Frederick County Public Schools

2021 Open Enrollment Benefits Information

Annual Benefits Open Enrollment May 1 – 25, 2021

FCPS Benefits Office
191 South East Street, 2nd Floor
T (301) 644-5080, F (301) 644-5122
Visit http://www.fcps.org/benefits for more information

Benefits Open Enrollment May 2021

Open Enrollment is **May 1st through May 25th.** Please review this important information to see if you need to take action regarding your benefits.

To enroll or make changes, you must do so ONLINE through the employee Self Service Portal, which opens on May 1st.

You can use Employee Self Service to enroll/change the following benefits:

- Flexible Spending Account Plan **(You must re-enroll in this plan every year)** Elect your Annual Amount
- Health Coverage
- Dental Coverage
  - ❖ Standard or Dental Buy-Up
- Life insurance beneficiary changes
- Paper enrollment forms will not be used during open enrollment
- You must enroll and/or make all changes by **May 25th**
- Instructions for enrolling in the medical and dental plans are found on page 20

Please note:

You may add eligible dependents to your health and/or dental coverage.

An eligible dependent is defined as follows:

- The eligible employee's legal married spouse;
- Children from birth through the end of the month in which they attain the age of twenty six (26) including:
  - ❖ Biological children
  - ❖ Adopted children or children placed for adoption or Stepchildren
  - ❖ Legal ward children
  - ❖ Disabled dependent children over the age of twenty-six (26)
    - ◊ Proof of disability must be provided using the medical carriers form
    - ◊ Proof of financial responsibility must be provided by submitting a current, signed, tax form listing the child as a claimed dependent (income information may be redacted). This may be requested each calendar year following income tax filing due dates.

WHAT'S NEW?

Updates for the 21-22 Plan Year

- Discovery Benefits is changing to WEX
- Delta Dental Cost Estimator tool and "Go Paperless" option
- OVIA – New premium app in partnership with FCPS and CareFirst for fertility, pregnancy and parenting. Review this app and features by logging onto your CareFirst account at www.carefirst.com/frederick.
- CareFirst members can participate in the Blue Rewards incentive program between July 1, 2021 and March 31, 2022 to earn up to $100 by completing activities. Look for **Employee News** announcement for more information.

FCPS Open Enrollment Information

The FCPS Benefits department is organizing web based informational sessions for April and May of 2021 in lieu of our regular location-based sessions. Email notifications will be sent to all employees through Employee News so that employees may request an invitation to these events.

Times and formats are subject to change due to meeting and social distancing guidelines announced by the Governor and Maryland State Department of Education.

Topic	Date	Time	Format
Benefits Presentation and Open Enrollment Information	Wednesday, April 28	2 p.m.	Google Meet hosted FCPS Benefits to present a general overview of available benefits and information about open enrollment.
Benefits Presentation and Open Enrollment Information	Wednesday, May 5	2 p.m.	Google Meet hosted FCPS Benefits to present a general overview of available benefits and information about open enrollment.
Benefits Presentation and Open Enrollment Information	Wednesday, May 19	2 p.m.	Google Meet hosted FCPS Benefits to present a general overview of available benefits and information about open enrollment.

NOTE:

The premium rate chart on the following page contains Board recommended premium payroll deductions. The premium rates and benefits included in this material are contingent upon final contract negotiations with FCTA, FASSE, FCASA and final adoption of the Board of Education's Fiscal Year 2022 budget. This rate represents a 1.25% increase in premiums from FY21.

JULY 1, 2021 – JUNE 30, 2022 (FY22)
FREDERICK COUNTY PUBLIC SCHOOLS
EMPLOYEE BENEFITS AND INSURANCE SUMMARY

INFORMATION ABOUT INSURANCE: • ***MEDICAL*** • ***PRESCRIPTION*** • ***DENTAL***	**PAYROLL DEDUCTIONS – EACH PAY PERIOD[1]**				
	HEALTH INSURANCE[2] CareFirst BlueChoice Advantage CareFirst BlueVision Plus CVS CareMark Prescription				**EMPLOYER'S CONTRIBUTION (How much FCPS pays on your behalf)**
	10-Month Employees 19 Pays	**10-Month Employees 20 Pays**	**11-Month Employees 22 Pays**	**12-Month Employees 24 Pays**	**Employer Annual Contribution**
Employee Only	$23.02	$21.87	$19.88	$18.23	$8,310.00
Employee + **One** Dependent[3]	$175.14	$166.38	$151.26	$138.66	$15,742.00
Employee + Family[4]	$232.51	$220.88	$200.80	$184.07	$15,702.00
Employees + Family[4, 5] (both parents employed by FCPS)	$47.65	$45.27	$41.15	$37.73	$19,214.00

	DENTAL INSURANCE[2] *Standard* Delta Dental $1,500 Maximum Benefit Per Covered Person				**DENTAL INSURANCE[2] *Buy-Up* Delta Dental $2,500 Maximum Benefit Per Covered Person**			
	10-Month Employees 19 Pays	**10-Month Employees 20 Pays**	**11-Month Employees 22 Pays**	**12-Month Employees 24 Pays**	**10-Month Employees 19 Pays**	**10-Month Employees 20 Pays**	**11-Month Employees 22 Pays**	**12-Month Employees 24 Pays**
Employee Only	**Paid 100% by FCPS ($345.84/year)**	**Paid 100% by FCPS ($345.84/year)**	**Paid 100% by FCPS ($345.84/year)**	**Paid 100% by FCPS ($345.84/year)**	$6.83	$6.49	$5.90	$5.41
Employee + **One** Dependent[3]	$38.24	$36.32	$33.02	$30.27	$59.43	$56.45	$51.32	$47.05
Employee + Family[4]	$44.25	$42.04	$38.21	$35.03	$67.68	$64.30	$58.45	$53.58
Employees + Family[4, 5] (both parents employed by FCPS)	$26.06	$24.75	$22.50	$20.63	$49.49	$47.02	$42.74	$39.18

[1] The premium rate chart contains Board recommended premium payroll deductions. The premium rates and benefits included in this material are contingent upon final contract negotiations with FCTA, FASSE, FCASA and final adoption of the Board of Education's Fiscal Year 2022 budget.

