life Insurance Enrollment/Cancellation*.

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. ERSC will initiate the process of providing evidence of insurability after receiving your enrollment form.

DEPENDENT LIFE INSURANCE

Benefits-eligible employees who are enrolled in basic employee 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.

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 ePaystub as EXS Life.

Basic Dependent 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 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. Your dependents are not covered automatically. You must enroll dependents when first eligible. You have 60 days following your hire date to complete MCPS Form 450-2: *Optional Dependent Term Life Insurance Enrollment/Cancellation*, and submit to ERSC.

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. ERSC will initiate the process of providing evidence of insurability after receiving your enrollment form.

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. This also is a good time to update all of your beneficiary information.

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 married 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 \$2,500 from your salary per calendar year to pay for qualified medical expenses. Qualified expenses include deductibles, co-payments, 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.

Please note that over-the-counter drugs are not eligible for reimbursement from your medical FSA without a prescription. Please consult the flexible spending summary plan document

available on the ERSC website for additional information.

Flexible spending accounts are administered by ADP (formerly SHPS). Please be aware that you will begin to see the ADP name on flexible spending account materials in the near future.

Visit the ADP (formerly SHPS) website at www.shps.net for a complete listing of eligible expenses for dependent care and medical spending accounts.

Important

MCPS will match the first \$100 contribution to the medical spending account for any employee who enrolls. For instance, if you set aside \$1,300 for qualified medical expenses, MCPS will add an additional \$100 to your medical spending account. As a result, you will have \$1,400 to apply toward qualified medical expenses.

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, using MCPS Form 450-3: *Flexible Spending Account Calendar Year 2014 Election*. After that time, you may only enroll for the FSA plan 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.

Qualifying events include marriage or divorce, addition or loss of a dependent, your spouse becomes eligible for or loses medical coverage, or your spouse loses full-time employment.

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 ADP (formerly SHPS). Then, you are reimbursed from your FSA plan with pretax dollars.

When you elect to contribute to the Medical 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 can provide immediate access to the funds in your FSA. You can use the debit card to cover the costs of certain eligible health care services at the time of payment so you do not have to file a claim for reimbursement.

When submitting for reimbursement using a claim form, mail or fax the form, Explanation of Benefits (EOB), and receipt(s) to ADP (formerly SHPS). You will be reimbursed for all eligible expenses not covered by your health plan. You can sign up for direct deposit at myspendingaccount.adp.com.

Important Reminder to Visa Debit Card Users

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

An envelope for retaining receipts is provided in the Visa debit card mailing. 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 ADP (formerly SHPS) for reimbursement.

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, 2014, through March 15, 2015, may be reimbursed from funds set aside for the 2014 calendar year.

If there is a balance in the 2014 plan year account, qualifying expenses incurred between January 1, 2015, and March 15, 2015, may be reimbursed from either the 2014 or 2015 plan year account (but not from both plan years). All claim requests for reimbursement of expenses incurred during the 2014 plan year must be submitted and received by ADP (formerly SHPS) no later than April 30, 2015.

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.

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 defined contribution plans to all employees as follows:

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

You can contribute to one or both plans up to the annual IRS limit. The plans offer a means to supplement retirement savings while reducing current taxable income. Participation in the plans is through voluntary contributions available to all MCPS employees.

Important

MCPS maintains a website that provides detailed information regarding the two plans including approved providers, contribution limits, and the necessary forms and instructions to begin contributions and/or withdrawal of funds. The Web address is <http://mcps.yourplan.info>.

To participate, you decide how much of your salary to contribute and how it will be invested. Your investments are made on a pretax basis through the convenience of payroll deduction. Current federal, state, or local income taxes are not withheld on money invested for retirement. Any earnings on your investments within the accounts also are tax deferred. Therefore, your account value has the potential to grow faster than it would in a taxable investment. You pay income taxes on your contributions and any earnings when you withdraw money from the account.

MCPS employees may begin participating in one or both of the plans at any time. To begin, you must first submit an enrollment application to one of the approved providers to open an MCPS account. Then, send a completed 403(b) salary reduction agreement and/or 457(b) salary deferral agreement to ERSC. If you do not open an MCPS account with one of the approved providers before you send the salary reduction agreement form to ERSC, all forms will be returned. You retain the right to stop your contributions at any time. If you need to make any adjustments, you must complete and return the signed form to ERSC. E-mails are not accepted.

