St. Mary's County Government

Benefit Guide

2024-2025

Reminders for the 2024-2025 Plan Year

The County will continue to offer the Incentive Payment for Declining Medical Coverage:

For each plan year (July 1 - June 30) in which an eligible employee does not participate in St. Mary's County Government group medical coverage (health and prescription) either as an employee, dependent or retiree, the employee will be eligible to receive an incentive payment. A signed waiver opting out of County coverage must be completed and submitted to HR each plan year to be eligible for the payment.

What's New?

Everside Health Center opens July 2024, and offers primary care and behavioral health services at a health center located in St. Mary's County. More info on page 10.

Incentive Payment for Declining Medical Coverage

**The Incentive Payment is taxable income to you. If you opt-out of coverage, you cannot enroll until the next open enrollment unless you have a Qualifying Life Event (QLE).*

*Incentive Payment	24 Pays	Annual
Full time	$40	$960
RPT 30-39	$30	$720
RPT 20-29	$25	$600
Variable hour 30+ per week	$25	$600

Voluntary Benefits: from The Standard (offered on a post-tax basis)

If you haven't already, enroll yourself and your dependents in Accident Insurance, Critical Illness and Hospital Indemnity Insurance through The Standard effective July 1, 2024. These plans offer extra protection from the expected and unexpected.

Whole Life with Chronic Care from UNUM - (Post-tax)

"Guaranteed issue" again for employees and children -- no health questions for most plans and policies include Chronic Care Benefits.

Dental

The calendar year maximum on the dental plan is $1,500. The orthodontia lifetime maximum is $1,000 and coverage for night guards is available.

Enrollment

This year is an "Active Enrollment". All employees must login to the bswift Benefits Platform and review their current benefit elections, add or remove coverage and update beneficiary designations for the new plan year. See page 2 of the guide for details or go to **https://SMCG.bswift.com** to start your enrollment.

Enhanced wellness coverage includes one additional eye exam and two additional dental exams for members with diabetes, hypertension and/or pregnancy.

Flexible Spending Accounts require annual elections. Please note: June 30, 2024, is the deadline to utilize funds in your FSA account. You will have 60 days from June 30, 2024, to submit claims for expenses incurred between July 1, 2023, and June 30, 2024. Up tp $640.00 of unspent funds in the FSA health account can be rolled over into the new plan year.

Contents

This benefits guide describes the highlights of benefits for all eligible employees in non-technical language. Your specific rights to benefits under the plan are governed solely, and in every respect, by the official plan documents and not the information in this summary. If there is any discrepancy between the descriptions of the programs as contained in this brochure and the official plan documents; the language of the official documents shall prevail as accurate. Please refer to the plan-specific documents for detailed plan information. Any plan benefits may be modified in the future as decided by St. Mary's County Government.

Welcome to St. Mary's County Government Benefits

St. Mary's County Government takes pride in offering a comprehensive and competitive benefits package to our employees. The County, through our benefits partners, offers you a benefits program that allows choice and flexibility.

2024-2025 Open Enrollment

– Open Enrollment is May 8, 2024 to May 22, 2024.

– You will again use the bswift benefits portal for Open Enrollment (see page 2 for more details).

– All benefits run on a July 1, 2024 – June 30, 2025 plan year.

– Review your current elections to ensure that you are enrolled in plans and coverage levels that meet your needs. No changes can be made after Open Enrollment unless a Qualifying Life Event occurs. Refer to the bswift library as to what qualifies as a Qualifying Life Event.

– Open Enrollment is a good time to review and update beneficiaries.

– Attend an informational session on May 8:

- 9:00 a.m. or 1:00 p.m. in the County Commissioner's Meeting Room
- Laptops will be set-up for self-service enrollment with assistance after each presentation.

IMPORTANT

This is an active enrollment year. Employees must log-in to enroll and to review your benefits and update beneficiaries.

– You are encouraged to meet in person with Decision Support Specialists from Bolton. These Specialists are trained specifically on your benefits and can answer questions and assist with your enrollment. You can schedule an appointment to meet with a Decision Support Specialist at https://go.oncehub.com/SMCG

Schedule an Appointment

Decision Support Specialists will be available in-person throughout open enrollment to assist you with enrolling and answering your questions at the following locations:

- Human Resources Office: 23115 Leonard Hall Drive, 3rd FL
- Department of Public Works: 44829 St. Andrews Church Road, Highway Assembly Room
- Department of Public Works - Building Services: 41870 Baldridge Street
- Sheriff's Office: 23150 Leonard Hall Drive
- EMS: 23090 Leonard Hall Drive
- Detention and Rehabilitation Center: 41880 Baldridge Street
- Rec & Parks/LUGM: 23150 Leonard Hall Drive

Please use the link above to review available dates and times and schedule your appointment.

If you have a question, need your password reset, or are having technical issues, please send an email to service@boltonusa.com outlining your request and the service team will assist you. You may also contact the County's Benefits Team at 301-475-4200 ext 1100 or email at Benefits@stmaryscountymd.gov.

Decision Support Specialists will also be available over the phone to assist you with your enrollment. Appointments will be available through the call center from May 8 - May 22 from 11:00 a.m. to 8:00 p.m. eastern time. You will be contacted at the appointed time on the phone number you provide in the online meeting scheduler. At the beginning of the call, to verify your identity, you will need to provide your bswift username and password.

The choice you make during open enrollment or as a new hire are in effect for the remainder of the plan year that ends on June 30, 2025. Once you enroll, you must wait until the next Open Enrollment period to make changes to your benefits unless you have a Qualifying Life Event (QLE) as defined by the IRS.

How to Enroll

All benefit elections/changes must be submitted online through bswift. The system allows you to access your benefits information and enroll online.

Go to: **https://www.stmaryscountymd.gov/EmployeeInformation/** to start your enrollment.

Option 1:

Employee Portal Home Page (The link to bswift is under Applications on the left ribbon.)

- Log-in to the employee portal **https://apps.stmarysmd.com/Employee** and select bswift under "Applications".
- Log-in to bswift with your SMCG network username and password.