[2] Contributions for medical and dental insurance coverage are deducted from your gross earnings before taxes are calculated.

[3] In this context, "Employee + One Dependent" would refer to employee + spouse or employee + dependent.

[4] In this context, "Family" refers to Employee + two or more dependents.

[5] The employees must be legally married spouses to qualify for rate tier.

This publication is intended to provide an overview of FCPS benefits; complete details can be found in the insurance companies' documents and the plans' legal documents, which will always govern in case of a dispute. The Board of Education of Frederick County, FCTA, FASSE and FCASA jointly reserve the right at any time to modify or amend, in whole or in part, any or all plan provisions.

Summary of Benefits Plans

CareFirst BlueChoice Advantage Medical Plan

FCPS will offer medical coverage through CareFirst for the 2021–2022 plan year.

CareFirst allows you to take advantage of two levels of care benefits:

- ***In-network*** — Selecting a physician or health care provider within the CareFirst's BlueChoice Advantage large local and national network means maximum coverage and lower out-of-pocket expenses. Copayments are charged for eligible services, and referrals are not required for specialty services.
- ***Out-of-network*** — Higher deductibles are required and you must file claims for reimbursement of 80% of eligible expenses.

Below is an at-a-glance chart that highlights the medical benefits under the CareFirst medical plans. This is not intended to be a comprehensive summary, it will only give you basic details about your plans. For more details, please refer to the Summary of Benefits for each plan.

To find a provider near you, visit the website at **www.carefirst.com/frederick**

BENEFITS HIGHLIGHTS

IN NETWORK		OUT OF NETWORK
CO-PAYMENTS:		***CO-INSURANCE:*** 20% after deductible
Primary Care Physician	$20.00	***DEDUCTIBLE:***
Specialist	$30.00	$200 per Covered Person
Outpatient Physician Services	$20.00	$400 for all Covered Persons in a family
Inpatient Hospital	$100.00	***MAXIMUM OUT-OF-POCKET:***
Emergency Room (Non-Emergency)	$75.00	$1,250 per Covered Person per policy year
DEDUCTIBLE: None		$2,500 for all Covered Persons in a family
MAXIMUM OUT-OF-POCKET: No Out-of-Pocket Maximum		Out-of-Pocket Maximum includes the Annual Deductible

CareFirst Vision Plan

The vision plan through CareFirst provides vision benefits for you and your eligible dependents. You may see any vision provider, but to keep your out-of-pocket costs down, consider using an in-network provider. You can use these benefits in addition to the coverage provided through our medical plans. **Out-of-network** – Adults are reimbursed according to a fee schedule for exam, lenses and frames. To locate a provider near you, visit the website at **www.carefirst.com/frederick**

CareFirst BlueVision Plus		
Benefit Level	**In-Network, Adult Age 20 or Older**	**In-Network, Children Age 19 or Under**
Eye exam (every 12 months)	$0 copay	$0 copay
Lenses (every 12 months)		
Single vision lenses	$0 copay	$0 copay
Anti-reflective lenses	$0 copay	$0 copay
Progressive lenses	$0 copay	$0 copay
Contact lenses or frames (every 12 months)		
Frames	Up to $150 retail allowance	Up to $200 retail allowance
Elective contact lenses	Up to $150 allowance	Up to $150 allowance

Please refer to the vision summary plans for more details.

Summary of Benefits Plans – continued

Delta Dental Plan

FCPS offers two dental plan options to allow you to choose the plan that best meets your needs. Both options provide a rich benefit for covered preventive dental services to encourage good dental habits. We use Delta as our dental carrier.

You'll receive the greatest value when you visit a Delta Dental PPO dentist because they generally accept lower fees for their services, and the Plan has enhanced Diagnostic and Preventive benefits with a PPO provider. But Delta Dental Premier dentists also discount their fees, which can help reduce your out-of-pocket costs.

To find a network provider, visit the website at **www.deltadentalins.com**

Feature/Service	Delta Dental			
	Standard		Buy-Up	
	In-Network	Out-of-Network[1]	In-Network	Out-of-Network[1]
	You pay:			
Individual Calendar Year Deductible (per person)	$0	$50	$0	$50
Family Calendar Year Annual Deductible (per family)	$0	$150	$0	$150
Annual Maximum/Person	$1,500		$2,500	
Preventive and Diagnostic (Deductible waived for preventive services)	$0		$0	
Basic Services	20%		20%	
Major Services	50%		50%	
Orthodontia	50%		50%	
Orthodontia Lifetime Maximum	Unlimited	After deduction $2,000	Unlimited	After deduction $2,000

[1] *Out-of-network dentists can bill you for the difference between what the plan pays and what the dentist actually charges.*

CVS/Caremark Prescription Drug Coverage

When you enroll in the FCPS medical plan, you automatically receive prescription drug coverage through CVS/Caremark. The Pharmacy Management Formulary Program provides a defined list of FDA-approved medications chosen for their medical effectiveness and value. The formulary list includes both generic and brand-name drugs. Your share of the cost will always be less for drugs that are on the formulary list; however, coverage is available for many non-formulary drugs.

The formulary drug program is divided into copayment categories called tiers. To get an updated copy of the tiered formulary list of drugs, visit **www.caremark.com.**

The prescription plan includes the following programs:

- **Maintenance Choice Program** – plan participants who take maintenance medications have the choice to purchase their 90-day supply from the mail order program or purchase from a CVS/Pharmacy store and pay the same mail order copayment.
- **Mandatory Generics** – when available as well as mandatory specialty pharmacy program for specialty prescription drugs.
- **Diabetic Meter Program** – plan participants with diabetes may qualify for a free blood glucose meter when diabetic testing supplies are ordered.

Summary of Benefits Plans – continued

Save Money - Use Mail Order!

The prescription plan also includes a Mail Order program through CVS/Caremark which allows you to purchase up to a 90-day supply of medications you take on an ongoing basis (known as maintenance drugs). When you order prescriptions through the mail or at a CVS Pharmacy, you will receive a significant savings for a 90-day supply.

To use the mail order program, have your doctor fill out your prescription and fill out an order form. Mail your form to CVS/CareMark, P.O. Box 94467, Palatine, IL 60094-4467. You can also fax it to 800-323-0161.

