OPEN ENROLLMENT BENEFITS INFORMATION

Frederick County Public Schools

INSPIRE ★ MOTIVATE ★ INNOVATE

Benefits Open Enrollment May 2024

Open Enrollment is **May 1st through May 24th.** Please review this important information to see if you need to take action regarding your benefits.

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Benefits Open Enrollment

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** - If no change, no action required
- **Dental Coverage** - If no change, no action required for options available.
  - ❖ Standard ($1,500 maximum allowance)
  - ❖ Dental Buy-Up ($2,500 maximum allowance)
- **Life insurance beneficiary changes**
- Paper enrollment forms will not be used during open enrollment
- You must enroll and/or make all changes by **May 24th**
  - Click on this link to view additional information and instructions. Benefits Dashboard - Existing Employee - Benefits Review/Editing Info
- **Confirmation of Change - When saving enrollment changes**, you will receive a confirmation to your FCPS email from **Benefits.System@fcps.org**

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 carrier's 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 24-25 Plan Year

- FSA Health maximum limit has increased from **$3050 to $3200**
- FSA Health carryover maximum has increased from **$610 to $640**
- Medical, CareFirst Co-Pay Changes
  - **Urgent Care $0 to $20**
  - **Specialist Visit $30 to $35**
- Prescription, CVS
  - **GoodRX** - CVS will introduce Cost Saver which will help you save money on commonly dispensed generic medications. Caremark Cost Saver makes certain that you automatically receive the lowest price for medications covered under our plan.
  - **Smart Logic** - Smart Logic will bypass the need for Prior Authorization for members prescribed GLP-1s approved to treat type 2 Diabetes, if records indicate clinical criteria is met; if criteria is not met, Prior Authorization is applicable.

Information Sessions

The FCPS Benefits department is organizing web based informational sessions for May of 2024. Session reminders will be shared through the weekly system communication provided to all employees. Scheduled pop-up reminders will also serve to remind employees of this important time.

Virtual Information Sessions			
Topic	**Date**	**Time**	**Format**
Benefits Presentation and Open Enrollment Information	Monday May 6	4:30 p.m.	Google Meet hosted by FCPS Benefits to present a general overview of available benefits and information about open enrollment
Benefits Presentation and Open Enrollment Information	Friday, May 10	7:30 a.m.	Google Meet hosted by FCPS Benefits to present a general overview of available benefits and information about open enrollment
Benefits Presentation and Open Enrollment Information	Friday, May 17	3:30 p.m.	Google Meet hosted by 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 2025 budget. This rate represents a 16% increase in premiums for health insurance for 2024 – 2025 Fiscal Year; dental rates will remain the same for this upcoming year.

JULY 1, 2024 – JUNE 30, 2025 (FY25)
FREDERICK COUNTY PUBLIC SCHOOLS
EMPLOYEE BENEFITS AND INSURANCE SUMMARY

INFORMATION ABOUT INSURANCE:

- ***MEDICAL***
- ***PRESCRIPTION***

	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	$30.86	$29.32	$26.65	$ 24.43	$11,136.62
Employee + One Dependent[3]	$234.72	$222.98	$ 202.71	$ 185.82	$21,096.65
Employee + Family[4]	$311.60	$296.02	$ 269.11	$ 246.68	$21,042.69
Employees + Family[4, 5] (Both parents employed by FCPS)	$61.72	$58.63	$ 53.30	$ 48.86	$25,790.38

- ***DENTAL***

	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 2025 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 Benefit Plans

CareFirst BlueChoice Advantage Medical Plan

FCPS will continue to offer medical coverage through CareFirst for the 2024–2025 plan year; In-Network and Out-of-network benefits. To find a provider near you, visit the website at **www.carefirst.com/frederick**

- ***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*** – Annual deductibles must be met and paid out-of-pocket. Out-of-network coverage includes Participating and Non-Participating Practitioners.
    - ***Participating Health Care Providers*** - Expenses are reimbursed at 80% of Allowed Benefit for a Covered Service and the member pays 20% co-insurance.
    - ***Non-Participating Health Care Providers*** - Expenses are reimbursed at 80% of Allowed Benefit for a Covered Service and the member pays 20% co-insurance. The member is also responsible for the difference between the Allowed Benefit and the practitioner's actual charge. * *Please review the Summary of Benefits Plan Description* for full details
- 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.

BENEFIT HIGHLIGHTS

IN NETWORK		OUT OF NETWORK
CO-PAYMENTS:		***CO-INSURANCE: Member pays deductible and then 20% of Allowed Benefit***
Primary Care Physician	$ 20.00	***DEDUCTIBLE:***
Specialist	$ 35.00	$200 Individual
Outpatient Physician Services	$ 20.00	$400 Family
Urgent Care	$ 20.00	***MAXIMUM OUT-OF-POCKET:***
Inpatient Hospital	$100.00	$1,250 Individual
Emergency Room (Non-Emergency)	$ 75.00	$2,500 Family
DEDUCTIBLE: None		***MAXIMUM OUT-OF-POCKET:*** Includes Annual Deductible
MAXIMUM OUT-OF-POCKET: No Out-of-Pocket Maximum		

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 Benefit 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 Dental 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. 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	$100	$0	$100
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 deductible $2,000	Unlimited	After deductible $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** or at **www.fcps.org/benefits/prescription-drug-plan.**

The prescription plan includes, but limited to, 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.
- **Good RX** – CVS will introduce Cost Saver which will help you save money on commonly dispensed generic medications. Caremark Cost Saver makes certain that you automatically receive the lowest price for medications covered under our plan.
- **Smart Logic Prior Authorization Program** – GLP-1, GIP/GLP-1 medications - to help make sure the medications covered by your plan are used safely and appropriately as prior authorization has been implemented. During a claim review, for substantiation not found to support the drug, prior authorization will be needed from your provider.