The agreement(s) authorize(s) MCPS to withhold a specific amount of money from each pay period and to forward the funds to your 403(b) and/or 457(b) carrier for your individual account. ERSC must receive your salary reduction agreement well in advance of the pay date from which you wish to have funds withheld. A list of applicable dates for deductions, approved providers, and frequently asked questions are available on the ERSC website. For additional details, please contact one of the approved providers.

Withdrawals are limited to those permitted by the plan as described in the plan document available on the MCPS defined contributions website at <http://mcps.yourplan.info>. If you choose to participate, you should recognize that you are investing for retirement and may not have free access to the funds until you meet one of the withdrawal requirements such as age or separation of service.

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

Participants enrolled in the 403(b) plan may begin withdrawals at age 59½, even if still employed. Participants in a 457(b) plan may begin withdrawals upon separation of service provided that they do not return to work for MCPS. Benefits are taxable in the year of

withdrawal. If the participant, postretirement, is reemployed by MCPS in any capacity, withdrawals are not permitted. Both plans require mandatory withdrawals by age 70½. You must complete the required vendor paperwork and obtain the appropriate eligibility certificate from the Retirement Manager website. For more information, contact your plan vendor or visit mcps.yourplan.info. A list of available vendors is included in this booklet.

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 staff wellness portion of the MCPS website. Simply search "staff wellness" from any MCPS web page.

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.

“Understanding Social Security (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

Membership

As a benefits-eligible MCPS employee, you are a member of either the Maryland State Teachers’ Pension Plan or the MCPS Pension Plan for your core benefit, depending on your job classification. The difference between the state and MCPS systems is administrative—both systems have similar features and provide retirement benefits. In addition, MCPS provides a supplemental retirement benefit to all eligible employees.

Enrollment

Enrollment in a pension system is mandatory and a condition of your employment. You must complete enrollment forms within 30 days of your employment for the state (if eligible) and MCPS pension systems, including the application for membership and designation of beneficiary forms. You also need to provide a copy of your birth certificate, valid passport, or valid driver’s license at the time of enrollment. Failure to complete your enrollment in a timely manner will result in a \$100 fine assessed to MCPS by the Maryland State Retirement Agency. Any such fines will be deducted from your future pay.

Contribution Rates

Employees contribute 7 percent of their salary to the core benefit and an additional .5 percent to the supplemental benefit.

Contributions are made on a pretax basis and are deducted from paychecks from September through June.

Pension Changes

Due to changes in 2011, pension benefits are different for employees hired on or after July 1, 2011. The following pension information differs for those employees hired prior to July 1, 2011, and those employees hired after July 1, 2011. Find your applicable section to learn more about your pension benefits.

PENSION BENEFITS FOR EMPLOYEES HIRED PRIOR TO JULY 1, 2011

Eligibility to Retire: Normal Retirement

Pension system members are eligible to retire as follows:

Age at Retirement	Minimum Eligibility Service
62	5 years
63	4 years
64	3 years
65	2 years
Any age	30 years

A year of eligibility service is defined by a specified number of scheduled hours worked from July 1 to June 30 each year. Prior to July 1, 1998, 700 hours were required to earn one year of eligibility service. Effective July 1, 1998, the requirement was changed to 500 hours. If you are scheduled to work less than 500 hours in a fiscal year, your eligibility service is prorated based on the number of scheduled hours worked divided by 500 hours.

Early Retirement

Early retirement plan provisions allow you to retire prior to your normal retirement date. You must be at least age 55 and have 15 years of eligibility service. Retiring early will result in a reduced retirement benefit. The reduction for early retirement is 6 percent per year or 0.5 percent per month for the number of months prior to age 62, in both the state and MCPS plans.

Benefit Amount

The amount of pension benefit you receive is based on the following:

- **Credited Service**—Credited service is used in the calculation of your retirement benefit. You earn credited service based on your scheduled hours. For example, if you are scheduled to work 80 hours biweekly from September to June, you will earn 10 months of credited service. Ten months equals one year. If you are scheduled to work less than 80 hours, your credited service will be prorated based on your scheduled hours. Credited service also may include purchased service, prior active duty military service, and any service that has been transferred to your current account.
- **Average Final Salary**—Average final salary for the pension system is the average of the highest three consecutive years of salary during your career and is used to calculate the benefit. For most employees, the final three years are the highest.
- **Benefit Formula**—The amount of your benefit is based on a defined formula that uses both your credited service and average final salary. For all employees, the benefit formula was enhanced retroactive to July 1, 1998. For employees who have service prior to July 1, 1998, the formula is as follows:

Benefit Formula for Employees with Service Prior to July 1, 1998

Core Benefit

Calculate the greater of

$$.008 \times \text{average final salary (AFS) up to the SSIL plus}$$

$$.015 \times \text{AFS in excess of the SSIL}$$

$$\times$$

$$\text{credited service before 7/1/98}$$

OR

$$.012 \times \text{AFS} \times \text{credited service before 7/1/98}$$

PLUS

$$.018 \times \text{AFS} \times \text{credited service after 7/1/98}$$

Benefit Formula for Employees with Service Prior to July 1, 1998, cont.