CVS/Caremark	
Benefit	**You Pay:**
Retail (any pharmacy) (up to 30-day supply)	Generic: $13 Brand: $25 Non-Formulary: $40
Mail Order or CVS Pharmacy (up to 90-day supply)	Generic: $21 Brand: $45 Non-Formulary: $65

Go Generic! Keep You and Your Wallet Healthy

1. What are generic drugs?
Generic drugs are prescription medications that have the same active ingredients, dosage amounts, strength, safety, and quality as brand-name prescription medications.

2. Are generic drugs just as safe as brand-name drugs?
Yes. Laboratories that produce generic drugs must meet the same high FDA standards as the facilities of brand-name drugs, and all generic drugs are FDA-approved to be therapeutically equivalent to brand-name drugs.

3. Why are generic drugs less expensive?
When a new medicine is invented, a patent is filed so that no other company may reproduce that drug. While the patent is current, companies can charge a much higher price for the drug because there is no competition. In addition, companies often spend large amounts of money for advertising and promotion, further increasing the cost of the brand name medication. When a medication's patent expires, other companies may produce this drug, creating generic medications. Due to increased competition, and because these other companies rarely spend money on advertising, the price of the generic drug is significantly lower.

4. What is different about generic?
The appearance of brand-name drugs is protected by law, so generic drugs will have different shapes, flavors, and/or colors. However, since the active ingredients are the same, they will work the same way in your body as the brand-name drug.

5. Does every brand-name drug have a generic drug equivalent?
No. Pharmaceutical companies have a patent on their brand-name medications, so new drugs will not have a generic equivalent until the patent expires.

6. What if my brand-name drug is not available in generic form?
Even if your brand name drug is not available in generic form, there may be a different generic drug that could work just as well. Ask your doctor if a therapeutic alternative might be right for you. A generic therapeutic alternative is the equivalent for a different brand-name drug and treats your condition using a different active ingredient. If your doctor agrees, you can feel confident about using the generic therapeutic alternative and feel good about saving money too!

FCPS Cafeteria Plan At a Glance

One of the many benefits of being employed with Frederick County Public Schools (FCPS) is that you have access to a Cafeteria Plan established by FCPS. A Cafeteria Plan allows you to pay for out-of-pocket medical expenses. (The major advantage of FCPS's Cafeteria Plan is that, by participating, you save money by paying for benefits you would normally pay for but you avoid having to pay Federal Income and Social Security taxes.) If you do participate in the Cafeteria Plan, you would not be eligible for a Federal income tax credit on your next tax return.

FCPS Plan Information

Plan Name:	Frederick County Public Schools
Address:	191 South East St. Frederick, MD 21701
Telephone:	(301) 644-5080
Plan Number:	37854
Plan Year Begin:	July 1
Amended:	N/A
Plan Year End:	June 30
Maximum Health FSA Limit:	$2,750
Maximum Dependent Care Limit:	$5,000
Annual Rollover Maximum:	$550
Grace Period:	No
Run-out Period for Active Employees:	90 days after Plan year ends (last day to submit claims is September 28th)
Run-out Period for Terminated Employees:	90 days after your termination date
Plan Administrator:	FCPS
Service Provider:	Discovery Benefits
Service Provider Contact:	866-451-3399 www.wexinc.com/discovery-benefits/

Elections

It is important for you to decide what benefits you will need for each Plan year. Your decision should be carefully made based on your expected health expenses for the coming year.

Unless a qualifying "change in status" event occurs, you will not be able to change your elections after the first month of the Plan year. To see a list of the qualifying "change in status" events please see your Summary Plan Description.

Eligibility

Open enrollment will take place each year prior to the start of the Plan year. After the Plan year begins, enrollment is limited to newly hired employees or those with special circumstances (see Summary Plan Document). For mid-year enrollments, participation will begin on the 1st of the month following hire date.

Beginning and Ending of Coverage

The coverage will begin the first day of the Plan Year for those who enroll during the open enrollment period. For mid-year enrollments the coverage date will begin as set forth by FCPS (see eligibility). The coverage will end at the end of the month of the termination date, or at the end of any applicable run-out/carryover period. This plan is subject to COBRA (see the Summary Plan Description for more details.)

Benefits Available

The FCPS Cafeteria Plan offers the following benefits:

Health Flexible Spending Account

A Health Flexible Spending Account (FSA) allows you to get reimbursed for qualified medical expenses with pre-tax funds (see Section 213D and Section 105 of the Internal Revenue Code for list of eligible expenses. You cannot use your FSA for expenses that have been paid by your medical insurance plan.) The maximum annual election amount is $2,750.

Dependent Care Flexible Spending Account

The Dependent Care Flexible Spending Account (DCAP) allows you to be reimbursed for qualified dependent day-care expenses with pre-tax funds. The maximum annual election amount is $5000 (married filing jointly or head of household) or $2500 (married filing separately). To be eligible for reimbursement you will need to provide a statement from the service provider with the following information: name, address, taxpayer identification number (in most cases), and incurred expense amount.

Please see the Summary Plan Description for dependent eligibility requirements.

Reimbursement

Throughout the Plan year you can submit for reimbursement for qualified medical and dependent care expenses in the following ways: fax (forms available at www.discoverybenefits.com), email, online, or mobile application. Employees may also pay for their qualified medical expenses directly from their FSA with the Discovery Benefits debit card. See the SPD for further details.

Expenses are "incurred" when the service has been provided. The reimbursement requirements will be listed on the reimbursement claim forms.

For Health FSA and DCAP accounts reimbursement claims must be submitted no later than 90 days after the end of the Plan Year. Any Health FSA funds exceeding $550.00 left over after the 90 day run-out period will be forfeited. See "Rollover" section below for additional details.

Non Discrimination

Per compliance with the various rules and regulations of the Internal Revenue Code the election amounts of "highly compensated employees" and "key employees" (officers, shareholders or highly paid employees) may be limited due to non-discrimination regulations. For more information, please see the Summary Plan Description.

Family and Medical Leave Act (FMLA)

If you go on a qualifying FMLA Leave this plan will comply with the rules and regulations set forth in the proposed CFR-IRS Regulation 1.125-3 as well as any additional policies established by FCPS. Please see the Summary Plan Description for more details.