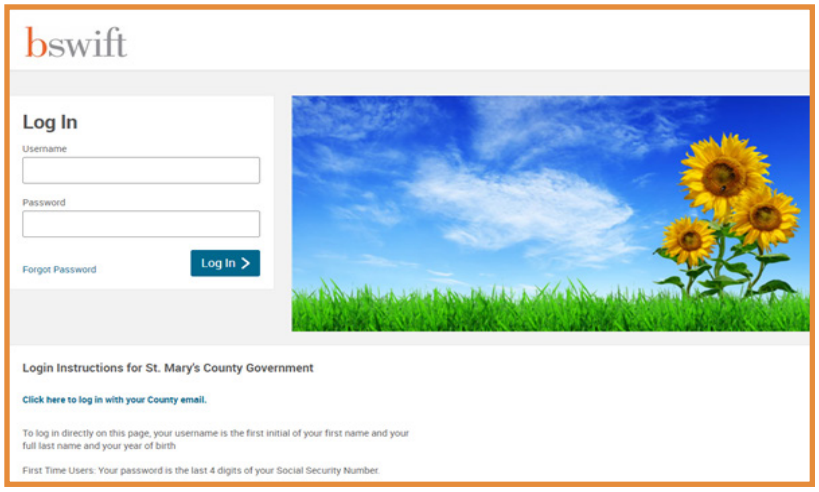
Option 2:

Log-in through bswift directly at https://smcg.bswift.com.

- Your username is your first initial+ full last name+ year of birth.

Logging in for the first time?

- Your password is the last four numbers of your Social Security Number (SSN).



Don't remember your login?

- Email **service@boltonusa.com** to reset your password.
- Email **Benefits@stmaryscounty.gov**
- Call the Benefits Team on 301-475-4200 extension 1100.

Qualifying Life Event

Making Changes

The choices you make during open enrollment are in effect for the remainder of the plan year that ends on June 30, 2024. Once you enroll, you must wait until the next Open Enrollment period to make changes to your benefits unless you have a qualifying life event as defined by the IRS.

Lifestyle Change/Event	Documentation Required
Marriage	Marriage Certificate & Social Security cards
Divorce	Divorce Decree
Birth or Adoption	Birth Certificate or Adoption papers & Social Security cards
Change in employment status from part-time or full-time or vice versa	No documentation required - Human Resources will confirm
Your child loses eligibility for dependent coverage	No documentation required
Your spouse gains or loses coverage under another plan	Letter from spouse's employer verifying the change
You go on or return from leave of absence	No documentation required - Human Resources will confirm

Benefits Eligibility

Employee Eligibility

Benefit eligible employees are all full-time and regular part-time employees as well as temporary employees working at least 30 hours per week. Hourly employee eligibility will be determined utilizing an initial measurement and an annual look back period. Those averaging 30 or more hours per week during the look back period will be eligible to elect benefits for the plan year beginning July 1.

Dependent Eligibility

You may enroll your eligible dependents in the same plans you choose for yourself. Eligible dependents include your legal spouse, dependent children including step children, and disabled adult children. Refer to the Dependent Eligibility Documentation Requirements on bswift for more details. For any new dependents, you will be required to upload documentation as evidence of your relationship status, e.g., marriage license, birth certificate, etc. Any loss of dependent status requires you to administer a life event in the benefits portal to remove the dependent.

Premium Contributions

The County's Group Health Insurance Program requires you to pay a portion of the premium. A Section 125 plan allows you to elect to make these payments pre-tax rather than on a post-tax basis. Therefore, as an employee, you will not owe Federal Income Tax or FICA Tax on the premium amounts. You walk away with more dollars in your paycheck.

You cannot change your election during the plan year without an IRS-approved Qualifying Life Event. You may change your election during the next Open Enrollment, which will take effect on July 1 of the next plan year.

Medical Coverage

You have a choice between two CareFirst medical plan options: BlueChoice HMO Open Access Plan and BlueChoice Advantage (full-time and regular part-time employees). Eligibile hourly employees (working 30+ hours per week) may participate in the BlueChoice HMO Open Access Plan. Both medical plans give you access to a quality network of practitioners and hospitals.

The BlueChoice Advantage plan allows you to access any CareFirst provider anywhere in the United States at in-network rates. You also have the flexibility to use out-of-network providers, but you will have higher out-of-pocket costs. You will be required to pay a deductible and a greater portion of the cost of medical treatment. You may also need to file the claim.

You're never alone. If you or someone you know is in crisis, dial 988 or contact the CareFirst support line at 800-245-7013.

The BlueChoice Open Access plan provides comprehensive coverage when you use CareFirst participating providers. If you do incur costs with an out-of-network provider, you will be responsible for 100% of the cost unless it's an emergency as defined by the plan documents.

Understanding your Options for Care

Seeking advice: 24-Hour Nurse Advice Line

- General questions about health issues on where to go for care
- Registered nurses are available 24/7 by phone at 800-535-9700

Want care quickly: CloseKnit Virtual Care

- Treatment for minor illnesses and injuries as well as therapy, psychiatry, diet and nutrition and breastfeeding support
- Board-certified doctors available by smart phone, tablet or computer

Need care soon: Primary Care Provider

- Diagnosis & treatment of illness, chronic conditions, check-ups

Need care now: Urgent Care Center

- Non-life-threatening illness or injury requiring immediate care
- Open 7 days a week

Emergency: 911 or Nearest ER

- Life-threatening illness or injury
- Open 24/7

Go to **https://www.carefirst.com/stmarys/** for additional plan information.

Medical Coverage

Full-Time and Regular Part-Time Employees

Below is a summary of the two medical plan options. For more details, including limitations and exclusions, please go to the bswift Library for the Benefit Summaries and Plan Documents.

