

M-NCPPC

2019 EMPLOYEE BENEFITS HANDBOOK



**HEALTHCARE, LIFE INSURANCE, FLEXIBLE SPENDING ACCOUNTS,
EMPLOYEE ASSISTANCE PROGRAM, WORKPLACE WELLNESS AND
MORE....**

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DISCLAIMER

This Employee Benefits Handbook is provided for information purposes only. This Handbook is not and shall not be construed as an actual or implied contract or a guarantee of continued employment between any employee or other person and The Maryland-National Capital Park and Planning Commission. Nor shall this Handbook be construed in any way as affecting or modifying terms and conditions of employment. Commission policy will govern all rights regarding benefit matters, consistent with applicable provisions of Collective Bargaining Agreements and other Commission contracts, all of which are subject to change. If there is a discrepancy between this handbook (or any oral representation concerning the benefits discussed herein) and the insurance provider's benefit provisions, the insurance provider's written agreements and contracts regarding those benefits will govern.

Throughout this book where days are referenced, it is assumed to be calendar days unless otherwise indicated.

Revised May 2025

GENERAL EMPLOYEE BENEFIT INFORMATION



GENERAL EMPLOYEE BENEFIT INFORMATION

THINGS TO KNOW

- You can find additional information about your benefits at www.mncppc.org/275 including the following and more.
 - Employee Benefits Guide
 - Benefit Plan Summary Descriptions
 - Medical Plan Comparison Chart
 - Benefit Premium Rate Charts
 - Vendor Contact List
 - Summary of Benefit Coverage for Medical Plans
 - Forms for Benefit Plan Enrollment, Benefit Changes and Beneficiary Designations
- If you do not enroll in your benefits when first eligible, i.e., within 45 days of your date of hire as a benefit eligible employee, you will not be able to make any benefit changes until:
 - You experience a qualifying event and submit required documentation to Health & Benefits within 45 days of the event (marriage, newborn, divorce, legal separation, loss of healthcare coverage, etc.), or
 - The following open enrollment period
- You are responsible for removing ineligible members and members who no longer require coverage from your elected benefit plans. Your premiums will not be adjusted due to removal of members from your benefit plan until you notify the Health & Benefits Office in writing with appropriate documentation. Premium adjustments will be applied to the next closing payroll period, provided all other eligibility rules are satisfied. Benefit premiums will not be refunded retroactively for untimely or late changes in benefits. The only exception is the removal of over age dependents when they reach age 26. Over age dependents are removed automatically the end of the month in which they reach age 26, unless they have been approved by the insurance carrier for continuance of coverage due to disability.
- If you are a union employee, the provisions of your collective bargaining agreement will supersede the benefits in this handbook. Please be sure to review your collective bargaining agreement in addition to this handbook for specific information regarding your benefits.
- To determine if you are eligible for a specific benefit plan, please refer to the Benefit Eligibility Chart by Employee Type that can be found in the section on General Employee Benefit Information.
- If you have any questions concerning any of the benefits in this Handbook contact the Office of Health & Benefits:
 - Phone: 301-454-1694
 - Email: benefits@mncppc.org
 - Visit/Mail: The Maryland-National Capital Park & Planning Commission
6611 Kenilworth Avenue, Suite 404
Riverdale, MD 20737

GENERAL EMPLOYEE BENEFIT INFORMATION

Employees are eligible for certain benefits based on their employee type. To determine the benefits that you are eligible for, refer to the Benefit Eligibility Chart below.

BENEFIT ELIGIBILITY CHART BY EMPLOYEE TYPE

Plans Available	Career FT/PT	Appointed	P/T Commissioners	Merit Board	Term-Contract	Long Term Disability	Retirees	Survivors	ERS	Seasonal **	COBRA
Medical – Kaiser Permanente HMO and Prescription Drugs	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Medical – UnitedHealthcare Choice Plus POS	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	No	Yes
Medical – UnitedHealthcare Select EPO Plan	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Prescription - Caremark	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Dental – Delta Dental	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	No	Yes
Vision – EyeMed	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	No	Yes
Employee Assistance Program (EAP)	Yes	Yes	Yes	Yes	<i>Only if benefit eligible</i>	Yes	No	No	Yes	<i>Only if benefit eligible</i>	No
Flexible Spending Account	Yes	Yes	Yes	Yes	Yes	No	No	No	Yes	No	Yes
Sick Leave Bank	Yes	Yes	No	No	No	No	No	No	No	No	No
Prepaid Legal Services	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	No	No
457 - Deferred Compensation	Yes	Yes	Yes	Yes	Yes	No	No	No	Yes	No	No
Life Insurance & AD&D	Yes	Yes	Yes	Yes	No	Yes	No	No	Yes	No	No
Supplemental Life Insurance: Self, Spouse/Dependent	Yes	Yes	Yes	Yes	No	Yes	No	No	Yes	No	No
Long Term Disability (LTD)	Yes	Yes	Yes	<i>Yes Optional</i>	No	No	No	No	Yes	No	No
Supplemental LTD*	Yes	Yes	Yes	Yes	No	No	No	No	Yes	No	No
ERS – Retirement Plan	Yes	Yes	Yes	No	No	Yes	No	No	Yes	No	No
Credit Union	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Direct Deposit	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Family Medical Leave	Yes	Yes	Yes	Yes	Yes	No	No	No	Yes	Yes	No
Tuition Assistance Program	Yes	No	No	No	No	No	No	No	No	No	No

* Your annual base salary must be more than \$108,000 to be eligible to enroll.