Rollover

Under the new IRS regulations, employees will be able to rollover up to $550.00 of their Health FSA funds from one Plan year to the next. (The rollover funds will be available to employees for one additional year. Any amount rolled over will not affect the election amount for the new Plan year. Any funds above $550.00 left over after the 90 day run- out period will be forfeited.)

Flexible Spending Frequently Asked Questions

What is a Flexible Spending Account (FSA)?

Flexible Spending is an employer sponsored program that allows you to set aside money pre-tax to use for certain IRS eligible expenses. The Medical FSA covers not only medical expenses, but also dental and vision services.

How does an FSA work?

During the open enrollment period with your employer, you will make an election for the amount you want contributed to your FSA. That annual amount will be divided equally over your yearly pay schedule, and deductions will be made pre-tax from each pay check and deposited to that account. As you incur expenses, you will submit for reimbursement from your account, either with a paper claim or with the Discovery Benefits debit card.

What are the advantages to having an FSA?

When you participate in the Flexible Spending program, your eligible expenses are paid for with tax-free money. Also, as the contributions are withheld from your paycheck pre-tax, it lowers your taxable income, meaning you pay less in taxes, and take more money home.

What are considered eligible expenses?

There are 3 things to consider as you determine whether an expense is eligible for reimbursement from your Medical FSA – services, service dates, and eligible dependents.

Services- Eligible medical expenses are defined by IRS Code §213(d) and must not be excluded by the plan documents. In order to qualify for reimbursement, the expense must diagnose, cure, mitigate, treat, or prevent disease, or affect a structure or function of the body. Expenses aimed at maintaining general health or improving a person's appearance (cosmetic procedures), are not considered eligible expenses.

Service Dates- In order to be eligible for reimbursement, services must be provided/incurred during the time that you are covered and active under the plan. The IRS is concerned with the actual date of service, not the date of payment.

Eligible Dependents- Coverage for a Medical FSA is extended to the employee, the employee's spouse, and the employee's child who is under age 26 or someone else who is a qualified tax dependent of the employee.

When can I enroll?

You may enroll in the plan during your employer's open enrollment period prior to the start of the plan year. You may also enroll mid-year if you are a newly hired employee, or if you have a qualified Status Change Event as outlined in the Summary Plan Description.

Can I make changes to my account mid-year?

Once you make your election during the open enrollment period, it cannot be changed or cancelled during the plan year, it is irrevocable. Exceptions to the irrevocability rule are allowed mid-year with a qualified Status Change Event such as a marriage, divorce, birth, adoption, death, etc. The election changes must be consistent with the status change.

What if my spouse has a Health Savings Account?

If your spouse is participating in a Health Savings Account (HSA), participation in this FSA may disqualify them from further contributions to that HSA.

What happens to money left in the account at the end of the plan year?

Under IRS regulations, employees are now able to rollover up to $550.00 of their Health FSA funds from one plan year into the next. This will allow participants an additional 12 months to spend the remaining balance. Funds that are rolled over will not affect election amounts for the new plan year. A run-out period will still be applicable, allowing you time to submit reimbursement claims for expenses incurred prior to the end of the plan year. **Rollover does not apply to the Dependent Care FSA.**

Do I have to wait for the money to be deposited before requesting reimbursement?

With a Medical FSA, you do not have to wait for the deposits to be made before requesting reimbursement. Your full annual election amount is available to you on the first day of the plan year.

What information do I need for reimbursement?

In order to verify the eligibility of an expense, we need a third party statement indicating the provider's name and contact information, the patient, the date of service (not the date of payment), a description of services rendered, and your portion of the expense. You should also retain a copy of the statement for your records.

How do I submit a reimbursement claim and when can I expect payment?

Reimbursement claims may be submitted electronically with the "Online Claims Entry" option on your account through www.wexinc.com/discovery-benefits/. Reimbursements may also be submitted with a printed reimbursement claim form and sent to the Discovery Benefits office via email, fax or postal service. Reimbursement claims will be processed daily.

Where can I find out my account information and balance?

As a participant, you will have access to a secure online account through www.wexinc.com/discovery-benefits/. Here you will be able to view your account history and balance, submit reimbursement claims electronically, view a list of eligible expenses, print various forms and documents, and much more. You will be provided the online registration information after enrollment.

Benefits Technology & Resources

Benefits debit card

The benefits debit card is the fastest and most convenient way to pay for eligible expenses. Just one debit card is all you need for your benefits regardless of how many plans you have with us.

Knowledgebase

Once you're enrolled, check out the knowledgebase to quickly search for answers to your questions. The knowledgebase boasts millions of views of our microvideos, articles and step-by-step how-tos empowering you to get the most out of your benefits. Have a question? Visit any time of day or night by logging in to your online account on DiscoveryBenefits.com.

Benefits eligible expenses

There are thousands of eligible procedures, items and expenses based on your plan. View our interactive list of eligible expenses at www.DiscoveryBenefits.com/eligibleexpenses

Benefits Mobile App & online account

Access your benefits 24/7 with the Benefits Mobile App by Discovery Benefits. Our app is free, convenient and offers real-time access to all your benefits accounts.

With our Benefits Mobile App you can:

- Get instant updates on the status of your claims.
- File a claim and upload documentation in seconds using your phone's camera.
- Scan an item's bar code to determine if it's an IRS Code Section 213(d) eligible expense.
- Report a card as lost or stolen, which cancels the card and ships you a new one.
- Log in through face recognition or fingerprint (depending on your phone).
- Check your balance and view account activity.
- Reset login credentials.

Don't have a smartphone? Access the same features on your desktop by logging in to your online account at www.DiscoveryBenefits.com and selecting "Login" in the navigation bar.

Have questions?
Contact our Participant Services department. Our Participant Services team is available Monday - Friday 6:00 a.m. to 9:00 p.m. Central time.

Toll-free: 866-451-3399
Ask a question: customerservice@discoverybenefits.com
Submit a form: forms@discoverybenefits.com
Live chat: www.discoverybenefits.com

Mail to:
Discovery Benefits, LLC, a WEX Company
P.O. Box 2926
Fargo, ND 58108-2926

Simplifying benefits for everyone.

