The BlueChoice Low Option HMO

FOR EMPLOYEES OF AACPS

PLAN YEAR 2022

Medical coverage is a valuable benefit. Permanent employees and qualified temporary employees have access to AACPS medical coverage through the BlueChoice Low Option HMO Plan. Eligible employees may also enroll a spouse and dependent children for coverage.

Who's Eligible?

You are eligible to participate in the BlueChoice Low Option HMO if you are a:

- Permanent active employee
- Permanent employee on a leave of absence
- Permanent employee on Family Medical Leave
- Permanent employee on sabbatical
- Former employee or dependent on COBRA
- Eligible temporary employee as defined by the IRS. In general, the rules provide that you meet the definition if:
  - » AACPS has determined in a measurement period that you have worked, on average, 30 or more hours per week (there are special rules for educational employers such as AACPS that determine how many weeks can be used for calculating this average, reflecting the fact that many employees are employed during the school year only).
  - » AACPS has determined at your start date that you are reasonably expected to work 30 hours or more per week on average.
  - » AACPS determines that the hours you work may have increased from a lower amount to 30 hours or more per week on average.

You may also cover your eligible dependents through AACPS healthcare benefits. Please note your coverage (and dependents if applicable) will terminate at the end of the month if you leave employment. COBRA benefits (continuation of coverage) are available and discussed on page 11 in this guide.

WHO IS AN ELIGIBLE DEPENDENT

- Your legally married spouse
- Your children, up to age 26 ("Children" include your natural children, legally adopted children, foster children, stepchildren, any children who live with you and for whom you are the legal guardian, and any children you are responsible for as a result of a court-ordered custody arrangement)
- Your disabled children as long as approved before age 26 (proof of disability required)

WHO IS NOT AN ELIGIBLE DEPENDENT

- Your live-in/domestic partner
- Children of your live-in/domestic partner
- Your parents
- Your grandchildren (unless you are their legal guardian)
- Your children over age 26 (unless approved for disability continuation by the insurance carrier before their 26th birthday)
- Your spouse after you've divorced
- Your stepchildren after you and your spouse (children's parent) divorce

It is fraudulent to include dependents on the AACPS healthcare plan when they do not meet eligibility requirements. Claims paid for ineligible dependents will be recouped by the healthcare vendor from the provider, which could possibly cause you to be financially liable.

Provide the Proof

If you cover dependents, you must provide hard copy proof of your relationship to HR/Benefits. Examples of valid proof may include:

- Marriage license and secondary supporting document, such as:
  - » Page 1 of federal tax return showing married, filing either jointly or separately*
  - » Mortgage statement or rental/lease agreement*
  - » Property tax bill*
  - » Joint checking or saving account statement*

**Financial information may be blacked out*

- Birth certificate
- Adoption papers
- Court decree for legal guardianship/custody

- Documentation from a doctor verifying disability for dependents under age 26 if disability is expected to be for an extended period of time. If you have questions about eligibility and coverage, contact HR/Benefits at 410-222-5221 or 410-222-5219.

Lifestyle Changes

If you are a permanent employee, you may enroll for benefits during your first 31 days of employment or during the annual benefits Open Enrollment period; after 31 days of employment, you may not make changes to your benefits except during the Open Enrollment period unless you have a qualified lifestyle change.

If you are a temporary employee, once you are initially determined to be eligible to enroll, you may not make changes to your benefits except during the Open Enrollment period each year, unless you have a qualified lifestyle change.

Qualified lifestyle changes include:

- Marriage
- Divorce or annulment
- Birth, adoption, placement for adoption, or appointment of legal guardianship of a child during the course of an adoption
- Change in your or your spouse's employment status due to termination or commencement of employment, a strike or lockout, an unpaid leave of absence, or a change in worksite
- Your death or the death of your dependent
- Loss of dependent status due to a child reaching age 26 (may be covered through the end of the month in which they turn age 26)
- Unpaid leave of absence for you or your spouse under the Family and Medical Leave Act
- Change in your spouse's healthcare coverage – if your spouse elects new healthcare coverage, you may notify HR/Benefits to change your coverage prior to Open Enrollment within the normal 31-day notification period
- You or your dependents become eligible for COBRA, Medicare, or Medicaid
- Moving into or out of an HMO's service area
- Gain or loss of a dependent's coverage
- Change in your employment status that results in a gain or loss of eligibility (e.g., a switch between part-time and full-time status)
- Significant change in the coverage under a healthcare plan (does not apply to the Flexible Spending Accounts (FSAs))
- Open Enrollment for your spouse's benefit plans (changes must be consistent with the offerings in your spouse's benefit program)
- Mid-year plan enrollment offering through your spouse's employer (changes must be consistent with the offerings in your spouse's benefit program)
- Judgment, decree, or order that requires you to cover a dependent child (this does not include custody of grandchildren or relationships other than parent and child)

LIFESTYLE CHANGE FORMS AVAILABLE ON-LINE

If you experience a lifestyle change, you can make changes to your benefits. Download a Lifestyle Change form on-line at www.aacps.org/hrforms and submit it to the HR/Benefits department, along with required documentation (marriage license, birth certificate, etc.) within 31 days of the event occurring. Contact the HR/Benefits office if you have questions.

Check Out CareFirst "My Account" Site for Tips and Tools

The CareFirst "My Account" site provides you with valuable resources to make the most of your medical plan benefits. Go to **carefirst.com/aacps** and click on "My Account" to register; you will need your membership card or social security number to get started. Once on the site, you can:

- Review up to a year of medical, prescription and vision claims
- Request new ID cards
- Sign up for paperless communications
- Much more

Paying for BlueChoice Low Option Medical/Prescription Coverage

AACPS pays part of the premium for individual coverage only and does not contribute towards the cost of dependent coverage in the plan. You pay 100% of the cost of coverage for your dependents.

The individual premium is 9.5% of Box 1 of W-2 pay and is deducted from pay after other pretax deductions are taken (e.g. Medical/Rx and Supplemental Retirement Plan deductions). Therefore, if your pay fluctuates from paycheck to paycheck, your medical premium rate will also fluctuate.

Coverage for dependents is paid on a monthly basis directly to our third-party benefits billing carrier, Discovery Benefits. Failure to submit payment by the specified due date will result in termination of coverage for your dependents.

Here is 2022 rate information for the BlueChoice Low Option HMO Plan:

Coverage Level	Rate
Individual	9.5% of box 1 of W-2 pay
Parent/Child	9.5% of box 1 of W-2 pay + $312.18/month
EE&Spouse	9.5% of box 1 of W-2 pay + $429.26/month
Family	9.5% of box 1 of W-2 pay + $677.05/month

How the Plan Works

The BlueChoice HMO requires that you designate a primary care provider. You have the right to designate any primary care provider who participates in the BlueChoice Open Access network and is available to accept you or your family members.

For information on how to select a primary care provider and for a list of the participating primary care providers, see "Find a Participating Provider" (at right). For children, you may designate a pediatrician as the primary care provider.

With the BlueChoice HMO, there is no coverage for out-of-network services, unless for emergencies.

No wellness-related office visit copayments apply for routine physicals, routine gynecological visits, well baby, and well child care visits.

You do not need prior authorization from the BlueChoice HMO or from any other person, including your primary care provider, in order to obtain access to obstetrical or gynecological care from a healthcare professional in the network who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating healthcare professionals who specialize in obstetrics or gynecology, visit the plan website for provider information.

Disease Management Resources

Chronic conditions such as diabetes, asthma, arthritis, and back pain can significantly affect your quality of life. If you suffer from a chronic condition, there are resources available to help you manage your condition. You may be contacted by Healthways, the disease management partner for CareFirst BlueCross and BlueShield. The goal of Healthways is to help you better manage your health conditions and provide information and resources to improve your care. Please consider working with the Healthways advisor if you are contacted.

You will receive a new ID card for medical and prescription drug benefits from CareFirst prior to the effective date of your coverage. Your effective date will be the first of the month following the date you become eligible.