** **Seasonal Employees:** If you are a seasonal employee, you are eligible for limited benefits if you worked, on average, 30 hours per week during your first 12 months of employment or from October 3rd to October 2nd each subsequent period following your first 12 months of employment. This equates to 1,560 hours over a 12-month period. If you are eligible for benefits, you will receive notification directly from the Health & Benefits Office.

GENERAL EMPLOYEE BENEFIT INFORMATION

WHEN COVERAGE BEGINS

Initial Coverage as a new hire (or becoming eligible for benefits), for yourself and your eligible dependents, starts on the first day of the month following the month in which a completed Application for Benefit Enrollment form and required documents are received by the Health & Benefits Office as long as the Application for Benefit Enrollment is received within 45 calendar days of hire or becoming eligible for benefits.

There are three exceptions:

- *Mandatory Benefits - You are automatically enrolled in mandatory benefits, i.e., Long Term Disability and the Employee Retirement System (ERS). Coverage begins as of your date of hire.*
- *Basic Life Insurance – You are automatically enrolled in Basic Group Life Insurance upon hire. You may opt-out by completing the appropriate form.*
- *Sick Leave Bank – New Hires can enroll within 60 calendar days of hire. If not, they must wait until the next annual Open Enrollment period, ~~not enroll in the Sick Leave Bank until successfully completing the probationary period; typically one year of service.~~*

When added to your healthcare plan, newborns are covered from date of birth. Adopted dependents are covered from date of adoption/placement for adoption as verified by appropriate documentation.

It is the employee's responsibility, not the Department's, to ensure that enrollments occur within the established timeframes. Even though a Department may follow-up on behalf of the employee; failure on the part of the Department to follow up will not qualify as an exemption from this rule. There will be no exceptions.

MAKING CHANGES IN BENEFIT ELECTIONS

If you do not enroll for coverage under the Medical, Dental, Prescription Drug, Vision, other Voluntary Benefits, or the Flexible Spending Accounts (Healthcare and Dependent Care) within 45 days of hire (or becoming eligible for benefits), you cannot enroll in or make changes in these benefit options until:

- The next annual open enrollment period. Coverage for benefit elections made during open enrollment are effective January 1st of the following calendar year.

or

- Within 45 calendar days of a qualifying life event. If you experience a qualifying life event, coverage begins the first of the month following the submission of all required documents, as long as they are received within 45 calendar days of the event. (Exception: Changes made due to birth or adoption are effective as of the date of birth or adoption.)

You can enroll in and make changes at any time during the year to your contributions to the Retirement Savings Vehicles (457, Traditional IRA and Roth IRA). You can also apply for basic and supplemental life insurance at any time during the year. If you apply for basic, supplemental or dependent life insurance and it is not within 45 days of hire (or becoming eligible for benefits), you (and your spouse, if applicable) will have to submit evidence of insurability and your coverage is subject to the approval by the carrier.

Making Changes Due to a Qualifying Life Event

Generally, your initial benefit elections remain in effect for the remainder of the Plan year in which you enroll. The benefit elections made during open enrollment usually remain in effect for the following Plan year, i.e., January 1st through December 31st. You may be able to change your benefit elections during the Plan year for Medical, Dental, Prescription Drugs, Healthcare Flexible Spending Account, Dependent Care Flexible Spending Account, Basic and Supplemental Life Insurance, Spouse/Dependent Life insurance if you experience one of the qualifying life events listed below. The changes that you make must be consistent with the qualifying life event. For example, if you get married, you may not change from one medical plan to another medical plan; you may only change the coverage level from individual to family coverage. If you are increasing your life insurance coverage amount for yourself and/or your spouse, proof of insurability may be required and coverage is subject to the approval/denial by the insurance company. You do not need to provide proof of insurability when requesting coverage for a dependent child.

List of Qualifying Life Events

- Your marriage or divorce, annulment, or legal separation;
- Your child's marriage, divorce or annulment;
- A birth, adoption or change in a child's custody;
- A change in your or your spouse's or child's employment status, including part-time, full-time or retirement, strike, lockout or change in worksite;
- You or your eligible dependent's loss of healthcare coverage;
- You receive a Qualified Medical Child Support Order (QMCSO);
- A change in your or your spouse's insurance (cost or coverage);
- Commencement of or return from an unpaid leave of absence taken by you or your spouse;
- Your dependent child no longer meets the eligibility requirements of a dependent;
- Gain or loss of Medicaid or Children's Health Insurance Program (CHIP) eligibility
- The death of your spouse or child;
- Your relocation out of your plan's coverage area;
- Your spouse's open enrollment period;
- A change in dependent eligibility due to a plan design change;
- A change in the dependent care arrangements; or
- A change in eligibility for a Commission plan (i.e. Medicare Complement Plan)
- Eligibility for Medicare of other coverage

Participation of individual medical providers and facilities is subject to change without notice. Any provider or facility change is not a qualifying event to change medical plans.