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Legal Notices

HIPAA Notice of Special Enrollment Rights

LOSS OF OTHER COVERAGE

If you are declining enrollment for yourself and/or your dependents (including your spouse) because of other health insurance coverage or group health plan coverage, you may be able to enroll yourself and/or your dependents in this plan in the future, if you or your dependents lose eligibility for that other coverage or if the employer stops contributing towards your or your dependent's coverage. To be eligible for this special enrollment opportunity, you must request enrollment within 31 calendar days after your other coverage ends or after the employer stops contributing towards the other coverage.

NEW DEPENDENT AS A RESULT OF MARRIAGE, BIRTH, ADOPTION OR PLACEMENT FOR ADOPTION

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/or your dependent(s). To be eligible for this special enrollment opportunity, you must request enrollment within 31 calendar days after the marriage and within 31 days after the birth, adoption or placement for adoption.

TERMINATION OF MEDICAID OR SCHIP COVERAGE OR ELIGIBILITY FOR PREMIUM ASSISTANCE UNDER MEDICAID OR SCHIP

If you or your dependent is eligible, but not enrolled for coverage, you may be able to enroll yourself and/or your dependent if either of the following events occur:

- You or your dependent is covered under a Medicaid plan or under a State Child Health Insurance Plan (SCHIP) and coverage under the plan is terminated as a result of loss of eligibility; or
- You or your dependent become eligible for premium assistance under Medicaid or SCHIP. To be eligible for this special enrollment opportunity, you must request enrollment within 60 calendar days after the date you or your dependent become eligible for premium assistance or you or your dependent's Medicaid or SCHIP coverage ends.

The Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act became effective January 1, 2010. The act prohibits health coverage discrimination and employment discrimination against employees based on their (or their family members') genetic information.

GENETIC INFORMATION INCLUDES:

- Genetic tests;
- The request for, or receipt of, genetic counseling or other genetic services; and,
- The manifestation of a disease or disorder in an individual's family member.

The availability of genetic testing and results of any genetic testing you undergo will be treated as confidential, as required by HIPAA and GINA. Likewise, genetic information collected about family history – such as through a Health Risk Assessment (HRA) – will be treated as confidential, as required by HIPAA and GINA.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, 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 vaginal delivery, or less than 96 hours following a Cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother from discharging the mother or her newborn earlier than the 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization for the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act requires group health plans that provide coverage for mastectomies to cover reconstructive surgery and prostheses following mastectomies. All medical plans provide this coverage.

If you receive benefits for a medically necessary mastectomy, and if you elect breast reconstruction after the mastectomy, you will also be covered for:

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

Medicare Part D Notice

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription 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. FCPS has determined that the prescription drug coverage offered by the FCPS Plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.

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 extra if you later decide to enroll in Medicare prescription drug coverage.

You can enroll in a Medicare prescription drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. Beneficiaries leaving employer coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. If you do decide to enroll in a Medicare prescription drug plan and drop your FCPS prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

If you continue your coverage through the FCPS Retiree Healthcare Plan Option, you will have prescription coverage included in your FCPS health plan that meets creditable coverage.

You should also know that if you drop or lose your coverage with FCPS and do not enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later. If you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without coverage, your premium will always be at least 19% higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE:

Contact your Medicare Division office for further information. You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through FCPS changes. You may also 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 prescription drug plans.

FOR MORE INFORMATION ABOUT MEDICARE PRESCRIPTION DRUG PLANS:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227) TTY 1-877-486-2048.
- For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at **www.socialsecurity.gov,** or you can call them at **1-800-772-1213 (TTY 1-800-325-0778).**

"Grandfathered Status"

Frederick County Public Schools (FCPS) has elected to be a "grandfathered health plan" under the Patient Protection and Affordable Care Act. As permitted by the Affordable Care Act, a "grandfathered health plan" can preserve certain basic health coverage that was already in effect when the law was enacted. As a "grandfathered health plan," FCPS is not subject to certain consumer protections of the Affordable Care Act that may apply to other plans.

Summary of Benefits and Coverage

To comply with the Patient Protection and Affordable Care Act (the Affordable Care Act), Frederick County Public Schools provides a Summary of Benefits and Coverage ("SBC"). The SBC can be found at the school system's website, www.fcps.org/benefits and paper copies are available upon request. The SBC is intended to be educational in nature. Complete details can be found in the insurance companies' documents and the plan's legal documents, which will always govern in case of a disparity.

Health Care Reform Update

Health Care Reform

The Affordable Care Act (or ACA) continues to impact health insurance plans for employers like Frederick County Public Schools. For the company, it means we continue to comply with all applicable health plan coverage and administration requirements and pay all applicable taxes and fees as required by the ACA.

For individuals, since 2019 there is no longer an ACA tax penalty for those who do not maintain health insurance coverage. However, individuals still have the ability to purchase coverage through the ACA Health Insurance Marketplace (www.healthcare.gov) and premium subsidies for that coverage remain available to qualifying individuals.

As a reminder, Frederick County Public Schools pays the majority of the cost for the health care coverage we offer to eligible employees. It's also important to note that, because you are eligible for coverage through Frederick County Public Schools, you may not qualify for premium subsidies if you choose to purchase a plan through the Marketplace. We encourage you to evaluate all your coverage options and compare their costs to make the best choice for you and your family.

New Tax Forms

Starting with the 2015 tax year, Frederick County Public Schools is required to provide all full-time employees (those working at least 30 hours per week) with an annual statement describing the health care coverage that was available to them through the company during each month of the year. If you were a full-time employee for at least one month during 2020, this statement (known as IRS Form 1095-C) will be provided to you by July 1, 2021. If you plan to claim premium tax credit subsidies for Marketplace coverage, you will need this form when filing your federal income taxes to confirm you are eligible to claim the tax credits.

FCPS Comprehensive Group Health Plan Benefit Communications

Discrimination is Against the Law

FCPS complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Frederick County Public Schools does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Frederick County Public Schools

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact 301-644-5080.

If you believe that Frederick County Public Schools has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Senior Manager for Benefits:

Senior Manager Benefits
Donna Clabaugh
191 S. East Street
Frederick, MD 21701
Phone: 301-644-5112
Fax: 301-644-5122
Email: benefits.office@fcps.org

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

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

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-301-644-5112.