	BlueChoice HMO Open Access	BlueChoice Advantage	
	In-Network (There is no out-of-network coverage for this plan)	**In-Network**	**Out-of-Network**
Annual Deductible Individual/Family	None	$250/$500	$500/$1,000
Coinsurance for most services	You pay 0%	After annual deductible, you pay a copay	After annual deductible, you pay 20%
Contract Year out-of-pocket maximum Individual/Family	$2,000/$6,000	$1,000/$2,000	$1,000/$2,000
Preventive Care (office visits and routine annual lab tests)	You pay $0	You pay 0%	After annual deductible, you pay 20%
Physician office visit	You pay: $10 PCP copay $20 Specialist copay	You pay: $20 PCP copay $20 Specialist copay	After annual deductible, you pay 20%
Inpatient hospitalization pre-certification required (semi-private hospital room and board and ancillary services)	You pay $0	After annual deductible, you pay 0%	After annual deductible, you pay 20%
Prescription drugs Generic/Brand/Non-Formulary	You Pay: $10/$20/$35 30-day supply	You Pay: $10/$20/$35 30-day supply	You Pay: $10/$20/$35 30-day supply
Prescription drugs Generic/Brand/Non-Formulary	You pay: $20/$40/$70 90-Day/Home Delivery	You pay: $20/$40/$70 90-Day/Home Delivery	You pay: $20/$40/$70 90-Day/Home Delivery

Medical Coverage

Hourly employees working at least 30 hours per week.

BlueChoice HMO Open Access	In-Network
Annual Deductible Individual/Family	None
Coinsurance for most services	You pay 0%
Contract Year out-of-pocket maximum	$2,000/$6,000
Preventive Care (office visits and routine annual lab tests)	You pay $0
Physician office visit	You pay: $10 PCP copay $20 Specialist copay
Inpatient hospitalization pre-certification required (semi-private hospital room and board and ancillary services)	You pay $0
Prescription drugs Generic/Brand/Non-Formulary	You Pay: $10/$20/$35 30-day supply
Prescription drugs Generic/Brand/Non-Formulary	You pay: $20/$40/$70 90-Day/Home Delivery

Vision Coverage

The County offers eligible employees a BlueVision Plus vision plan, through the Davis Vision, Inc., national network. The vision plan includes routine eye examinations, eyeglasses, and contact lenses offered through a national network of providers.

This is only a brief summary of the plans. For more details, please go to the bswift Library for the Summary of Benefits.

Benefit	Description	Davis Vision In-Network
Your Coverage		**Cost**
WellVision Exam	Focuses on your eyes and overall wellness	$10
Frequency		**Every 12 Months**
Prescription Glasses		
Frame	Davis Vision Frame Collection	$0 Copay (for approximately 200 frames)
	Other Frames	Plan pays up to $100, you pay the balance
Lenses	Single Vision Bifocal Trifocal	$0 Copay
Contacts	Elective Contact Lenses	Plan pays $97, you pay balance
	Medically Necessary	$0 Copay (with prior approval)

Covered members who have diabetes, hypertension and/or are pregnant, (Up to 6 months post-delivery) have access to additional vision and dental screening at no cost.

Finding an In-Network Provider

To find an in-network provider, search online at **https://www.carefirst.com/stmarys/** and utilize the Find a Provider Feature or call Davis Vision at 800-783-5602. Be sure to ask your provider if they participate in the Davis Vision network.

Medical & Vision Premiums

Full-Time Employees - 40+ Hours per week

Note : 24 pays per year

	CareFirst HMO Open Access w/Rx		CareFirst BlueChoice Advantage w/Rx		CareFirst BlueVision Plus	
Coverage Level	Employer Cost per Pay	Employee Cost per Pay	Employer Cost per Pay	Employee Cost per Pay	Employer Cost per Pay	Employee Cost per Pay
Employee	$356.64	$62.94	$454.27	$80.17	$2.13	$0.38
EE + Child	$607.70	$107.24	$681.43	$120.25	$3.07	$0.54
EE + Spouse	$809.59	$142.87	$908.53	$160.33	$4.28	$0.76
Family	$1,050.78	$185.43	$1,181.13	$208.43	$5.27	$0.93

Regular Part-Time Employees - 30-39 Hours per week

Note : 24 pays per year

	CareFirst HMO Open Access w/Rx		CareFirst BlueChoice Advantage w/Rx		CareFirst BlueVision Plus	
Coverage Level	Employer Cost per Pay	Employee Cost per Pay	Employer Cost per Pay	Employee Cost per Pay	Employer Cost per Pay	Employee Cost per Pay
Employee	$356.64	$62.94	$411.52	$122.92	$1.93	$0.58
EE + Child	$550.55	$164.44	$617.30	$184.39	$2.78	$0.83
EE + Spouse	$733.39	$219.07	$823.02	$245.84	$3.88	$1.16
Family	$951.88	$284.33	$1,069.96	$319.60	$4.78	$1.43

Medical & Vision Premiums

Regular Part-Time Employees - 20-29 Hours per week

Note : 24 pays per year

	CareFirst HMO Open Access w/Rx		CareFirst BlueChoice Advantage w/Rx		CareFirst BlueVision Plus	
Coverage Level	Employer Cost per Pay	Employee Cost per Pay	Employer Cost per Pay	Employee Cost per Pay	Employer Cost per Pay	Employee Cost per Pay
Employee	$356.64	$62.94	$288.60	$245.84	$1.36	$1.15
EE + Child	$386.07	$328.87	$432.91	$368.78	$1.95	$1.66
EE + Spouse	$514.33	$438.13	$577.18	$491.68	$2.72	$2.32
Family	$667.55	$568.66	$750.36	$639.20	$3.35	$2.85

Hourly Employees Eligible for Coverage

Note : 24 pays per year

	CareFirst HMO Open Access w/Rx		CareFirst BlueVision Plus
Coverage Level	Employer Cost 85% per Pay	Employee 15% Cost per Pay	Employee (100%) per Pay Cost
Employee	$356.64	$62.94	$2.51
Coverage Level	Employer 77% Per Pay	Employee 23% Per Pay	
EE + Child	$550.50	$164.44	$3.61
EE + Spouse	$733.39	$219.07	$5.04
Family	$951.88	$284.33	$6.20

Everside Health Center - Grand Opening July 1, 2024

Everside is excited to partner with St. Mary's County Government (SMCG)

Covering up to 90% of your comprehensive and primary care needs with no out-of-pocket costs. SMCG employees, dependents of employees, retirees and retiree dependents who are enrolled in the CareFirst health insurance can access Everside Health Services including virtual care and 24/7 access to manage your care. Everside providers are dedicated to your healthcare and are easy to reach at convenient locations near your home or work, as well as virtually (by phone or video). For more information, visit **eversidehealth.com/stmaryscounty.**