If you are affected by a qualifying life event, contact the Health & Benefits Office within 45 calendar days of the event. You will need to supply written documentation of the qualifying event and complete an *Application for Benefit Enrollment* form to change your coverage within the 45 days following the event. When a fully completed application and documents are received, the change will be effective the first of the month following receipt, provided it is received within the 45-day window.

Failure to notify the Health & Benefits Office in writing within the 45-calendar day period may result in a loss or delay of coverage for your dependents until the next open enrollment period. If you do not drop dependents from your coverage in a timely manner, you will be responsible for any claims paid beyond the date the coverage should have ended.

GENERAL EMPLOYEE BENEFIT INFORMATION

If the application and all required documentation is received by the Health & Benefits Office within 45 days of the qualifying life event, changes to your enrollment will be effective the first of the month following receipt thereof.

Exceptions:

- Newborn dependents or those added due to adoption/placement for adoption are covered from date of birth or adoption/placement for adoption.
- Life insurance coverage amount changes, except for dependent child coverage, is effective upon approval by the insurance company.

Documentation Required for Qualifying Life Events

The following chart provides examples of the required documentation that you must submit within 45 days of the event to Health & Benefits along with your enrollment/change form in order to add/remove a dependent due to a qualifying life event.

Qualifying Event	Proof Required
<p>You want to add a dependent child due to:</p> <ul style="list-style-type: none"> • Birth – Newborns are covered from date of birth • Loss of Other Coverage (Child up to age 26) * • Adoption (Children under age 18) • Legal Guardianship (Children under age 18) • Qualified Medical Child Support Order (QMSCO) • Loss of Children’s Health Insurance Program Eligibility (CHIP)* 	<p>Birth certificate (document from hospital accepted initially) and Social Security card required within 3 months of date of birth.</p> <p>Official copy of birth certificate and Social Security card.</p> <p>Copy of amended birth certificate (when available), Social Security card <u>and</u> documentation showing when the child was placed in your custody. Finalized adoption papers must be received within three months of placement.</p> <p>Copy of birth certificate, Social Security card <u>and</u> documentation showing when the child was placed in your custody. Finalized court order must be received within three months of placement.</p> <p>Copy of signed QMSCO listing the dependent’s name and effective date in addition to copy of birth certificate and Social Security card.</p> <p>CHIP letter listing the name of person(s) affected and the effective date in addition to copy of birth certificate and Social Security card.</p>

GENERAL EMPLOYEE BENEFIT INFORMATION

Qualifying Event	Proof Required
You want to add a dependent child disabled prior to age 26.	Disability certification forms completed by physician along with any additional supporting documents.
You get married and want to add your spouse.	Copy of your marriage certificate and spouse's Social Security card.
You want to join the Commission's group health plan(s) due to loss of healthcare coverage through your spouse's employer due to your spouse's termination of employment or loss of eligibility. *	Letter from spouse's employer or carrier listing name of individual(s) affected, the type of coverage(s) lost and the date coverage was terminated.
Your spouse or other eligible dependent loses healthcare coverage and you want to add them to your coverage. *	Documentation noting name of individual(s) affected, the type of coverage(s) lost and the date coverage was terminated, in addition to birth certificate(s), marriage certificate and copy of Social Security card(s) if not already on file in the Health & Benefits Office.
You <u>must</u> remove your ex-spouse due to a divorce. An ex-spouse is not considered an eligible dependent.	Copy of your divorce decree or annulment, and your ex-spouse's address for COBRA notification. Note: In the event of a divorce, your ex-spouse <u>must be removed</u> within 45 days of the divorce or you will be responsible for any claims incurred after the end of the month following the date of the divorce. <i>(If you lose coverage due to divorce, you have 45 days from the event to enroll in the Commission's healthcare program; otherwise you will have to wait until Open Enrollment.)</i>
You want to remove your spouse due to legal separation.	Copy of a court-approved order recognizing the separation or a copy of a fully executed separation agreement (does not have to be court-approved) and your spouse's address for COBRA notification.

The examples above represent the most common qualifying events and do not represent a complete listing. If you have any questions, please contact a representative of the Health & Benefits Office at 301-454-1694.

**Tag Along Rule Applies - Other previously eligible dependents who were not enrolled may also be enrolled at this time.*

GENERAL EMPLOYEE BENEFIT INFORMATION

The following is a summary of when benefit coverage ends. This list is not complete. If you need more information concerning your benefits, please contact the Health & Benefits Office. Certain benefits may continue upon retirement-refer to the section on Retirement Planning.