注意 : 如果您使用繁體中文 , 您可以免費獲得語言援助服務。請致電 1-301-644-5112

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 **http://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 **http://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 **http://www.askebsa.dol.gov** or call **1-866-444-EBSA (3272).**

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2021. Contact your State for more information on eligibility –

PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462
VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

To see if any other states have added a premium assistance program since January 31, 2021, or for more information on special enrollment rights, contact either:

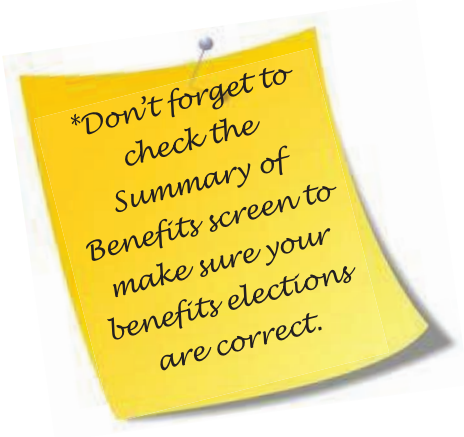
U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

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

How to Update Your Benefits by Using Employee Self Service

Open enrollment is fast and easy. Go to www.fcps.org and click on ***For Staff*** **>** ***Employee Portal.*** Select ***Employee Self-Service*** then follow the directions below:

1. Log into ***Employee Self-Service.*** You will need to do this twice.
2. Click on ***Main Menu*** **>** ***FCPS Menu*** **>** ***Employee Self Service*** **>** ***Benefit Information*** **>** ***Medical/Dental Enrollment***
3. Under **Medical Coverage,** the button for coverage change will be selected.
4. Select your level of **Employee Coverage.**
5. To add dependents, click on **Add a Dependent** towards the bottom of the page.
6. Read the **"Attestation for Dependent Eligibility",** click **I Agree,** and click **OK** (be advised that we perform periodical audits to verify dependent eligibility and you may be required to provide documentation as follows: marriage certificate, 1040, or birth certificates as necessary).
7. Enter all of your dependent information and then click on **Save** at the bottom of the page.
8. Click **OK** on the confirmation page.
9. Click **Return** at the bottom of the page to return to the enrollment screen.
10. Repeat steps 5 – 9 until all of your dependents have been added.
11. View your dependents and under the **Medical Coverage** select their **Coverage Election.**
12. Under **Dental Coverage,** the button for coverage change will be selected.
13. There is an option to enroll in the **Dental Buy Up** plan. Check this box if you would like to enroll.
14. Select your **Employee Coverage.**
15. View your dependents and under the **Dental Coverage** select their **Coverage Election.**
16. Scroll down to the bottom of the page, click the box next to **Date Signed** and click **Save.**
17. Click **OK** on the confirmation page.
18. When your change request has been received, a confirmation email will be sent to your FCPS email account from **Benefits.Systems@fcps.org.**
19. Remember to securely exit by clicking **Sign Out** in the upper right-hand corner of your screen or click on the door icon.



Making Changes Once Enrolled

Once you enroll, ***you may not change*** your benefit elections until the next open enrollment period. You may add or drop coverage during the Plan Year if you have a qualified change in family status. Circumstances that qualify as a change in family status include:

- Marriage, divorce or legal separation
- Birth or adoption of a child
- Loss of a spouse or dependent (death or loss of dependent status)
- Change in spouse's employment (termination or loss of eligibility)
- Significant change in spouse's coverage
- Retirement

If you are changing your elections due to a change in family status, you must complete the appropriate form and submit it to your HR Representative, along with supporting documentation, within 31 calendar days of the event. If your change form and documentation is not received within the 31-day timeframe, you will be unable to make the desired changes until the next open enrollment period.

How to Update Your Benefits – continued

Making Changes Once Enrolled – continued

A change in coverage elections due to a birth, adoption or placement for adoption will be effective as of the date of the birth, adoption or placement for adoption. All other changes in coverage elections will be effective as of the first day of the month following the date the change in election application is received by the Plan Administrator.

Please refer to the full Summary Plan Description for additional details for when coverage begins and ends and the qualifying events for changes for you and/or your dependents.

NOTE: If you decline enrollment in medical/dental coverage for you or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in the plan as long as you request enrollment no more than 30 days after your other coverage ends

INSURANCE COMPANY CONTACT INFORMATION

Plan/Contact	Address	Phone & Website
Health/Vision Insurance		
CareFirst Medical	CareFirst Administrator P.O. Box 14116, Lexington, KY 40512	Phone: 1-866-386-2043 www.carefirst.com
CareFirst Vision	CareFirst Administrator P.O. Box 14116, Lexington, KY 40512	Phone: 1-866-386-2043 www.carefirst.com
Dental Insurance		
Delta Dental	One Delta Drive Mechanicsburg, PA 17055	Phone: 1-800-932-0783 www.deltadentalins.com
Flexible Spending Accounts		
WEX	P.O. Box 2926 Fargo, ND 58108-2926	Phone: 1-866-451-3399 www.wexinc.com/discovery-benefits/
Prescription Plan		
CVS/CareMark Claims Office	P.O. Box 52010 Phoenix, AZ 85072-2010	Phone: 1-866-260-4646 www.caremark.com
CVS/CareMark Mail Order	P.O. Box 94467 Palatine, IL 60094-4467	Fax: 1-800-323-0161
Life Insurance and Disability		
The Standard Life and AD&D	One Moody Plaza Galveston, TX 77550	Phone: 1-800-628-8600 www.thestandard.com
The Standard Short Term Diability	One Moody Plaza Galveston, TX 77550	Phone: 1-800-368-2859 www.thestandard.com

FCPS BENEFITS OFFICE CONTACT INFORMATION

Contact	Email	Phone Number
Benefits Office	benefits.office@fcps.org	301-644-5080
Phoebe Barreto	phoebe.barreto@fcps.org	301-644-5085
Molly Bentz	molly.bentz@fcps.org	301-644-5093
Evelyn Davis	evelyn.davis@fcps.org	301-644-5115
Christine Hobble	christine.hobble@fcps.org	301-644-5052
Laura Sargent	laura.sargent@fcps.org	301-644-5076

FOR STAFF, BENEFITS, ABOUT EMPLOYEE BENEFITS, REQUIRED NOTICES, HIPPA PRIVACY NOTICE
http://www.fcps.org/benefits

The HIPAA Privacy Rules require health plans to provide a Notice of Privacy Practices to persons covered under the health plan. Eligible employees may obtain a copy of the Notice of Privacy Practices by visiting the school system's website: **www.fcps.org.** Go to: **Departments, Human Resources, Benefits Links & Forms, HIPAA Privacy Statement.** Employees may also contact the school system's Benefits Office for a copy of the privacy practice notice.