Summary of Benefit 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!

CVS caremark®

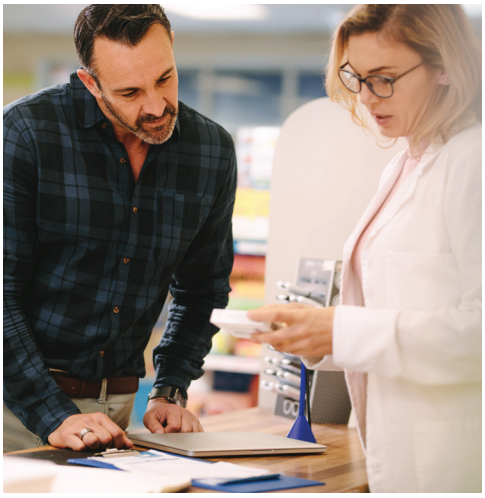
COST SAVER

Helping you save money on your medications

We know that keeping your out-of-pocket costs low is important to you and your family. That's why we've created Caremark® Cost Saver™, powered by GoodRx®, to help you save money on your medications.

How Cost Saver works

Cost Saver makes sure you get the lowest available cost for your prescription medications. All you have to do is present your CVS Caremark member ID card when you pick up your prescriptions. We'll manage the rest for you by automatically applying the lowest available discount price.



Cost Saver, powered by GoodRx, benefits include:

- **Providing you with the lowest available prices** for many commonly prescribed, non-specialty generic drugs
- **Automatically applying your out-of-pocket costs to your deductible** and out-of-pocket thresholds
- **Delivering you a seamless experience** that avoids wasted time shopping around for the lowest available price

Your CVS Caremark member ID card is all you need for Cost Saver to work for you. Just show it to your pharmacist and we'll take it from there.

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 but save money on federal, state and FICA taxes. If you 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:	$3,200
Maximum Dependent Care Limit:	$5,000, file married
Annual Health FSA Rollover Maximum:	$640
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:	WEX
Service Provider Contact:	866-451-3399 www.wexinc.com

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 (SPD).

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 pay 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 $3200.

Dependent Care Flexible Spending Account

The Dependent Care Flexible Spending Account 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.wexinc.com), email, online, or mobile application. Employees may also pay for their qualified medical expenses directly from their FSA with the WEX 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 and Dependent Care Accounts reimbursement claims must be submitted no later than 90 days after the end of the Plan Year. Any Health FSA funds exceeding $610.00 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 IRS regulations, employees will be able to rollover up to $640.00 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 $640.00 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, prescription 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 WEX 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 $640.00 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. Reimbursements may also be submitted with a printed reimbursement claim form and sent to the WEX 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. 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.

What happens if I do not substantiate transactions that are required?

The IRS has strict guidelines on the substantiation of claims. If upon the Plan Closing of the applicable year of spend, claims remaining unsubstantiated will require a ***payroll deduction*** to recoup the unsubstantiated payment.

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 dis- crimination 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 Frederick County Public Schools, 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.

1095C Form

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 2023, this statement (known as IRS Form 1095-C) will be provided to you by July 1, 2024. 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 complaint as noted below:

Director of Human Resources / Title IX Coordinator
Frederick County Public Schools
191 South East Street
Frederick, MD 21701
301-644-5081

Complainant may use the **Discrimination Complaint Form** attached to the Policy.

If you need help filing a complaint as associated with an accommodation, the Senior Benefits Manager 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 1-301-644-5080.

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 1-301-644-5080

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, 2024. Contact your State for more information on eligibility –

PENNSYLVANIA – Medicaid

Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP- Program.aspx

Phone: 1-800-692-7462

CHIP Phone: 1-800-986-KIDS (5437)

VIRGINIA – Medicaid and CHIP

Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp

Medicaid Phone: 1-800-432-5924

CHIP Phone: 1-800-432-5924

WEST VIRGINIA – Medicaid and CHIP

Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/

Medicaid Phone: 304-558-1700

CHIP 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, 2024, 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

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 Life Qualifying Event (LQE). Circumstances that qualify as a LQE include but are not limited to:

- 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 30 calendar days of the event. If your change form and documentation is not received within the 30-day timeframe, you will be unable to make the desired changes until the next open enrollment period.

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.

Carrier Information

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 Vision Care Processing Unite P.O. Box 1525, Latham, NY 12110	Phone: 1-800-783-5602 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
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 Disability	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
Christine Hobble	Christine.Hobble@fcps.org	301-644-5052
Evelyn Davis	Evelyn.Davis@fcps.org	301-644-5115
Julie Carlton	Julie.Carlton@fcps.org	301-644-5076
Khris Keepers	Meredith.Keepers@fcps.org	301-644-4126
Kimberly Huff	Kimberly.Huff@fcps.org	301-644-5085
Mackenzi Carr	Mackenzi.Carr@fcps.org	301-644-5093
Sarah Minnick	Sarah.Minnick@fcps.org	301-644-5112
Sharde' Twyman	Sharde.Twyman@fcps.org	301-644-5092

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
Senior Benefits Manager
191 South East Street
Frederick, MD 21701