When Your Coverage Ends

Benefits other than health insurance benefits, usually end at midnight on the day that any of these events occur:

- You leave the Commission due to resignation or termination, or
- You become ineligible for benefits due to a reduction in your working hours, (i.e., part-time, or temporary), or eligible employment status change or
- You die
- The Commission discontinues a plan
- You elect not to continue a benefit plan that is sponsored by the Commission (excluding LTD which is a mandatory benefit for eligible active employees)
- Note: Benefits are also subject to end if you fail to pay premiums in a timely manner

Exceptions:

- Healthcare benefits (medical, dental, vision and prescription drugs) end the last day of the month following the events above.
- If you are approved for Long Term Disability:
 - Your LTD coverage ends the date you are approved for LTD benefits
 - Your Life and AD&D coverage end after being disabled for one year. It may be possible to continue your Basic Life coverage if you apply for a waiver of premium:
 - If the waiver is approved, you do not have to pay your portion of the premium while totally and permanently disabled.
 - If the waiver is denied, you will be responsible for paying your portion of the premium. If you fail to pay your portion of the premium, coverage is subject to termination.
 - Your coverage for medical, prescription, dental, vision and legal will end on the last day of the month in which your employment is terminated
- If you take a medical leave of absence while on Long Term Disability:
 - You can continue your healthcare insurance for yourself and your dependents by paying your share of the premium (same as an active employee) on a monthly basis through the Self-Pay Program.
- If you are on Leave Without Pay:

You can continue your healthcare insurance for yourself and your dependents for up to 12 months for an approved, qualifying reason, by paying your share of the premiums (same as an active employee) on a monthly basis through the Self-Pay Program.
- Whenever your healthcare (medical, dental, vision and/or prescription drug) coverage ends, you may be able to continue your coverage for up to 18-36 months under the Consolidated Omnibus Budget Reconciliation Act (COBRA). For additional information, refer to the section on COBRA under Government Regulated Benefits and Required Notices.

GENERAL EMPLOYEE BENEFIT INFORMATION

- While your Flexible Spending Account before-tax contributions end with your last paycheck, you may be reimbursed for eligible expenses under the following conditions:
 - Health Care Account –
 - You may be reimbursed for covered expenses incurred during the rest of the calendar year if you continue contributing to the account on an after-tax basis and follow the normal timeline, including the 2.5 month filing extension.
 - If you stop making contributions after you receive your last paycheck, your coverage will end and you may be reimbursed only for eligible expenses incurred before your termination date. You must file for reimbursement within 90 days of your termination/resignation.
 - Dependent Care Account
 - You may be reimbursed only for eligible expenses incurred before your termination date. You may not make additional contributions to the account in order to continue coverage. If you are not working, you cannot use the dependent care account. You must file for eligible expenses within 90 days of your separation/termination date, but only up to the amount that you contributed to your account.
For more information refer to the section on Flexible Spending Accounts.

When Coverage Ends for Your Dependents (Spouse/Child(ren))

Benefit coverage for your dependents ends the same date that your coverage ends or in the following situations:

- Non-payment of premium for your family.
- A divorce or legal separation (spouse's coverage ends).
- A child no longer qualifies as a dependent.
- Your death. In this case, the Commission will continue to make 100% contributions to medical care and prescription premiums for up to 6 months after your death. For more information refer to the Family Security and Survivor Benefits section in this handbook.
- A Qualified Medical Child Support Order (QMCSO) is no longer in effect.

When healthcare (medical, dental, vision and/or prescription drug) coverage ends for your dependents, they may be able to continue coverage for up to 18-36 months under the Consolidated Omnibus Budget Reconciliation Act (COBRA). Please refer to page 47 for additional information.

BENEFIT PREMIUMS

Pre-Tax and Post-Tax Premiums

Pursuant to Section 125 of the Internal revenue Code, premiums paid through payroll deduction for medical, prescription, vision and dental, are pre-tax or tax-exempt. This means that you do not pay income tax on this money. The IRS Code 125 allows pre-tax contributions as a way to provide you with a larger take-home paycheck. Some restrictions are placed on you because of the tax benefits. For plans that provide the tax-exempt premium, the Internal Revenue Code prohibits changes in the employee's deduction during the plan year unless there is a qualifying change in status (qualifying event). If the Commission is not in compliance, the plan could lose its tax-exempt qualification and/or employees could be subject to an IRS audit and be required to pay additional taxes and possible penalties. The Irrevocability Rule applies to both increases and decreases in coverage, such as adding or dropping dependents from health coverage.

Premiums for life insurance and the disability plans are paid on a post-tax basis.

Self-Pay

Who May Participate

While you are on an extended leave of absence such as Leave Without Pay, Family Medical Leave or Long-Term Disability, you may continue your health benefits by paying your premiums directly to Benefit Strategies, the third party vendor who administers this program for the Commission. A retiree or a survivor of a deceased retiree may also pay for health benefits for all eligible family members through this self-pay program.

How the Program Works

The employee, retiree or survivor should contact the Health & Benefits Office to receive information about how to get started. Your information will be sent to Benefit Strategies and they will send you a letter with instructions and coupons for payment of your monthly premiums.

Payment of Premiums

It is your responsibility to pay premiums when due. If there is a past due amount owed, this amount will be reflected in the total due on the first premium coupon. Premium payments are due on the first day of each month, regardless of receipt of a premium coupon(s). To ensure proper posting of your premium payment, it is required that you return the coupon with your payment and should be mailed on or before the due date. You will have a grace period for each monthly premium. Consideration will be given for the initial payment on self-pay.