Questions concerning the HIPAA Privacy Rules may be directed to: Frederick County Public Schools
Donna Clabaugh, Senior Benefits Manager
191 South East Street
Frederick, MD 21701

DELTA DENTAL®

Estimate Your Costs

Looking to budget your dental costs? Try the Cost Estimator. This feature of Delta Dental's online account gives you a personalized estimate of how much you'll pay for your next dentist visit.

Whether you're getting braces or need a cavity filled, you'll choose from the top reasons for visiting the dentist, written in everyday language. The Cost Estimator organizes information logically, so you don't need to be concerned whether the service involves multiple procedure codes or visits.

Advantages

- **Easy to use.** Questions guide you through the process, letting you add services to your visit, like getting x-rays or a cleaning alongside your dental exam.
- **Based on real data.** Your cost estimate is calculated from actual claims Delta Dental has processed, updated daily.
- **Personalized.** You'll get a customized cost based on your actual benefits, taking into account any maximums and remaining deductible.
- **Available on desktop and mobile.** Get an estimate on your computer, tablet or phone.

Features

- **Change your dentist.** Want to know if you'd save by switching to another dentist? Test it out by comparing up to five dentists.
- **Personalize your procedure.** Specify which tooth is being treated, the type of filling you need or whether you're going to a specialist. The price will be calculated accordingly.
- **Keep track of your benefits.** A handy sidebar shows the current status of any deductibles and annual and lifetime maximums.

We keep you smiling®
deltadentalins.com/enrollees

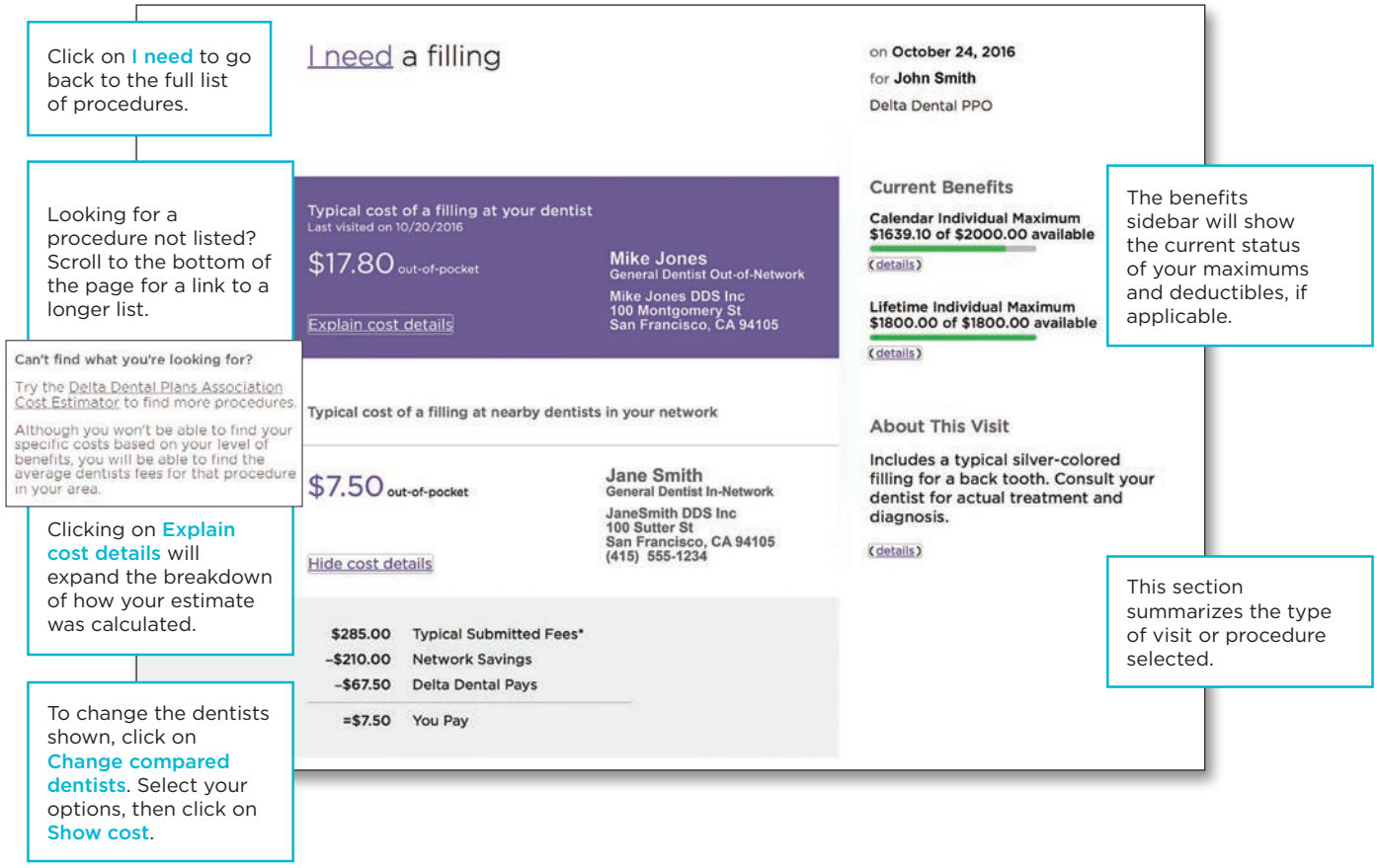
Try it out

Ready to get an estimate?