Services:

- Annual physical exams
- Chronic condition management
- Full-scope family medicine
- Men's & women's health
- Mental Health
- No cost on-site lab work
- School and sports physicals
- Select on-site medications at little to no cost
- Sick and urgent care

Clinic Hours

Sun. Closed
Mon. 6 am - 3 pm
Tue. 11 am - 7 pm
Wed. 6 am - 3 pm
Thu. 11 am - 7 pm
Fri. 6 am - 3 pm
Sat. 8 am - 4 pm

Clinic Location:

- 23000 Moakley Street | #202 | Leonardtown MD 20650
- 240-744-1100
- eversidehealth.com/stmaryscounty

Dental Coverage

The County offers eligible employees the CareFirst Preferred Dental PPO Plan. The Preferred Dental PPO plan provides coverage in and out of network, but you will pay less when you use in-network PPO providers. Search for in-network providers at **https://www.carefirst.com/stmarys/**. The following chart shows what you pay for covered dental services:

This is only a brief summary of the plans. For more details, please go to the bswift Library for the Summary of Benefits and Patient Charge Schedule.

	Preferred Dental	
	In-Network	Out-of-Network
Calendar Year Deductible Individual/Family	You pay: $25/$75	You pay: $50/$150
Calendar Year Benefit Maximum	$1,500	$1,500
Preventive and Diagnostic services *(for example, cleanings)*	You pay $0	You pay 25%
Basic services *(for example, fillings)*	After annual deductible, you pay 20%	After annual deductible, you pay 40%
Major surgical services *(for example, root canals, surgical extractions)*	After annual deductible, you pay 20%	After annual deductible, you pay 40%
Major restorative services *(for example, dentures, crowns bridges, and night guards)*	After annual deductible, you pay 50%	After annual deductible, you pay 65%
Orthodontic services	You pay 50% $1,000 lifetime maximum	You pay 65% $1,000 lifetime maximum

Dental Premiums

All premiums noted below are per pay.
Note: 24 pays per year.ote

CareFirst Dental PPO	
Coverage Level	**Employee Cost Per Pay**
Employee	$13.42
EE + Child	$21.28
EE + Spouse	$29.14
Family	$39.52

Flexible Spending Accounts - Voya

Flexible Spending Accounts (FSAs) allow you to set aside pre-tax dollars for health care and/or dependent care expenses. You must enroll each year to participate in an FSA.

FSA Contributions

When you elect an FSA, you contribute a portion of your salary to pay for health or dependent care expenses that you will have to pay for "out-of-pocket." The amount you defer to an FSA will automatically be deducted from your earnings pre-tax in regular, biweekly payments. FSAs allow you to save money as your contributions reduce your taxable income.

Healthcare Flexible Spending Account (HC FSA)

Healthcare FSA funds may only be used to pay for eligible "out-of-pocket" medical, dental, vision and prescription drug expenses without federal tax liability or penalty.

- **For the 2024-2025 plan year, you may contribute a minimum of $130.00 or up to a maximum of $3,200 to your HC FSA.**

Dependent Care Flexible Spending Account (DC FSA)

The Dependent Care FSA can be used to pay day care expenses for your eligible dependents. Your eligible dependents are any individuals under age 13, and those not able to care for themselves because of a physical or mental disability that you claim as dependents on your federal income tax return.

The Dependent Care FSA can also be used to provide dependent care while you or your spouse are actively looking for work (does not include unpaid volunteer work, or volunteer work for a nominal salary). If you are married, you can use the Dependent Care FSA only if your spouse is employed, a full-time student for at least five months of the year or disabled.

Expenses you pay for dependent care while you are out of work due to illness are not eligible for reimbursement.

DC FSAs cannot be used to pay for care provided by your spouse, or anyone claimed by you as a dependent.

The maximum annual amount that you may contribute to the DC FSA is:

- **$5,000 if single, or married, filing jointly**
- **$2,500 if married, filing separately**

Important Rules

You may not change your FSA elections during the plan year unless you experience a qualifying life event.

Participants in the HC FSA with unused funds at plan year end on June 30, 2025 may carry over up to $640 of unused funds into the next plan year without changing the amount they can contribute in the new plan year.

You must submit all eligible expenses for reimbursement no later than 90 days after the end of the plan year.

If your employment ends during the year, you will have 60 days from your date of termination to submit HC FSA claims for reimbursement for claims incurred prior to your date of termination.

Critical Illness Insurance - The Standard

Critical Illness Insurance can help relieve the financial impact of a sudden, life-threatening illness. You may have medical insurance, but that does not mean you're covered for all the expenses resulting from a serious illness that you probably haven't budgeted for — things like copays, deductibles, loss of income, childcare, and travel expenses. Group Critical Illness insurance helps fill the gap caused by these out-of-pocket costs, creating a financial safety net for you and your family.

The Critical Illness plan provides:

- Premiums that are locked in at the age when you purchase the coverage
- Guaranteed Issue coverage of up to $30,000 for you and your spouse
- Coverage for children automatically at 100% of the employee's elected amount
- $100 Health Maintenance Screening benefit per insured per calendar year
- Covered Conditions:
  - Heart attack, Stroke, Cancer, Paralysis, Advanced MS, ALS, Major organ failure, End-stage renal failure, Coma, Advanced Alzheimer's, Bone Marrow transplant, and more
  - 21 additional covered children's diseases
  - No Evidence of Insurability requirement when you enroll in any coverage amount this year or for any ease during Open Enrollment in future years up to the $30,000 maximum coverage—that means no health questions required to be answered. Plus, the rate at which you purchased your initial policy will be the rate used for the additional coverage.
  - Pre-existing condition limitations have been waived. What does this mean? The Standard will not complete any investigation into a claim related to a pre-existing condition. If the claim meets The Standard's definition of a covered critical illness, then The Standard would pay the claim. However, the plan requires that the initial diagnosis of the critical illness be made while covered under the group policy.

For full details of the benefits covered under the Critical Illness plan and exclusions, please review plan documents available in the bswift Library.