Supplemental Benefit

.0008 x AFS up to the SSIL plus
 .0015 x AFS in excess of the SSIL x
 credited service before 7/1/98
 plus
 .002 x average final salary x credited service after 7/1/98

Please Note: SSIL is the Social Security Integration Level and is an average of the Social Security wage base over a 35-year period prior to retirement. The SSIL changes each calendar year, as determined by the Social Security Administration. The SSIL for 2013 is \$64,500, and the projected SSIL for 2014 is \$67,300.

Employees who entered the system between July 1, 1998, and June 30, 2011, will receive a core benefit of 1.8 percent multiplied by average final salary multiplied by credited service. They also will receive a supplemental benefit of .2 percent multiplied by average final salary multiplied by credited service.

Benefit Formula for Employees Hired Between July 1, 1998, and June 30, 2011

Core Benefit

.018x AFS x credited service

Supplemental Benefit

.002 x AFS x credited service

PENSION BENEFITS FOR EMPLOYEES HIRED ON OR AFTER JULY 1, 2011

Eligibility to Retire: Normal Retirement

Pension system members are eligible for normal retirement as follows:

- Age 65 with at least 10 years of eligibility service or
- Age + Years of Eligibility Service = 90

A year of eligibility service is defined as working at least 500 scheduled hours from July 1 to June 30 each year. If you are scheduled to work less than 500 hours in a fiscal year, your eligibility service is prorated based on the number of scheduled hours worked divided by 500 hours.

Early Retirement

Early retirement plan provisions allow you to retire prior to your normal retirement date. You must be at least age 60 and have 15 years of eligibility service. Retiring early will result in a reduced retirement benefit. The reduction for early retirement is 6 percent per year or .5 percent per month for the number of months prior to age 65, in both the state and MCPS plans.

Benefit Amount

The amount of pension benefit you receive is based on the following:

- **Credited Service**—Credited service is used in the calculation of your retirement benefit. You earn credited service based on your scheduled hours. For example, if you are scheduled to work 80 hours biweekly from September to June, you will earn 10 months of credited service. Ten months equal one year. If you are scheduled to work less than 80 hours, your credited

service will be prorated based on your scheduled hours. Credited service also may include purchased service, prior active duty military service, and any service that has been transferred to your current account.

- **Average Final Salary**—Average final salary for the pension system is the average of the highest five consecutive years of salary during your career and is used to calculate the benefit. For most employees, the final five years are the highest.
- **Benefit Formula**—The amount of your benefit is based on a defined formula that uses both your credited service and average final salary. New employees entering the system on or after July 1, 2011, will receive a core benefit of 1.5 percent multiplied by average final salary multiplied by credited service. They also will receive a supplemental benefit of .2 percent multiplied by average final salary multiplied by credited service.

Benefit Formula for Employees Hired On or After July 1, 2011

Core Benefit

1.5% x average final salary x credited service

Supplemental Benefit

.2% x average final salary x credited service

Postretirement Health Benefits

As a result of changes implemented on July 1, 2011, retiree benefit plan costs will differ depending on the year you were hired with MCPS and your length of service.

If you were hired on or before June 30, 2006, you will pay 36 percent of the retiree benefit plan cost and MCPS will pay 64 percent. You

will be eligible to receive postretirement benefits if you have at least five years of eligible service upon retirement.

If you were hired on or after July 1, 2006, the cost of your retiree benefit plan depends on your years of eligible service. However, in an effort to minimize the impact of this change on current employees who are least able to adjust their retirement plans, certain employees are “grandfathered” and will continue to pay 36 percent of their retiree benefit plan cost, as long as they have at least five years of eligible service upon retirement. You are grandfathered if you were hired between July 1, 2006, and June 30, 2011, and if—

- You were at least 55 years old as of July 1, 2011, or
- You will have at least 30 years eligible service in the State Teachers’ Pension Plan upon retirement.

If you are a grandfathered employee, you will be eligible to receive postretirement benefits if you have at least five years of eligible service with MCPS upon retirement.