Find a Participating Provider

1. Go to **www.carefirst.com**
2. Under "Find a Doctor", click "Search for Care"
3. Log in as a member (My Account) or continue as guest
4. Select a Plan
   - For a BlueChoice HMO Provide select BlueChoice HMO Open Access
5. To modify search area, type in zip code or city and state and select desired location.
6. To find a physician/specialist, browse by category, enter the name of the provider/specialist, or select from common searches.

Prescription Drug Benefits

Drug Tiers

Prescription drug benefits are included in AACPS medical plan coverage. To help manage the cost and effectiveness of our prescription drug program, medications are divided into four tiers:

- Generic drugs have the same active ingredients and effectiveness as their brand-name counterparts, but are less expensive and have lower co-pays.
- Preferred Brand drugs are brand name drugs that do not have a generic equivalent available.
- Non-Preferred Brand drugs are drugs that have generic and preferred brand alternatives.
- Specialty drugs treat complex disease states.

There is a deductible of $500 per person for prescription drug benefits that is separate from the medical plan deductible. You must meet the prescription plan deductible before benefits for prescription drugs begin.

The Patient Protection and Affordable Care Act (PPACA) requires employers and healthcare vendors to manage maximum annual combined medical and prescription out-of-pocket limits such as deductibles, co-payments and co-insurance, for employees and their families. AACPS works with CareFirst BlueCross BlueShield (medical plan administrator) and CVS Caremark (prescription benefits administrator) to manage these annual out-of-pocket costs.

For 2021, the annual out-of-pocket maximum for combined medical and prescription drug expenses such as deductibles, copayments and coinsurance is $6,350 (employee only) and $12,700 (employee and dependents). Once you reach those limits, further payment of plan benefits will be at 100%.

Please note that preventive medications (such as birth control) are covered with no deductible and a $0 copay.

	Retail (30-day supply)	Mail-order/ Maintenance Choice (90-day supply)
Deductible	$500 per person *(separate from medical deductible)*	
Retail Generic	$15 copay *(after deductible satisfied)*	$30 copay *(after deductible satisfied)*
Retail Preferred	$35 copay *(after deductible satisfied)*	$70 copay *(after deductible satisfied)*
Retail non-preferred	$60 copay *(after deductible satisfied)*	$120 copay *(after deductible satisfied)*
Specialty	50% coinsurance up to a maximum payment of $150	50% coinsurance up to a maximum payment of $300

Carefirst.com Tools That Assist With Your Prescription Benefits

As a prescription drug program participant, you can take advantage of valuable tools and resources on the **www.carefirst.com** website, which links to your CVS Caremark program. Registration is required so that you can:

- Set up new prescriptions and manage refills,
- Review AACPS prescription drug program benefits,
- See the best ways to save money, such as using generics, Maintenance Choice and mail-order services,
- Learn about medications, including generics, drug interactions and health conditions, and
- Ask a pharmacist your questions about prescription and over-the-counter medicines.

Carefirst.com is the best place to find and print the most current copy of the preferred drug list so you can discuss medication options with your physician.

Short-Term Prescriptions

A prescription for a medication that you will take for a limited time – often 30 days or less – is considered short-term. You may fill short-term prescriptions for up to a 30-day supply, plus one refill, at any participating pharmacy.

CVS Caremark's retail pharmacy network includes more than 98% of pharmacies nationwide – including most grocery store chains, other drug store chains like Walgreen's, and many independent local pharmacies.

If you need a short-term prescription refilled more than once, you will need to follow the procedures for maintenance medications.

Maintenance Medications

A prescription for a medication that you will take for more than 60 days is considered a maintenance medication prescription. For convenience and cost-effectiveness, you can receive up to a 90-day supply of medication using your choice of:

- Home delivery (mail order), or
- Pick up at a CVS pharmacy (Maintenance Choice program)

Your cost is the same with either choice.