All premiums noted below are per pay. Note: 24 pays per year

$10,000 Policy	
Age at Issue	**Rates per Pay**
Age 30	$2.85
Age 40	$4.65
Age 50	$7.45
Age 60	$12.40

Click here or login to **https://smcg.bswift.com/** to watch a short video on how Critical Illness Insurance benefits you and your family.

Accident Insurance - The Standard

Accident Insurance pays cash benefits directly to you for covered injuries and treatments. Accidents happen frequently: working around the house, driving a car, and children riding bikes or playing soccer. Accidents can be painful, and costly. Even with major medical insurance, there may be out-of-pocket expenses that you'll have to pay.

The Standard Accident Insurance is designed to help you meet your out-of-pocket expenses and extra bills resulting from an accidental injury. Coverage provides a lump sum benefit based on the type of injury (or covered incident) you sustain or the type of treatment you need.

It also helps with surgery expenses, hospital stays, needed medical appliances (e.g., braces, canes, wheelchairs, prostheses), and hearing aids. It can also be used on daily expenses during recovery.

Click here or login to **https://smcg.bswift.com/** to watch a short video on how Accident Insurance benefits you and your family.

Additional benefits include:

- Youth Organized Sports Benefit – Additional 25% of total benefit payable
- Hospital Admission and Daily Confinement Benefit – $1,500 for first 24 hours admitted; $400/day after
- $50 Health Maintenance Screening benefit per insured per calendar year
- To view the Schedule of Benefits for a full list of covered injuries and expenses go to the bswift Library.

All premiums noted below are per pay. Accident rates are not based on age or smoker status.
Rates per pay:

Coverage Level	Employee	Employee & Spouse	Employee & Child(ren)	Family
Per Pay Deduction	$7.15	$11.19	$13.50	$21.15

Keep In Mind

- Most injuries are not work-related and, therefore, are not covered by worker's compensation.
- You can cover yourself, your spouse, and your children.

Hospital Indemnity Insurance - The Standard

Hospital Indemnity Insurance pays an amount for each day the insured is hospitalized, up to specific maximum limits. Because the benefits are paid directly to the insured, they can be used to help pay for out-of-pocket expenses, such as deductibles and copays, as well as costs that would be hard to pay due to missed time at work, like a car payment, rent, and childcare.

Plan Features

Hospital Admission

Pays $1,000 for a stay at a hospital for at least 20 consecutive hours for examination by a physician for diagnosis of treatment of a loss. This benefit is limited to one payment per calendar year.

Daily Hospital Confinement Benefit

Pays $100 each day an insured person is confined to a hospital as the result of a covered accident or sickness. This covers up to 15 days per stay.

Critical Care Unit Admission

Pays $500 for a stay in a Critical Care Unit for at least 20 consecutive hours for examination by a physician for diagnosis of treatment of a loss. Pays in addition to the Hospital Admission benefit. This benefit is limited to one payment per calendar year.

Daily Critical Care Unit Confinement

Pays $50 each day an insured person is confined to a critical care unit as the result of a covered accident or sickness. This covers up to 15 days per stay. Pays in addition to the Hospital Confinement benefit.

Health Maintenance Screening

Pays $100 per calendar year per insured individual if the insured receives one of the 22 covered health screening tests, including lipid panel, mammography, and colonoscopy. Refer to the bswift Library for a list of covered health screenings.

The Bottom Line
Includes a $100 Health Maintenance screening benefit per insured per calendar year.
No pre-existing condition limitations.
No termination age for employees or spouses.
Annual Guaranteed Issue enrollment with issue age to 99.
Coverage is portable at same rates.
Provides coverage for injuries and illnesses, including pregnancy.

Click here or login to **https://smcg.bswift.com/** to watch a short video on how Hospital Indemnity Insurance benefits you and your family.

Please note: claim forms are available in the bswift library.

All premiums noted below are per pay. Hospital Indemnity rates are not based on age or smoker status.
Note: 24 pays per year. Rates per pay:

Coverage Level	Employee	Employee & Spouse	Employee & Child(ren)	Family
Per Pay Deduction	$6.56	$11.42	$9.33	$16.52

Life and AD&D Coverage

Life insurance provides your beneficiaries with a benefit in the event of your death. Our life insurance plans allow you to decide how much life insurance is right for you. You also have a variety of life insurance options for your dependents.

Basic Term Life and Accidental Death & Dismemberment (AD&D) Insurance

Full-time and regular part time employees are provided with Basic Life and Accidental Death and Dismemberment Insurance equal to one times your annual salary up to a $150,000 maximum.

The coverage is automatic, and the premiums are 100% employer paid while employed by the County.
The AD&D insurance pays in addition to the Basic Life, in the event an employee dies in a covered accident or suffers a dismemberment or disability as defined by the insurance company.

Important Information

If you terminate employment, you may be able to continue some or all of your life insurance coverage under the plan's portability or conversion provision. Rates and coverage amounts for terminated employees will vary and will be provided by the carrier when you apply to continue your coverage.

Supplemental Employee Term Life Insurance

Eligible employees can purchase Supplemental Term Life Insurance coverage for themselves and their family members. Consider the cost of funeral expenses, legal expenses, and general living expenses for your surviving family members when electing your additional coverage. **Please note this a is post-tax benefit. Rates can be viewed in the bswift platform.**

	Employee	Spouse	Child
Benefit Schedule	Increments of $5,000	Increments of $5,000	$10,000 or $15,000
Maximum Benefit	$500,000	$250,000	$15,000
Minimum Benefit	$5,000	$5,000	$10,000
Guaranteed Issue (new hires only)	$250,000	$50,000	$15,000
Age Reduction Schedule	N/A	N/A	N/A
Employer Contribution	0%	0%	0%

An Accelerated Benefit is included. Terminally ill members may withdraw up to 100% of their Life benefit (Basic Life and any Supplemental Life) if their life expectancy is 12 months or less.

Whole Life Insurance with Chronic Care - Unum

An innovative plan that provides Life Insurance with built-in Chronic Care benefits.

Just starting out? Growing your family? Thinking about retirement? This policy can be an important part of your overall financial wellness. It provides a life insurance benefit and could be used to pay for chronic care expenses. It eliminates the possibility of paying for coverage you may never use. That's why these hybrid policies have become so popular.