DIRECT DEPOSIT

What is Direct Deposit?

Direct Deposit is the electronic transfer of your paycheck, benefit check, or other payment into your checking account, savings account, credit union, or other designated electronic transfer account. Instead of receiving a check in the mail and taking it to the bank, you can rest assured that your money is in your account. The money is available to you the morning of the payment date. Employees are encouraged to use direct deposit.

Direct Deposit offers these benefits:

- Convenience: No more special trips to the bank or credit union to deposit your check;
- Reliability: Funds are automatically deposited into your account on scheduled dates even if you are sick or on vacation. Funds are available for withdrawal upon deposit;
- Security: You do not have to worry about lost, stolen, or misplaced checks;
- Flexibility: If you decide to switch accounts or your financial institution, it is easy to change your direct deposit arrangements;
- Manage Your Money: You can have your funds deposited directly into more than one account. A portion of your funds can be deposited into a checking account with the remainder deposited into a savings account. You decide.

What types of payments can be made by Direct Deposit?

- Your paycheck from the Commission or other employer;
- Benefit checks from the federal government, such as Social Security, Supplemental Security Income (SSI), Railroad Retirement, Veterans Benefits and Civil Service retirement payments;
- Benefit checks issues by state governments, including retirement and unemployment;
- Pensions;
- Income from investments;
- Federal and state income tax refunds; and
- Reimbursements from your Flexible Spending Accounts.

Will my money be safe?

Your money is protected by the Federal Deposit Insurance Corporation (FDIC), an independent agency of the United States. The FDIC insures funds deposited in banks and savings associations, including any accrued interest, up to \$250,000 per depositor, per insured bank. Since 1933 when the FDIC was established, no depositor has lost any of their funds insured by the FDIC.

How can I avoid problems?

Keep track of deposits and withdrawals. Compare them with your statement. Contact your bank or other institution immediately if you find an error. Generally, you have 60 days from the date your statement was mailed to provide notification of errors.

Retirees

It is mandatory that all retirees sign-up for Direct Deposit in order to receive their monthly annuity. If you are a retiree and you are making any changes in direct deposit, please contact the Employee Retirement System (ERS).

How Do I Sign Up for Direct Deposit?

If you are an active employee, contact the Payroll Division. If you are a retiree or survivor, contact the Employee Retirement System office (ERS).

CREDIT UNION

Eligibility

You are eligible to join the credit union if you are:

- An employee of the Commission full-time, part-time, or seasonal;
- A retiree from either the Commission or the Credit Union;
- A member of an eligible employee or retiree's family, which includes spouse, natural or adopted children, parents, grandparents, grandchildren, nieces, nephews, brothers and sisters;
- A member of organizations sponsored by the common bond.

Ending Membership

You cease to be a member if you withdraw all of your shares and fail to maintain a balance of \$5.00 or more for one year or more.

Available Benefits

The following types of benefits are available:

- Savings accounts
- IRA accounts
- Loans
- Life insurance
- On-line banking
- Certificates of deposit
- Credit disability insurance
- Financial counseling
- Additional services as reflected in quarterly newsletter
- Checking accounts
- Christmas Club Savings

Payroll Deduction

If you are an active employee, you may contribute to your savings accounts or repay loans through payroll deduction. If you are an active employee, please contact the Credit Union to start, stop, or change your deductions. If you are a retiree, please contact the Employee Retirement System (ERS) to start, stop or change your deductions.

GENERAL EMPLOYEE BENEFIT INFORMATION

Account Balance Requirements

\$ 5.00	To keep your account open
\$200.00	To earn dividends on your money
\$150.00	Minimum required at all times for loan approval and maintenance