Home Delivery: Mail-Order Service

To best utilize this benefit, ask your physician to write two prescriptions:

1. One for a 30-day supply. Have this filled at a retail pharmacy to meet your immediate needs.

2. One for up to a 90-day supply, plus up to three refills. Send this to CVS Caremark's mail-order service. First-time requests for home deliveries generally take 14 days. After you receive your prescription from the mail-order service, refills are processed quickly and may be easily ordered three ways:

- **On-line.** For the quickest delivery of refills, log on to www.caremark.com and click on "Refills." Have your prescription order number (it's on your prescription) and credit card information ready. You will receive a confirmation email that your medication has been shipped.
- **By phone.** Call CareFirst Pharmacy Services at 1-800-241-3371; have your prescription order number (it's on your prescription), Social Security number, and credit card information ready.
- **By mail.** Attach the refill label provided by CVS Caremark on a mail-order form (usually included with your original prescription when you receive it from CVS Caremark) and include your payment.
- **Pick Up at CVS:** Maintenance Choice
  If you are filling a prescription for maintenance medication for the first time and want to use a CVS pharmacy:
  - » **Bring the prescription to a CVS pharmacy.** CVS will fill it, up to a 90-day supply.
  - » **If your prescription is for a 30-day supply with refills,** CVS will contact the prescriber after the last allowable fill to request a 90-day prescription.

Need Help?

For answers to your questions about the prescription drug program, call the CareFirst Pharmacy Services department to discuss your CVS Caremark benefits at 1-800-241-3371 and identify yourself as a participant with Anne Arundel County Public Schools.

Maryland Health Exchange Information

Affordable healthcare plans are also available through the Maryland Health exchange. Open enrollment for the Maryland Health exchange plans begins November 1, 2021. More information can be obtained at /www.marylandhealthconnection.gov/ or by calling 855-642-8572

Maryland Health Connection has trained staff in communities throughout the state to provide free help enrolling in health coverage, understanding health insurance, and choosing the best plan for you and your family

Plans are available through multiple providers.

The chart highlights features of the BlueChoice Low Option HMO Plan.

Feature	Highlights
Individual Deductible	$4,500
Family Deductible	$9,000
Individual Out-of-Pocket Maximum *(Combined medical and prescription drugs)*	$6,350
Family Out-of-Pocket Maximum *(Combined medical and prescription drugs)*	$12,700
Coinsurance	70% CareFirst/30% Member
Preventive Care Services	100% covered
Office Visits	
Primary Care	$30 copay after deductible
Specialist	$40 copay after deductible
Emergency Room	$40 copay after deductible
Urgent Care	$40 copay after deductible
Inpatient Hospital Services	
Facility	70% covered after deductible
Physician	70% covered after deductible
Outpatient Mental Health Services	
Facility	70% covered after deductible
Office	$30 copay after deductible
Diagnostic Services	
Lab & X-ray	$40 copay after deductible
Imaging *(CT/Pet Scans, MRIs)*	$40 copay after deductible
Rehabilitative Services	
Speech Therapy	$40 copay after deductible
Occupational Therapy	$40 copay (limit 30 visits/year) after deductible
Physical Therapy	$40 copay after deductible
Skilled Nursing Facility	70% covered after deductible
Prescription Drugs	
Deductible	$500 per person *(separate from medical plan deductible)*
Retail Generic	$15 copay after deductible
Retail Preferred Brand	$35 copay after deductible
Retail Non-Preferred Brand	$60 copay after deductible
Specialty	50% coinsurance up to a max of $150 after deductible
Mail-Order/Maintenance Choice	90-day supply available for 2x retail copays

The BlueChoice Low Option HMO Plan is a medical and prescription drug plan, and is the only plan available to eligible temporary employees.

Wise Consumerism

Wise consumerism and wellness go hand-in-hand. AACPS encourages you to make smart choices about your health and about how you use the healthcare options available to you.

While there are some factors beyond the control of the consumer, there are some things you can do to help keep healthcare costs down — both for you and for AACPS. Below are a few tips to help you become a wiser consumer of healthcare:

- Ask your provider if he/she accepts your AACPS healthcare plan. The BlueChoice Low Option HMO is an "in-network only" plan; services provided out of the network will not be covered except in cases of emergencies.
- Get regular annual check-ups, physical exams and recommended screenings. Annual exams and screenings can uncover early warning signs before they become more significant health issues — and routine preventive care is covered at 100% with no deductible or office visit copays. And remember to take advantage of regular vision and dental exams, too.
- Save the emergency room for emergencies. Emergency room visits are two to three times more expensive than a visit to the doctor's office or an urgent care center. These ER visits are not only costly, but they can be unnecessarily stressful and time-consuming for you and your family if what you need is routine care. Urgent care facilities are available in the area and may be used for a variety of urgent health problems for a lower co-pay than the ER.
- Use generic medications. Generics have the same chemical equivalency as brand-name drugs, and are held to the same standards by the Food and Drug Administration, but they cost less than brand-name drugs.
- Make notes, take notes. Make notes before a doctor's office visit of any symptoms or issues you're having so you can remember to ask your doctor about them. And take notes during your visit of any terms your doctor uses so that you can research them later.

Wellness

Your most important choice is caring for your health. It is your responsibility to make lifestyle changes that promote good health, and to become an informed healthcare consumer. AACPS is committed to helping you and your dependents by offering a comprehensive and affordable healthcare package. Take time to evaluate your lifestyle habits and see if they promote your optimal health.

Some important lifestyle habits are:

- increase your fruit and vegetable intake
- reduce portion size
- do at least 30 minutes of moderate intensity activity five days per week
- wear your seatbelt
- wear sunscreen year-round
- quit smoking
- get at least seven hours of sleep a night

AACPS is concerned about your health and wellness. We encourage you to visit **www.aacps.org/wellness** to review valuable information about fitness center discounts for employees, health themes of the month, and other useful information and links.

Required Notices

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

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

ON-LINE	PHONE
DELAWARE – Medicaid	
www.dhss.delaware.gov/dhss/dss/medast.html	1-800-464-4357
MARYLAND – Medicaid	
https://mmcp.dhmh.maryland.gov/chp/SitePages/Home.aspx	1-800-284-4510
PENNSYLVANIA – Medicaid	
www.dhs.pa.gov/citizens/healthcaremedicalassistance	1-800-692-7462
VIRGINIA – Medicaid and CHIP	
www.coverva.org/hipp	1-855-242-8282
WASHINGTON D.C. – Medicaid	
http://dhcf.dc.gov/node/151012	1-877-685-6391

To see if any more States have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Notice of Privacy Practices

Responsible Office for Administration:

Office of HR Operations – Benefits
410-222-5221

Contact Information

Anne Arundel County Public Schools
Office of Human Resources Operations
Attn: Benefits Manager
2644 Riva Road
Annapolis, Md. 21401

This notice describes how medical information about you may be used and disclosed, and how you may gain access to this information. Pleased review this notice carefully.

This notice applies to the privacy practices of all Anne Arundel County Public Schools (AACPS) health plans. Please be advised since these plans are affiliated (related) entities, we might share your protected health information and the protected health information of others on your insurance policy as needed for payment or Healthcare operations in regards to the plans listed below:

CareFirst Medical, Dental, and Vision Plans, CVS Caremark Prescription Plan, UCCI Dental Plan, and the AACPS Flexible Spending Account Program.

Our Legal Duty

AACPS is required by law to maintain the privacy of your protected health information (PHI). We are obligated to provide you with a copy of this Notice of our legal duties and of our privacy practices with respect to PHI, and we must abide by the terms of this Notice. We reserve the right to change the provisions of our Notice and make the new provisions effective for all PHI that we maintain. If we make a material change to our Notice, we will mail a revised Notice to the address that we have on record for the policyholder.

Effective Date

This Notice of Privacy Practice became effective on April 14, 2003, and was revised effective September 23, 2013.

Uses and Disclosure of Medical Information

Payment: We may use or disclose your PHI to pay claims for services provided to you, and to fulfill our responsibilities for plan coverage and providing plan benefits. For example, we may disclose your PHI to pay claims for services provided to you by doctors, hospitals, pharmacies and others for services delivered to you that are covered by your health plan. We might also use this information to determine your eligibility for benefits, coordination of benefits, to obtain premiums, to determine medical necessity, and to issue explanations of benefits.

Healthcare Operations: We might use and disclose your PHI for all activities as defined by the HIPAA Federal Regulations. For example, we might use and disclose your protected health information to determine premiums for the health plans, for underwriting, to conduct quality assessment, to engage in care and case management, and to manage our business. However, we will not use your genetic information for underwriting purposes.