If you were hired on or after July 1, 2006, and you do not meet the above requirements, or if you were hired on or after July 1, 2011, the cost of your retiree benefits will depend on your years of eligible service, as follows—

Eligible Service upon Retirement	Retiree Pays	MCPS Pays
10 up to 15 years	60%	40%
15 up to 20 years	50%	50%
20 or more years	36%	64%

To Learn More about Retirement

Additional information about retirement is available on the ERSC website. This information includes the document *Understanding Your Retirement*, which explains the fundamentals of retirement, the timeline for retirement, the payment options, required forms, and frequently asked questions. Employees who are within one year of retirement may request an estimate of their MCPS retirement benefit. MCPS Form 455-2a: *Request for Estimate of Retirement Benefits*, is available on the ERSC website.

Employees who are enrolled in the state pension plan can visit the Maryland State Retirement Agency (SRA) website at sra.state.md.us. You also may contact the SRA by telephone at 1-800-492-5909.

Active Employee Cost - Calendar Year 2014

Healthcare Costs

Effective January 1, 2014

Medical Plans	Coverage Level	Employee Percentage	Biweekly 10-Month Employee	Biweekly 12-Month Employee
Open Point Of Service Plans				
CareFirst BlueChoice	Individual	10%	27.52	21.17
	2 Party	10%	55.04	42.34
	Family	10%	74.90	57.61
Cigna Open Access Plus	Individual	10%	27.71	21.31
	2 Party	10%	55.42	42.63
	Family	10%	75.40	58.00
Health Maintenance Organization Plans				
CareFirst BlueChoice	Individual	5%	9.64	7.42
	2 Party	5%	18.13	13.94
	Family	5%	29.69	22.84
Kaiser Permanente	Individual	5%	13.48	10.37
	2 Party	5%	26.87	20.67
	Family	5%	38.91	29.93
Cigna Open Access Plus In Network	Individual	5%	11.95	9.19
	2 Party	5%	22.45	17.27
	Family	5%	36.79	28.30

Supplemental Plans	Coverage Level	Employee Percentage	Biweekly 10-Month Employee	Biweekly 12-Month Employee
Caremark Prescription	Individual	10%	7.37	5.67
	2 Party	10%	14.72	11.32
	Family	10%	18.16	13.97
Kaiser Prescription	Individual	10%	3.93	3.03
	2 Party	10%	7.85	6.04
	Family	10%	11.38	8.75
Aetna Dental Preferred Provider Organization	Individual	10%	1.96	1.51
	2 Party	10%	3.92	3.02
	Family	10%	5.76	4.43
Aetna Dental Maintenance Organization	Individual	10%	1.62	1.25
	2 Party	10%	3.25	2.50
	Family	10%	4.77	3.67
Vision	Individual	10%	0.06	0.05
	2 Party	10%	0.11	0.09
	Family	10%	0.14	0.11

Closed Point Of Service Plan Cigna Open Access Plus Open to employees hired <i>before</i> January 1, 1994 only	Coverage Level	Employee Percentage	Biweekly 10-Month Employee	Biweekly 12-Month Employee
MCEA Employees	Individual	15%	65.92	50.70
	2 Party	15%	131.83	101.41
	Family	15%	179.35	137.96
SEIU Local 500 and MCAASP Employees	Individual	20%	87.89	67.61
	2 Party	20%	175.77	135.21
	Family	20%	239.14	183.95

Employee Life Insurance 100% Rate = \$.111 Per Thousand Of Insurance Per Month
Based on two times current salary rounded to the nearest \$1,000

Active Employee Cost - Calendar Year 2014

LEAVE RATE SCHEDULE

100% ACTIVE EMPLOYEE RATE

Effective January 1, 2014

		Component Cost	
		MONTHLY	ANNUAL
CareFirst BlueChoice POS	IND	458.74	5,504.88
	2	917.45	11,009.40
	FAM	1,248.31	14,979.72
Cigna Open POS	IND	461.82	5,541.84
	2	923.61	11,083.32
	FAM	1,256.71	15,080.52
Cigna Closed POS	IND	732.38	8,788.56
	2	1,464.77	17,577.24
	FAM	1,992.78	23,913.36
CareFirst BlueChoice HMO	IND	321.44	3,857.28
	2	604.15	7,249.80
	FAM	989.80	11,877.60
Kaiser HMO	IND	449.38	5,392.56
	2	895.53	10,746.36
	FAM	1,297.05	15,564.60
Cigna HMO	IND	398.23	4,778.76
	2	748.50	8,982.00
	FAM	1,226.30	14,715.60
Caremark Prescription	IND	122.78	1,473.36
	2	245.30	2,943.60
	FAM	302.71	3,632.52
Kaiser Prescription	IND	65.55	786.60
	2	130.87	1,570.44
	FAM	189.66	2,275.92
Aetna PPO Dental	IND	32.68	392.16
	2	65.39	784.68
	FAM	96.06	1,152.72
Aetna HMO Dental	IND	27.05	324.62
	2	54.13	649.56
	FAM	79.55	954.60
NVA Vision	IND	1.00	12.00
	2	1.84	22.08
	FAM	2.33	27.96