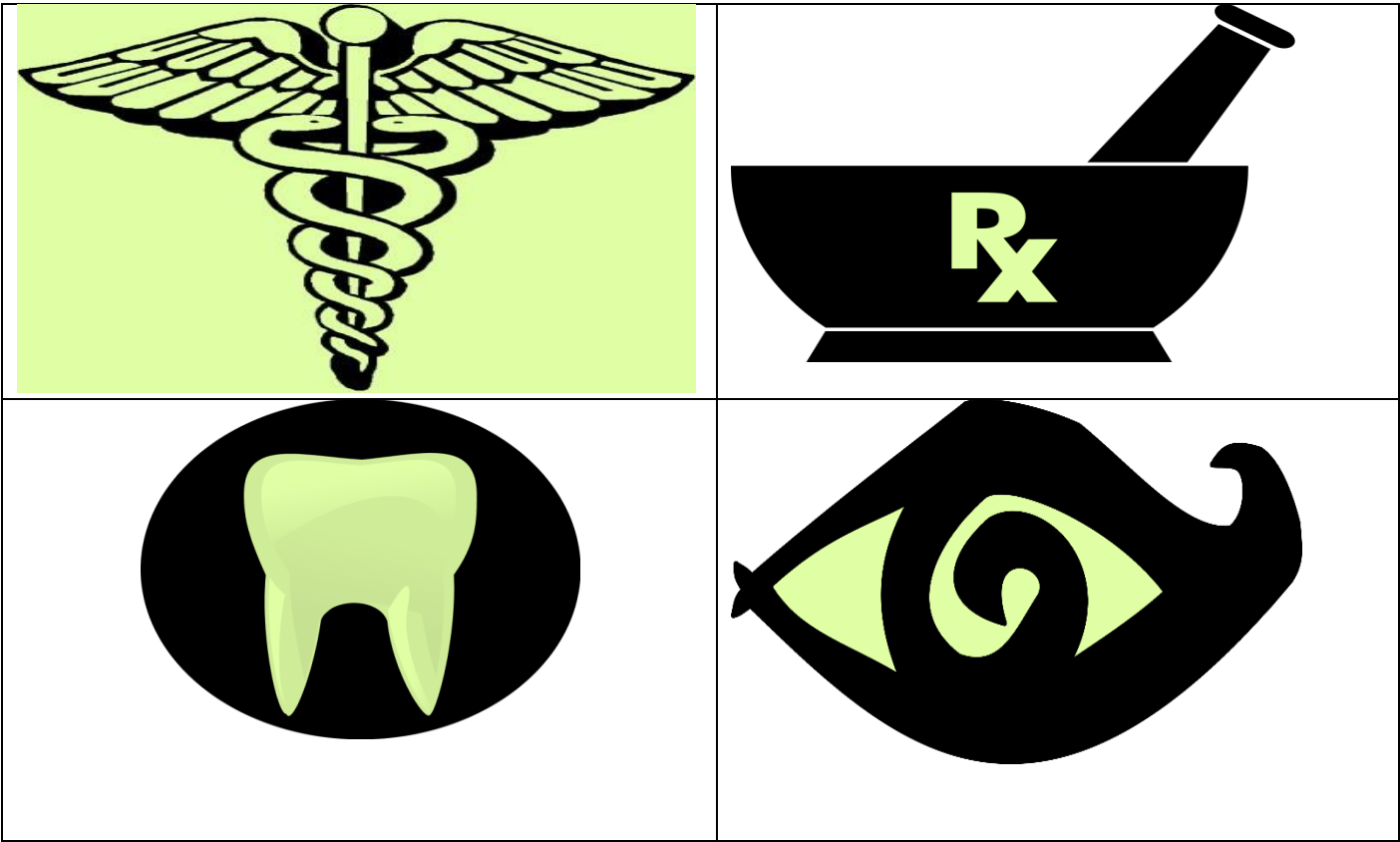
How Safe Is Your Money?

Your money is safe in the MNCPPC Federal Credit Union. The National Credit Union Association (NCUA), a government agency, insures all deposits up to \$250,000. After one year of inactivity, if your account(s) have balances below a set minimum, it will be considered dormant and closed. If you cannot be located, the funds are reported to abandoned property as required by law.

The Credit Union's phone number is 301-277-8630. The main branch is located at:

5211-A Campus Drive
College Park, MD 20740

HEALTHCARE BENEFITS



HEALTHCARE BENEFITS

DEPENDENT ELIGIBILITY

Eligible Dependents

The following are considered eligible dependents:

- Legal spouse (as recognized under Maryland law)
- Natural, step, or adopted ~~or~~ children *
- A child for whom you or your covered dependent spouse/partner has permanent (12 months or longer) legal guardianship before his/her 18th birthday and who meets the above requirements (copy of court order required).

* Dependent children are covered up to the end of the month in which they reach age 26. Unmarried children who are disabled prior to age 26 due to mental or physical incapacitation may be covered indefinitely if they meet certain criteria and are approved for continuance of coverage by the insurance carrier.

NOTE: In order for benefits to become effective for your dependents, the enrollment form submitted must be legible and include required information such as employee and dependent names, Social Security Number(s) and address. Any required documents such as marriage certificate, birth certificate(s), a copy of the Social Security card(s) and adoption documents must also be submitted along with the enrollment form. Documentation required is the same as if you were adding/dropping a dependent due to a qualifying event. For specific documentation required, refer to the chart under the section on Qualifying Events.

Ineligible Dependents

The following are examples of ineligible dependents (this list is not all-inclusive):

- Your ex-spouse
- Your parent(s), grandparent(s), or stepparents
- Your sister, brother, stepsister or stepbrother
- Your aunt or uncle
- Your niece or nephew
- Young adult children over age 26 who were not permanently incapacitated prior to age 26 and continue to be approved as such.
- Individuals that do not meet dependent eligibility requirements even if court ordered, unless it is a Qualified Medical Child Support Order (QMCSO).

If one or more of your dependents becomes ineligible for benefits, you, the employee will be responsible for submitting an Application for Benefits Enrollment/Change form to the Health & Benefits Office within 45 days of the event. If the removal of your dependent would result in a reduction in your premium such as moving from Family coverage to 2-Member coverage, the premium reduction will not occur until the first of the month after you submit your enrollment/change form; there will be no retroactive refund of any premium differential. In addition, failure to submit your enrollment/change form in a timely manner may result in the denial of benefits for your dependent in which case you will be responsible for the Commission's portion of the insurance premiums and/or claims that were incurred after the dependent was no longer eligible.