Business Associates: We contract with individuals and entities (Business Associates) to perform certain types of services. To perform these functions or services, our Business Associates will receive, create, maintain, use or disclose PHI, but only after we require the Business Associates to agree in writing to contract terms designed to appropriately safeguard your information. For example, we may disclose your PHI to a Business Associate to administer claims or to provide service support, utilization management, coordination of benefits, or pharmacy benefit management.

Other Covered Entities: We may use or disclose your PHI to assist other covered entities in connection with payment activities and certain healthcare operations. For example, we may disclose or share your PHI with other insurance carriers in order to coordinate benefits.

Other Possible Uses/Disclosures of Protected Health Information
In addition to uses and disclosures for payment and healthcare operations, we may use/or disclose your PHI for the following purposes (this list is not completely inclusive):

Personal Representatives: We may disclose PHI to the patient or patient's personal representative. That could be a legal guardian, or a person designated by you to act on your behalf in making decisions related to your healthcare.

Required by Law: We may use or disclose your PHI when we are required to do so by law. For example, such information may be disclosed to the U.S. Department of Health & Human Services upon request for determining whether we are in compliance with federal privacy laws as well as for requests pursuant to workers' compensation or similar programs. This could also include releasing information to a medical examiner as authorized by law and law enforcement officials in compliance with a legal order.

To You or with your Authorization: We must disclose your PHI as described in the Individual Rights section of this notice. You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose not listed in this notice. We will not use or disclose your health information for any other reason without your authorization. For example, in general and subject to specific conditions, we will not use or disclose your psychiatric notes; we will not use or disclose your PHI for marketing; and we will not sell your PHI, unless you give us a written authorization. If you provide such authorization, you may revoke it in writing at any time.

Public Health & Safety/Military and National Security: We might use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to the U.S. Department of Health & Human Services upon their request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your PHI to authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or other crimes.

We might disclose to military authorities the protected information of Armed Forces personnel under certain circumstances. We might disclose to federal officials protected health information required for lawful intelligence, counterintelligence, and other national security activities.

Your Rights
Right to Inspect and Copy: You have the right to inspect and copy your PHI that is contained in a "designated record set." This information contains your medical and billing records, as well as other records that are used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set. You may request access to your health records in an electronic format if they are available electronically. You may request that your electronic health records be transmitted directly to you or someone you designate. You may be charged a fee for access to electronic health records, but this amount must be limited to the cost of labor involved in responding to your request. To inspect and copy your PHI, in paper or electronic form, you must make your request in writing to the Privacy Officer, through the HR Department.

Restriction Requests: You have the right to request a restriction on the PHI we use or disclose about you for treatment, claim payment, or healthcare operations. In addition, you have the right to restrict disclosure of PHI to the health plan for payment or health care operations (but not for carrying out treatment) in situations where you have paid the health care provider out-of-pocket in full. To request a restriction, you must make your request, in writing, to the Privacy Officer through the HR Department. We are not required to agree to any restriction that you may request, unless it involves a situation described above where you paid a provider out-of-pocket in full. If we do agree to the restriction, we will comply with the restriction unless the information is needed to provide emergency treatment to you.

Right to Request Confidential Communications: If you believe a disclosure of your PHI may endanger you, you may request that we communicate with you regarding your information in an alternative manner or at an alternative location. For example, you may ask that we only contact you at your work address or via your work e-mail.

Right of an Accounting: You have a right to an accounting of certain disclosures of your PHI that are made for reasons other than treatment, claim payment, or healthcare operations. This includes an accounting of disclosures of electronic health records, even those used for treatment, payment, and health care operations. No accounting is required for disclosures you authorized. You should know that most disclosures of your PHI will be for purposes of treatment, claim payment or healthcare operations, and therefore, will not be subject to accounting. You may request an accounting of disclosures for the previous six years (previous three years, if it was a disclosure of electronic health records). For these requests, you must submit your request, in writing, to the Privacy Officer through the HR Department.

Right to Amend: You may request us to amend your information if you believe that PHI is incorrect or incomplete. This office may deny your request if the information you want to amend is not maintained by us, but by another entity.