Active Employee Cost - Calendar Year 2014
Optional Term Life Insurance
Effective January 1, 2014

Optional Employee Term Life Insurance		
Eligible employees enrolled for basic term life insurance are entitled to purchase additional 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	0.015	0.012
25 - 29	0.018	0.014
30 - 34	0.020	0.016
35 - 39	0.024	0.018
40 - 44	0.027	0.021
45 - 49	0.042	0.032
50 - 54	0.060	0.046
55 - 59	0.117	0.090
60 - 64	0.177	0.136
65 - 69	0.342	0.263
70 and over	0.558	0.429
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 .024		\$1.10

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 23 rd 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

Montgomery County Public Schools

**Vendor List for the
§403(b) Tax Sheltered Savings (TSA) and
§457(b) Deferred Compensation Plans**

<http://mcps.yourplan.info/>

Currently, there are nine Board-approved providers:

Fidelity Investments	800-343-0860	www.fidelity.com/atwork
Hendershot Financial Group (Lincoln Investment Planning)	301-987-7211	www.lincolninvestment.com
ING	800-525-4225	www.ingretirementplans.com
Lincoln Financial Group	800-234-3500	www.lincolnalliance.com
MetLife Resources	800-543-2520	www.metlife.com
Morgan Stanley Wealth Management	301-556-2360	www.trsuretire.com
TIAA-CREF	800-842-2008	www1.tiaa-cref.org/tcm/mcps/
T. Rowe Price	800-922-9945	rps.troweprice.com/mcps
VALIC	410-859-2164	www.valic.com

MCPS does not review, approve or endorse any of the investment options that may be offered by any vendor in connection with the plan. As a plan participant, you are solely responsible for the review and selection of any and all plan investment options. Not all investment options that may be offered by vendors may be appropriate or suitable for plan investments. 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.

Frequently Requested Websites and Phone Numbers

Employee and Retiree Service Center www.montgomeryschoolsmd.org/departments/ersc	301-517-8100
Office of Human Resources www.montgomeryschoolsmd.org/departments/personnel	301-279-3204
ADP (formerly SHPS) Flexible Spending Accounts www.myshps.net	800-678-6684
Aetna Dental Plan www.aetna.com	
DMO	800-843-3661
PPO	800-282-0555
CareFirst BlueChoice HMO and POS Plan Away From Home Care (see Benefit Summary for details) www.carefirst.com	800-545-6199 888-452-6403
Cigna Open Access Plus Plans (POS) www.cigna.com	855-213-3848
Cigna Open Access Plus In Network Plans (HMO) www.cigna.com	855-213-3848
CVS/Caremark Prescription Plan www.caremark.com	800-378-7558
COBRA: Benefit Strategies www.benstrat.com	888-401-3539
Kaiser Permanente HMO and Prescription Plans www.kp.org	800-777-7902
Maryland State Retirement Agency www.sra.state.md.us	800-492-5909
MCAAP (Administrators Union)	301-762-8174
MCBOA (Non-Certified Supervisors Union)	301-762-8174
MCEA (Teachers Union) www.mceanea.org	301-294-6232
National Vision Administrators Plan www.e-nva.com	800-672-7723
Retirement Manager Hotline www.myretirementmanager.com	866-294-7950
SEIU Local 500 www.seiu500.org	301-740-7100
403(b)/457(b) MCPS Defined Contribution Plans www.mcps.yourplan.info	

This document is available in an alternate format, upon request, under the *Americans with Disabilities Act of 1990*, by contacting the Department of Public Information and Web Services, at 850 Hungerford Drive, Room 112, Rockville, MD 20850, or by telephone at 301-279-3391 or via the Maryland Relay at 1-800-735-2258.

Individuals who request (need) sign language interpretation or cued speech transliteration in communicating with Montgomery County Public Schools (MCPS) may contact the Office of Interpreting Services in the Deaf and Hard of Hearing Program at 301-517-5539 or 301-637-2958VP, or send an e-mail message to interpreting_services@mcpsmd.org.

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