Did you know that:

- Most people outlive their employer-paid life insurance and need coverage for retirement.
- Qualification is easy; there are no exams, tests, or lengthy applications.
- You can lock in rates that will not increase with age.
- Coverage for yourself, your spouse, or both of you is affordable.
- Inexpensive coverage for kids is available too!

Click here or login to **https://smcg.bswift.com/** see a video that explains the difference between this policy and the group term plan.

Here's how it works:

- You can choose the benefit amount that you want: as little as $10,000, up to $200,000. This is referred to as the face amount or death benefit.
- There is a second part of the policy, the Cash Value, which builds over time. It gives you many options that your group term benefit does not provide.
- The Cash Value earns a minimum of 3.75% interest annually.
- You can borrow from the policy once it has developed a Cash Value.
- Because of the Cash Value, you have three options, whether you have the policy as an employee at St. Mary's County Government, or you decide to keep the policy if you leave employment and pay Unum directly (at the same rates):

  - Keep the policy. If you pay the premiums, and the policy is in force, your beneficiary will receive the death benefit.
  - Cancel your life insurance and receive a check for the Cash Value.
  - Choose a Reduced Paid-Up policy (payments stop, but the policy doesn't). Simply notify Unum to do this. Unum will use your Cash Value to buy a new policy for a smaller death benefit, but there will be no more premiums due (because it is "Paid Up").

Please schedule an appointment with a Decision Support Specialist or send an email to **service@boltonusa.com** if you have additional questions on the Whole Life Insurance plan or need assistance enrolling.

Whole Life Insurance with Chronic Care

Chronic Care Rider

The Chronic Care Rider provides a monthly benefit of 6% or a one-time lump sum payment of 50% of the death benefit, your choice; no care setting required. You are eligible if you require substantial supervision due to severe cognitive impairment or inability to perform at least two of the six Activities of Daily Living (ADLs). The ADLs are bathing, dressing, eating, continence, toileting, transferring, and severe cognitive impairment.

The easiest way to learn more about this is to schedule a call with a Decision Support Specialist by clicking here: **https://go.oncehub.com/SMCG**. You can send an email to **Service@BoltonUSA.com** if you need help with your enrollment.

Identity Theft Protection

Allstate Identity Protection Pro Plus

Employees will receive a welcome email from Allstate Identity Protection (AIP) which contains their Member ID and a link to login to the AIP portal.

St. Mary's County Government offers employer-paid identity protection services through Allstate Identity Protection Pro Plus (AIP). Sharing data is a fact of life, but with convenience comes risk. Allstate Identity Protection Pro Plus delivers advanced identity and privacy protection. Unique tools and proactive monitoring help you see, manage, and protect your personal data. You can monitor your identity, credit, financial transactions, social media, and more – all in one place! Allstate Identity Protection Pro Plus includes these features, plus much more:

- Allstate Digital Footprint
- Comprehensive identity and credit monitoring
- Dark web monitoring
- Financial transaction monitoring
- Social media monitoring
- Data breach notifications
- Full service, 24/7 remediation support
- Stolen fund reimbursement
- $1 million identity theft insurance policy

Long-Term Disability Insurance

Regular part-time and full-time employees of St. Mary's County Government are provided with a Long-Term Disability plan 100% paid for by the County. Long-Term Disability is meant to provide protection for more significant disabilities that cause you to be out of work for longer than 180 days.

Highlights of the Long-Term Disability Plan:

- Pays a benefit of 60% of monthly pay up to a maximum monthly benefit of $5,000.
- Benefits are paid for a maximum of 5 years.
- If you become disabled at age 60 or older, the benefit duration is determined by your age when disability begins.

Maximum Benefit Period: Determined by your age when Disability begins	**Age Maximum Benefit Period**
59 or younger	5 years
60 - 64	To age 65, but not less than 1 year
65 or older	1 year

Voya 457(b) Plan

What Is a 457(b)?

A 457(b) is a tax-advantaged retirement plan primarily for those employed by state and local governments. Like other employer-sponsored retirement plans, the 457(b) provides tax-efficient growth for retirement savings: You don't pay capital gains taxes on the investments you buy and sell in your account, giving your retirement nest egg additional room for growth.

Contributions to your 457(b) are deducted from your paycheck and may be taxed in one of two ways: with a traditional 457(b), your contributions are taken out of your paycheck before taxes, lowering your overall tax bill today. When you take out money in retirement, you pay income taxes on the withdrawals. With a Roth 457(b), you fund your account with money that's already been taxed in exchange for tax-free withdrawals in retirement. This includes any earnings your money makes while it's in your 457(b).

457(b) Contribution Limits

For 2024, the annual contribution limit for a 457(b) plan is $23,000. Employees aged 50 and older may make additional catchup contributions of $7,500, for a total contribution limit of $30,500 in 2024. To enroll, go to: enroll.voya.com, enter plan #664270, enter verification #019149.

For more information on the 457(b) Plan, go to bswift's library for literature and videos.

Employee Assistance Program

We recognize you may experience issues that affect the quality of life at home or at work. The Deer Oaks Employee Assistance Program (EAP) is available to you and your household family members 24 hours a day, seven days a week by calling 800-327-2251. All calls are completely confidential and there is no cost to you for using the service. The professionals at the EAP can help by assessing, advising, and recommending options to you or your family members to assist with problems.

The EAP Can Help with many issues Including:

- Conflicts at work
- Financial or legal problems
- Depression, grief, stress, or anxiety
- Marital or family concerns
- Elder care
- Drug and alcohol dependency
- And more

Program benefits Include:

- Up to 3 FREE counseling sessions with an EAP professional for you and your household members on the following topics:
  - Financial consultation & referrals
  - Legal consultation & referrals
  - Childcare resources & referrals
  - Elder care resources & referrals

For information about the EAP services, go to www.deeroakseap.com SMCG is the username and password.

Employee Wellness Program

St. Mary's County Government offers an employee wellness program designed to encourage healthier lifestyles through holistic programs focusing on 5 dimensions of well-being: emotional, environmental, financial, physical, and social elements. Together these elements help to inspire a whole and healthy you!

Emotional Wellness – Inspires self-care, relaxation, stress reduction and the development of inner strength.

- Deer Oaks Employee Assistance Program
- Webinars and seminars about self-care, stress reduction and relaxation techniques.