DISABLED DEPENDENT CHILDREN OVER AGE 26 - ELIGIBILITY REQUIREMENTS

Coverage for an unmarried dependent child who is not in a legal partnership and is disabled due to mental or physical limitations will not end just because the child has reached age twenty-six (26). Coverage may be extended beyond age twenty-six (26) if the insurance carrier approves your application for continuance based on certain criteria. The insurance carrier may request periodic recertification by the health care provider.

Contact your medical plan carrier to apply for continuance of coverage for a disabled dependent child. You must apply 30 days prior to child reaching age 26. If you need further assistance, contact the Health & Benefits Office.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

A Qualified Medical Child Support Order (QMCSO) is a court decree stipulating that a child of a covered member is entitled to enroll in the participant's group health plan.

If you are ordered by a QMCSO to provide medical coverage for one or more of your dependents, you must immediately submit a copy of the QMCSO to the Health & Benefits office for a determination that the QMCSO will be recognized by the group health plan. Upon notification that the QMCSO will be recognized, you must complete a new *Application for Benefit Enrollment* form for dependent coverage and submit it to the Health & Benefits Office. If the Health & Benefits Office is otherwise in receipt of the QMCSO and you do not complete a new form, a payroll deduction will automatically be made to provide medical coverage for your dependent. The dependent's other parent or the state agency administering benefits may be asked to provide enrollment information. Coverage begins on the date the child is ordered to be enrolled in the plan.

An order is "qualified" only if it:

- Clearly specifies the name and last known mailing address of the covered member, each child to be covered, and the custodial parent or guardian;
- Includes a reasonable description of the type of coverage to be provided by the plan or the manner in which such coverage is to be determined;
- Specifies the period to which it applies; and
- Does not require the plan to provide any type or form of benefit not otherwise provided under the plan.

To stop coverage for a child covered by a QMCSO, written evidence stating that the court administrative order is no longer in effect must be supplied to the Health & Benefits Office. Children covered as the result of a QMCSO will be treated as any other child enrolled in the plan.

GUARDIANSHIP OF DEPENDENT CHILDREN

Dependent children are eligible when placed in your court ordered custody. Minors for whom guardianship is granted by court or testamentary appointment for at least twelve (12) months duration are eligible for the health benefits programs established by the Commission provided you and the eligible minors comply with plan eligibility requirements and you are enrolled in those benefits. Court appointments made after a child's 19th birthday will not be recognized. The child will no longer be considered a dependent. Foster care arrangements are not the same as guardianship and therefore do not qualify the child for Commission benefits.

ADOPTION OF CHILDREN

For purposes of adoption or placement for adoption, the term "child" is an individual who has not attained age 18 as of the date of adoption or placement for adoption. The term "placement" or "being placed" for adoption means the assumption and acceptance by you or your spouse of a legal obligation for total or partial support of a child in anticipation of adoption of the child. If an adoption is planned upon the birth of a child, coverage will not begin for the child until a petition of adoption is received that certifies the date of placement of the child. Under no circumstances will the medical expenses of the birth mother be eligible for reimbursement.

Foster care arrangements are not the same as placement for adoption and therefore do not qualify the child for Commission benefits, even if the intent is to eventually adopt the child.

If the adoption has been finalized, a copy of the final adoption paperwork must be provided along with an amended birth certificate from the state in which the child was born. Once adoption paperwork has been received, coverage will be effective the later of the final adoption date or the date your coverage as the employee became effective in a plan.

HEALTHCARE BENEFITS

If the child is placed for adoption, a copy of the petition for adoption must be provided. When the adoption is finalized, a copy of the amended birth certificate from the state in which the child was born must also be provided. Documentation supporting the continued petition for adoption may be requested from time to time. If at any point in the process the placement is terminated, you must notify the Health & Benefits Office immediately or you may be responsible for any claims and other expenses or premiums incurred that were paid for by the Commission after the placement was terminated. A child placed in your home pending finalization of adoption will not be added to your coverage until proper documentation is received showing when the child was placed in your custody.

As with other dependents, initial paperwork, including the completed enrollment/change form must be received in the Health & Benefits Office within 45 calendar days of date of placement or coverage will be denied until the next open enrollment period.

DOUBLE COVERAGE EXCLUSION

If you and your spouse both work for or are retired from the Commission, you may not elect to cover each other as dependents. You also may not both elect family healthcare coverage while enrolling the same eligible children as dependents.

For example, if two employees are married, they cannot both elect vision coverage and cover the other spouse as a dependent. If one employee is an active employee and the other is a retiree, you both may not have two-member coverage with each other as a dependent or family coverage that has the same eligible children enrolled.

COORDINATION OF BENEFITS

If you, your spouse and other dependents are enrolled in one of the Commission's health plans and also in your spouse's health plan:

- The Commission's plan is the primary payer for you and your spouse's plan is primary for him/her. For the children, the primary plan is determined in the following order:
 - When a dependent is covered under the health plan of both parents, the plan of the parent whose birthday falls earlier in the year is the primary plan.
 - If the parents' birthdays fall on the same month and day, the gender rule applies, providing the father's coverage first, then the mother's.