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

Questions and Complaints
If you have questions in regards to your PHI, you may contact:

Contact Office: AACPS HR Office of Operations
Telephone: 410-222-5221, 410-222-5219 or 1-800-909-4882
Fax: 410-222-5610
Address: 2644 Riva Road, Annapolis, MD 21401

You may notify our office if you believe your PHI privacy rights have been violated. You may file a written complaint with the above address or contact us at the designated phone numbers.

You may also file a written complaint with the Office for Civil Rights of the U.S. Department of Health & Human Services. This complaint may be submitted to:

Office for Civil Rights
Department of Health & Human Services
Suite 372, Public Ledger Building
150 S. Independence Mall West
Philadelphia, PA 19106-9111

Please be advised we will not penalize you in any way if you choose to file a complaint with us or the U.S. Department of Health & Human Services.

Important Notice From Anne Arundel County Public Schools About Your Prescription Drug Coverage And Medicare

NOTICE OF CREDITABLE COVERAGE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Anne Arundel County Public Schools (AACPS) and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. AACPS has determined that the prescription drug coverage offered by the AACPS Prescription Plan CVS Caremark is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered Creditable Coverage.

   Note: Medicare eligible retiree members will be group enrolled into a Medicare Part D plan through CVS Caremark SilverScript that is expected to pay out as much as standard Medicare prescription drug coverage.

Your Share Of Prescription Cost—For The 2022 Plan Year

	Medical Option	Deductible	Retail	Mail Order	Maximum You Could Pay Per Benefit Year
AACPS Plans	CareFirst BlueChoice Triple Option "Open Access" Plan CareFirst BlueChoice HMO "Open Access" Plan	None	You pay: $5 (generic) or $20 (brand-name) or $35 (non-preferred brand) 5% or $75 (specialty)	You pay: $10 (generic) or $40 (brand name) $70 (non-preferred brand) 5% or $150 (specialty)	Unlimited
Medicare	Standard Medicare Part D Prescription Drug Benefits	$480	You pay: 5% or 25%[1] of the prescription cost (depending on where you are in accumulating drug costs during the year)		Unlimited You pay first $7,050 in out-of-pocket spending, then 5% thereafter

Remember, the insurance companies who offer Medicare Part D plans may have benefit structures that are different from the Standard Medicare Part D structure shown above.

[1] *For 2022, Medicare Part D participants will receive a 70% discount from pharmaceutical manufacturers on the total cost of Medicare Part D-covered brand-name drugs purchased while in the coverage gap. The full retail cost of the brand-name drugs, minus the Medicare Part D plan payment equal to 5% of the brand-name drug cost, will still apply to satisfying your $7,050 in out-of-pocket spending before reaching the 5% catastrophic coverage level, even though the 70% was paid by pharmaceutical manufacturers. In addition, Medicare Part D participants will pay 25% of the cost of Medicare Part D-covered generic drugs purchased while in the coverage gap.*

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. This may mean that you may have to wait to join a Medicare drug plan and that you may pay a higher premium (a penalty) if you join later. You may pay that higher premium (a penalty) as long as you have Medicare prescription drug coverage. However, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible for a two (2)month Special Enrollment Period (SEP) because you lost creditable coverage to join a Part D plan.

In addition, if you lose or decide to leave employer/union sponsored coverage, you will be eligible to join a Part D plan at that time using an Employer Group Special Enrollment Period.

You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area.

Please note if you drop your AACPS prescription coverages, you may have to wait until the following October to join for the upcoming January.

If you decide to join a Medicare drug plan, your AACPS coverage will be affected. Read on for more information about what happens to your current coverage if you join a Medicare drug plan.

If you do decide to join a Medicare drug plan and drop your AACPS prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

You should also know that if you drop or lose your coverage with AACPS and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (incur a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium may go up by at least 1% of the base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may consistently be at least 19% higher than the base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For more information about this notice or your current prescription drug coverage…

Contact the Human Resources Retirement Office at 410-222-5224 for more information. NOTE: You will receive this notice each year. You will also receive it before the next period you can join a Medicare drug plan, and if this coverage through AACPS changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage…

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

For more information about Medicare prescription drug coverage:

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

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

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

COBRA Continuation Coverage

If you leave AACPS, or your covered dependents lose eligibility for healthcare coverage, you and/or your dependents may elect to continue coverage through COBRA (Consolidated Omnibus Reconciliation Act). COBRA allows you to continue coverage when that coverage would otherwise end because of a life event known as a "qualifying event."