Environmental Wellness – Refers to how one's environment can influence behavior and mood. These environments can include home, work and outdoors.

- Workplace safety-training and resources to keep you and your work environment safe.

Financial Wellness – Involves your ability to manage money in order to manage your day-to-day expenses and achieve your long-term financial goals.

- Blue Wellness Discount Program (for SMCG employees covered by CareFirst).
- Up to 20% discount on St. Mary's County Recreation & Parks programs.
- Voya Financial 457(b) Deferred Compensation plan for optional tax-advantaged retirement savings Blue Rewards Program.

Physical Wellness – Involves taking proper care of our bodies for optimal health.

- Fitness challenges, fitness classes, fitness reimbursement program, employee health and wellness day, Blue Rewards Program, wellness room, Burnalong health and wellbeing online program.

Social Wellness – Involves building healthy, nurturing and supportive relationships as well as fostering a genuine connection with those around you.

- Friday Fitbit, Go Red for Women's Cardiovascular Health, Wear Blue for Men's Health Month, Wear Pink for Breast Cancer Awareness, Meal Planning and Cooking Demonstrations, United Way & Creating Healthier Communities Campaign.
- The County's employee wellness program emphasizes the importance of education, awareness, self-care, and behavioral change programs to enhance overall well-being.

Wellness Committee – The County has established a Wellness Committee to advocate, recommend, and advise the County Administrator regarding employee health and wellness initiatives. Membership is comprised of employees from each department or agency of the County. Regular meetings are held in January, April, July, and October. Special meetings may be called as required for particular activities. Please contact wellness@stmaryscountymd.gov if you'd like to become more involved with the County's wellness initiatives.

Human Resources Department Staff Directory

Human Resources Department
Main Telephone Number: 301-475-4200, Ext 1100

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Deputy Director
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Cynthia Tomlinson, ext. 1108
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Kelly Pelczar, ext. 1114
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Kelly.Pelczar@stmaryscountymd.gov

Colleen Wood, ext. 1105
HR Assistant
Colleen.Wood@stmaryscountymd.gov

Questions?

Your Benefits Contacts

Benefit Plans	Contact	Phone	Website or Email
bswift Online Enrollment	Bolton	301-276-7760	service@boltonusa.com
CareFirst/Medical	CareFirst	800-628-8549	www.carefirst.com/stmarys
Vision	CareFirst/Davis	800-783-5602	www.carefirst.com/stmarys
Dental	CareFirst	866-891-2802	www.carefirst.com/stmarys
Flexible Spending Account/COBRA	Voya	833-232-4673	Voya.Benstrat.com HASinfo@voya.com
Basic & Supplemental Term Life	Minnesota Life Company	800-392-7295	www.ochsinc.com
Long Term Disability	Madison National Life Insurance	800-392-7295	www.ochsinc.com
The Standard Critical Illness	Bolton	301-276-7760	service@boltonusa.com
The Standard Accident	Bolton	301-276-7760	service@boltonusa.com
Hospital Indemnity	Bolton	301-276-7760	service@boltonusa.com
Short-Term Disability	Bolton	301-276-7760	service@boltonusa.com
Deferred Compensation Plan - 457(b)	Voya -- Marta Steane, ChFC	703-304-9077	Marta.steane@voyafa.com
Whole Life Insurance w/Chronic Care	Bolton	301-276-7760	service@boltonusa.com
Employee Assistance Plan (EAP)	Deer Oaks	866-327-2400	deeroakseap.com
Identity Theft	Allstate	800-789-2720	Customercare@AIP.com
Health Center	Everside Health Center	240-744-1100	eversidehealth.com/stmaryscounty

Annual Notices

St. Mary's County Government is required by applicable law to provide you with certain notices each year that inform you of your rights and our responsibilities with respect to the City's health plan (the "Plan"). Please carefully review the information contained below and share it with your covered dependents. We suggest you keep this information for future reference.

Medicare Part D-Creditable Coverage

Important Notice from St. Mary's County Government About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with St. Mary's County Government and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this 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. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. St. Mary's County Government has determined that the prescription drug coverage offered by St. Mary's County Government Health Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 - December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage will be affected. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will not be eligible to receive all of your current health and prescription drug benefits. If you drop your current coverage with St. Mary's County Government and enroll in Medicare prescription drug coverage, you may enroll back into St. Mary's County Government Health Plan during the Open Enrollment period or if you experience a qualifying event. If you do decide to join a Medicare drug plan and drop your current TSt. Mary's County Government Health Plan coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with St. Mary's County Government and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) if you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

For further information contact the Human Resources Department. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through St. Mary's County Government changes. You also may request a copy of this notice at any time.

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show if you have maintained creditable coverage and, therefore, if you are required to pay a higher premium (a penalty).

HIPAA Notice of Availability of Privacy Practices

St. Mary's County Government Health Plan (the "Plan") maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. The Notice describes the legal obligations of the plan and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Among other things, the Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Human Resources.

Annual Notices

HIPAA Notice of Special Enrollment

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). *

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

Also, you may be entitled to special enrollment rights pursuant to the Children's Health Insurance Program Reauthorization Act of 2009 (the Act) if you or your dependents:

1. Lose coverage under a Medicaid or State Plan; or
2. Become eligible for group health premium assistance under a Medicaid plan or State Plan.

If a special enrollment right is provided pursuant to the Act, you may change your election consistent with such special enrollment right within 60 days if the election is made consistent with the special enrollment.

Waiver of Coverage

If you elect to waive coverage for yourself or your dependents (including your spouse), you acknowledge that you and your spouse and/or dependent child(ren) can only enroll later during an annual Open Enrollment period. An exception to this is if you and your spouse and/or dependent child(ren) are entitled to enroll in accordance with the "Special Enrollment Rights" described above.

To request special enrollment or obtain more information, contact Human Resources.

Women's Health and Cancer Rights Act (WHCRA)

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Contact Human Resources for more information.

Annual Notices

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

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

If you or your dependents are already enrolled in Medicaid or CHIP your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP, to see if your state has a premium assistance program, or for more information on special enrollment rights, contact the U.S. Department of Labor or the U.S. Department of Health and Human Services or the Employee Benefits Security Administration Centers for Medicare & Medicaid Services at 1-866-444-EBSA (3272) 1-877-267- 2323, Menu Option 4, Ext. 61565.