1. Log in to your account at **deltadentalins.com**. (If you don't have one yet, click on **Register**.)
2. Click on the **Cost Estimator** link by your name.

How to navigate

Start by selecting the service you need. As you explore, you can answer additional questions (like "Which tooth?" or "Are you a new patient?") to further customize your results. If you've been using your dental benefits, your current dentist will show up by default, but if you want to see other options, just click on **Select dentists to compare**. Whenever you're ready, click **See cost**.



DELTA DENTAL

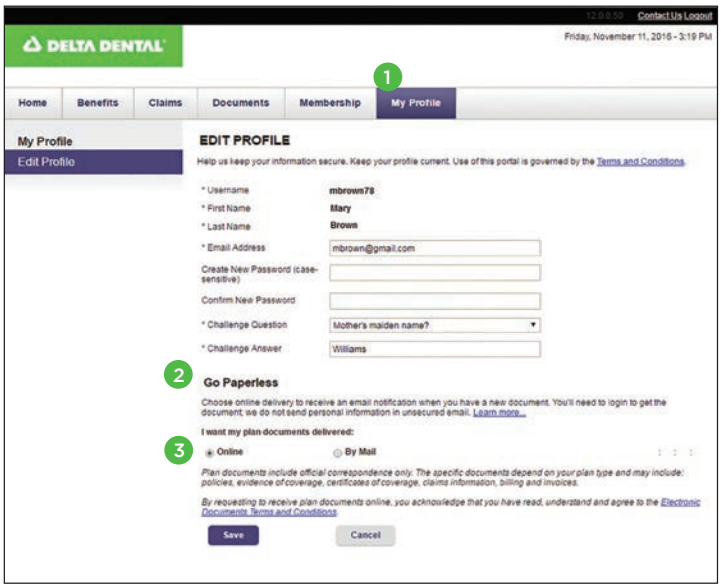
Delta Dental PPO™
Delta Dental Premier®

Go Paperless

View your documents online

Why go paperless?

- **It's convenient.** Get your claim statements, pre-treatment estimates and other important plan documents online. You'll get an email alert every time a new document is available.
- **It saves paper.** You'll reduce your ecological footprint.
- **It's faster.** No need to wait for "snail mail."
- **It's easy.** Updating your settings takes only a few moments.



How do I change my settings?

Visit **deltadentalins.com**. Log in to your account. (If you don't already have one, click **Register Today** to sign up.)

1. Click on the **My Profile** tab.
2. Go to the **Go Paperless** section
3. Select **Online** and click **Save**.

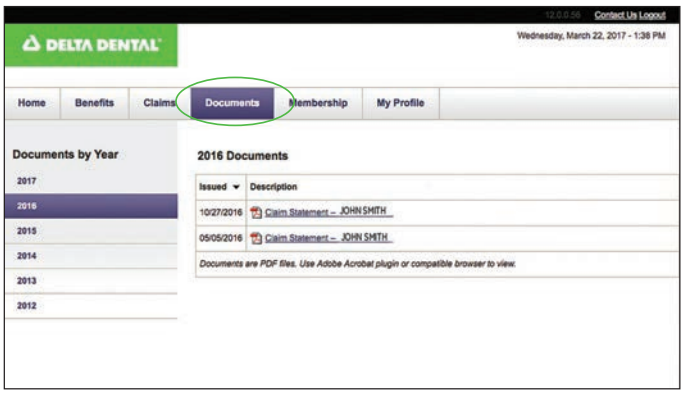
Turn the page to learn how to download and read your electronic claims statements.

We keep you smiling®
deltadentalins.com/enrollees

Where can I find my claims?

To view your claim statements as PDFs, simply log in to your online account.

1. Go to **deltadentalins.com**. Log in.
2. Click on **Documents** tab at the top.
3. Choose the claim you want to view. A new window will pop up with the PDF, which you can save to your desktop for reference. (If the window does not pop up, make sure your browser has not disabled pop-ups.)



Note: You can also see claim information listed under the **Claims** tab, although this feature does not allow you to download the full statement in PDF form.

What's in my claim statement?

#1 Claim number: 20160255494511

PROCEDURE NUMBER AND TYPE OF SERVICE	A SUBMITTED FEE ($)	B ACCEPTED FEE ($)	C MAXIMUM CONTRACT ALLOWANCE ($)	D AMOUNT APPLIED TO DEDUCTIBLE ($)	E PAID BY ANOTHER PLAN ($)	F CONTRACT BENEFIT LEVEL	G DELTA DENTAL PAYS ($)	H PATIENT PAYS ($)
Date of service: January 1, 2016 Treatment type: Restorative (D2393) RESIN-BASED COMPOSITE - TWO SURFACES, POSTERIOR TOOTH Tooth: 30 Surface(s): B,O	280.00	255.00	255.00	0.00	--	80% Treating provider: JANICE LEE	204.00	51.00
Date of service: January 1, 2016 Treatment type: Restorative (D2393) RESIN-BASED COMPOSITE - TWO SURFACES, POSTERIOR TOOTH Tooth: 31 Surface(s): D,O	280.00	255.00	255.00	0.00	--	80% Treating provider: JANICE LEE	204.00	51.00
Claim total for JOHN SMITH	**560.00**	**510.00**	**510.00**	**0.00**	**0.00**		**408.00**	**102.00**

A. **Submitted fee:** The amount charged by the dental office.

B. **Accepted fee:** The total owed to the dentist, including your share and the amount paid by insurance.

C. **Maximum contract allowance:** The total on which Delta Dental bases its payment portion.

Note: If you go to an out-of-network dentist, this amount may be lower than the accepted fee.

D. **Amount applied to deductible:** How much of your deductible you have fulfilled with the given procedure(s).

Note: Not all plans include a deductible (a fixed dollar amount you are required to pay before your coverage applies).

E. **Paid by another plan:** The amount covered by your primary plan, if you have dual coverage.

Note: This column only applies if Delta Dental is your secondary plan (such as coverage through your spouse or second job).

F. **Contract benefit level:** The percent of the maximum contract allowance that's paid by your dental plan.

G. **Delta Dental pays:** The amount your dentist is paid through your current dental plan.

H. **Patient pays:** How much you owe the dentist: This is what's left over from the accepted fee after your insurance covers its portion(s).