COBRA must be offered to each person who is a "qualified beneficiary." Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Qualified beneficiaries who elect COBRA continuation coverage must pay 102% of the full premium.

If you are an employee, you are a qualified beneficiary if you lose your coverage because:

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

If you are the spouse of an employee, you are a qualified beneficiary if you lose your coverage because the employee:

- Dies
- Employment ends for any reason other than his or her gross misconduct
- The spouse-employee's hours of employment are reduced
- Becomes enrolled in Medicare (Part A, Part B, or Part D) or
- Becomes divorced

Your dependent children become qualified beneficiaries if they lose coverage under the plan because:

- The parent-employee dies
- The parent-employee's hours of employment are reduced
- The parent-employee's employment ends for any reason other than his or her gross misconduct
- The parent-employee becomes enrolled in Medicare (Part A, Part B, or Part D)
- The parents become divorced or
- The child stops being eligible for coverage under the plan as a "dependent child"

HOW COBRA CONTINUATION COVERAGE WORKS

AACPS' COBRA administrator is Discovery Benefits. Discovery Benefits will send out COBRA notifications to eligible participants based on the criteria listed earlier. Notice must be provided within certain timeframes, and documentation may be required. COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

Keep in mind that COBRA is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, Part D), your divorce, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage generally lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended: in the case of disability and a second qualifying event.

Please Note: This section is a summary of COBRA continuation coverage.

For additional information about specifics of COBRA coverage, COBRA rights, and COBRA costs, please

contact Discovery Benefits, our COBRA administrator, at 1-866-451-3399. For additional information, you may visit Discovery's website at www.discoverybenefits.com.

Maternity and Newborn Length of Stay

Under federal law, group health plans and health coverage issuers offering group coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to:

- Less than 48 hours following a normal vaginal delivery.
- Less than 96 hours following a cesarean section.

They may also not require that a provider obtain authorization from the plan or coverage issuer for prescribing a length of stay not in excess of those periods. The law generally does not prohibit an attending provider of the mother or newborn (in consultation with the mother) from discharging the mother or newborn earlier than 48 hours or 96 hours, as applicable.

Right to choose a Primary Care Provider

The AACPS HMO and Triple Option Plans generally allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation the AACPS HMO and Triple Option Plans designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, see page 11 of this Guide.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from any AACPS medical plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology.

The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For information on how to find participating health care professionals who specialize in obstetrics or gynecology, see page 11 of this Guide.

Notice of Special Enrollment Rights

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Benefits Manager, AACPS Office of HR Operations—Benefits, 410-222-5221.

Women's Health and Cancer Rights Act Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Acts of 1998. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prosthesis and;
- Treatment of physical complications of the mastectomy, including lymphedema.

Some Final Words

This guide contains highlights of the medical plan available to Anne Arundel County Public Schools employees—it is the only plan available to eligible temporary employees. This guide does not include every detail about the plan. The plan is governed by an official plan document or insurance contract. If there is a conflict between this guide and the wording of the corresponding plan documents, the plan documents will prevail.

CareFirst BlueCross BlueShield provides detailed summaries to participants. Summaries are available on-line at www.aacps.org/healthcare.

Anne Arundel County Public Schools
Division of Human Resources

George Arlotto, Ed.D., Superintendent of Schools

Anne Arundel County Public Schools prohibits discrimination in matters affecting employment or in providing access to programs on the basis of actual or perceived race, color, religion, national origin, sex, age, marital status, sexual orientation, genetic information, gender identity, or disability. ***For more information, contact:*** Anne Arundel County Public Schools, Division of Human Resources, 2644 Riva Road, Annapolis, MD 21401; 410-222-5286 TDD 410-222-5000; www.aacps.org