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, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

Coordination of Benefits (COB)

All medical and dental plans contain a "non-duplication of benefits," or Coordination of Benefits (COB), clause. Under the COB provision, to determine which plan pays benefits first (the "primary" plan), the general rules below apply:

- The plan under which the person is covered as an employee is primary.
- CHAMPUS and Medicare are normally secondary.
- Qualified children are covered first under the plan of the parent whose birthday (month and day) falls earlier in the year (insurance companies call this "the Birthday Rule").
- If the parents are divorced or separated, the plan of the parent with custody pays first; the plan of the custodial parent's spouse pays second; the plan of the parent who does not have custody pays third.
- The plan that covers an active employee and qualified children pays first; the plan that covers a laid-off or retiree employee and dependents pays second.
- Contact your health plan's Member Services department to confirm your plan's specific COB rules.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law took effect in 2014, there was a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October for coverage starting as early as January 1.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit1.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution — as well as your employee contribution to employer-offered coverage — is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about health coverage offered by your employer, contact your Benefits Team at 301-475-4200, extension 1100. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit www.marylandhealthconnection.gov you c.an also access hefp through the Maryland Health Connection customer service center by calling 855-642-8572 or 855-642-8573.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information.

Please see bswift for more information.

Family & Medical Leave (FMLA)

Employees may be eligible for leave under the Family Medical Leave Act (FMLA) if they have been employed for at least 12 months and have worked at least 1,250 hours during the 12 months immediately preceding the start of the leave.

Go to the bswift library or to www.dol.gov/whd/fmla for additional information.

General Glossary of Terms

AD&D	Accidental Death & Dismemberment (AD&D) Insurance pays a benefit if you suffer certain types of injuries, such as the loss of a hand, foot, or eye as a result of an accident, or if you die as a result of an accident. AD&D coverage is automatically provided as part of your Basic Life Insurance.
Annual Benefits Election Period	A period during the year when your employer allows you to elect new benefits or make changes to your current benefits. Also referred to as Open Enrollment.
Basic Life Insurance	The group term life insurance provided at no cost to full-time and full-time equivalent employees.
Beneficiary	A person(s) or an entity (such as an association or organization) that you name to receive your life and AD&D insurance benefits if you die while covered; or to receive your vested account balances in your Retirement and Savings Program if you should die.
Calendar Year	The period spanning from January 1 to December 31 of each year.
Coordination of Benefits (COB)	A provision of the insurance industry, which limits benefits if you are covered under multiple insurance plans. Benefits are limited to 100% of covered expenses. The order in which insurance companies are paid is also designated by this provision.
Co-insurance	A fixed percentage of medical or dental costs that you are required to pay for covered services under your insurance policy. This applies if you use out-of-network providers, or if your plan specifies that it will pay a fixed percentage of covered services. Co-insurance is not the same and does not include a co-pay.
Co-payment (Co-pay) Covered	The amount you pay when you use in-network providers or purchase prescription drugs.
Expenses	Charges that are paid in part, or in full, by the plan.
Covered Service	A medical or dental service covered by your medical or dental plan.
Deductible	The amount you must pay in covered health care expenses before the plan begins to pay a percentage of your costs.
Flexible Spending Account	A Flexible Spending Account (FSA) allows you to set aside pre-tax dollars for unreimbursed medical, prescription, vision, and dental expenses, and dependent care costs.
Formulary	Also known as “Prescription Drug List.” A list of drugs approved by a particular insurance carrier.
Generic Drug	A drug that may be sold under more than one name, by more than one company.
Guaranteed Issue	A provision that allows you to purchase insurance coverage regardless of the health of the person applying for coverage.

General Glossary of Terms

Guaranteed Issue Maximum	The maximum amount of life insurance you may purchase without providing medical evidence.
Health Savings Account (HSA)	A tax-advantaged savings account that allows you to set aside pre-tax dollars to pay for eligible healthcare expenses as defined by Section 213(d) of the tax code. Also known as HSA. An HSA may only be established in conjunction with an eligible high deductible medical plan.
In-Network Benefits	Benefits that are paid at a higher level when you use network participating providers.
Medical Evidence of Insurability	You may be required to complete a health questionnaire to be approved for certain benefit plans, thus providing evidence that you are insurable. The insurance company will review your health information and determine whether they will provide coverage to you.
Non-Formulary	A drug not included on the list of approved drugs of an insurance carrier.
Non-Reimbursed Expenses	Services you have paid for, and that are not reimbursable by your insurance company; for example, co-pays, deductibles, charges more than the reasonable and customary or the allowed benefit, or other charges not covered by your insurance company
Open Enrollment	See "Annual Benefits Election Period."
Out-of-Pocket Maximum	The most you will pay in a calendar year before the plan pays 100% of covered medical expenses, not including prescription drug co-pays.
Plan Year	The period spanning from the beginning of the benefit plan year to the end of the benefit plan year. Currently for The City of Frederick this is from July 1 to June 30 of the following year.
Precertification	Your insurance company may require your physician to obtain approval before services are rendered for the insurance company to pay for the services.
Preferred Provider	A provider who has contracted with your insurance company to be paid directly for covered services, and who will accept the allowed benefit as a payment in full. Also referred to as a participating provider, or an in-network provider.
Prescription Drug List	Also known as "Formulary." A list of drugs approved by a particular insurance carrier.
Prescription Drugs	Allergy serums, biologicals, prescription drugs, and injectable insulin that are approved by your insurance company, or that by law must be dispensed with a prescription.
PPACA	Patient Protection and Affordable Care Act of 2010. Sometimes referred to as the Affordable Care Act, or ACA.
Qualifying Event	An occurrence that entitles a person to select or change benefits outside of a defined "Open Enrollment" period. Events could include but are not limited to termination of employment, death of a covered person, marriage, divorce, birth, adoption, Medicare eligibility, a dependent child's loss of dependent status, or commencement of or return from an unpaid leave of absence.

Notes:


ST. MARY'S COUNTY MARYLAND
FATTI
MASCHII
PAROLE
FEMINE
1637