MEDICARE ELIGIBLE EMPLOYEES ACTIVELY WORKING

Any person who has reached age 65 *and* who is entitled to Social Security benefits is eligible for Medicare Part A, usually *without charge*. That is, there are no premiums for this part of the Medicare program. Medicare Part A covers institutional care in hospitals and skilled nursing facilities, as well as certain care given by home health agencies and care provided in hospices.

If you are actively working and covered under the Commission's medical plan when you or your dependent becomes eligible for Medicare Part A, the Commission's medical plan remains primary. While actively employed, neither you or your Medicare eligible dependent has to enroll in Medicare Part B but will need to do so when you retire or separate from employment.

If you/your dependent choose to enroll in Medicare Part A it will not negatively impact your benefits under the Commission's medical plan.

You will also be considered for enrollment in Medicare Part B at this time. However, if you have group medical insurance through the Commission and are still working, you can delay enrolling in Medicare Part B. Medicare Part B plan covers doctor's visits and other outpatient services and requires a monthly premium. When you eventually retire or separate from the Commission you can then enroll in Medicare Part B during a special enrollment period of eight month following your retirement/separation without incurring a late enrollment penalty. If your spouse is covered as your dependent under the Commission's medical plan while you are working, he/she may also defer their enrollment in Medicare Part B without penalty. *This does not apply to an employee that has retired and has been rehired as a seasonal or term-contract employee.*

MEDICAL PLANS

General Information on Medical Plans

Emergency Room Treatment

Generally, the emergency room is used for treatment of a medical condition where the absence of medical attention within 24-48 hours from onset of the condition could reasonably be expected to result in a more serious or life-threatening health issue. If you seek treatment at the emergency room and the plan determines that you could have received timely treatment through a provider or urgent care center, you may be responsible for the charges associated with treatment/diagnosis secured at an emergency room.

Prior Authorizations

There are certain services that require prior approval from the health plans before services are rendered. Depending on the plan, the process of getting prior approval is referred to as Pre-certification, Pre-authorization or Prior notification. Before you receive these services, you must ask the provider who is recommending the service to contact the health plan for prior approval. In most cases, if you are using an in-network provider it is the provider's responsibility to obtain the prior approval, but it would be in your best interest to make certain that it is done as coverage may be reduced or denied.

Purpose of Prior Authorizations

The prior approval process allows you to know in advance whether a procedure, treatment or service will be covered under your plan. It helps ensure that you receive the appropriate level of care in the appropriate setting and enables the health plan to identify situations that may allow you to receive additional attention, (e.g., referrals to disease or case management programs) based on the type of service requested. In general, network providers are responsible for notifying the claims administrator before they provide these services to you. However, there are some services for which you are responsible for notifying the health plan. If you are in the Choice Plus POS when you choose to receive certain covered health services from a non-network provider, you are responsible for pre-notification before you receive the services. If you do not obtain prior approval, your coverage may be reduced or denied.

When Prior Authorization Is Required

This list does not include all services requiring pre-certification. These are only examples based on common procedures, treatments, and services. If your physician recommends an unusual procedure or service, you should contact your health plan's customer service for guidance.

- All inpatient admissions and non-obstetric observation stays, including those for:
- Back surgery
- Biofeedback
- Dental services when done on an in-patient basis
- Durable medical equipment
- External Prosthetic Device/Appliances
- Home Health Care/Home Infusion Therapy

HEALTHCARE BENEFITS

- Injectable Drugs
- Maternity stays longer than 48 hours (vaginal delivery) or 96 hours (cesarean section)
- Mental Health & Substance Abuse Services
- MRIs/MRAs, CT Scans and PET Scans
- Nonemergency ambulance service
- Potentially experimental and investigational procedures
- Potentially cosmetic or reconstructive procedures
- Speech Therapy
- Transplant Services
- Requests for in-network only coverage of services from out-of-network health care professional

Medical Case Management

Case management is a service offered to you through all of our health plans. They are voluntary programs that help you coordinate access to care, explore service alternatives, monitor progress, assist with discharge planning and follow up, and help ensure that benefits are used effectively. If you or a family member were suddenly faced with a complex medical condition, where would you turn? How would you cope with the overwhelming number of decisions you would be forced to make? Case management can help. The goal is to make sure you receive access to timely and appropriate medical care.

Case management teams have specially trained nurses and other credentialed health care specialists with the skills, experience and compassion to assist you with your particular medical and mental needs. Supported by a nationwide staff of board-certified physicians, case managers are well informed about the latest medical treatments and resources. They are experienced in both medicine and medical insurance and will help you get the care you need – whether that care is through outpatient or inpatient hospital services, or care you receive at home.

Your case manager will work closely with you and family members to:

- Guide you through the maze of complicated medical questions that may arise in the midst of a serious medical situation.
- Educate you and your family about the medical condition, including treatment options and available medications.
- Assist you in navigating the health care system to get the medical attention needed and help coordinate the various stages of treatment and recuperation.
- Help you and family members cope with the unexpected and help make informed decisions.
- Work with doctors to understand what is happening and investigate different treatment options to help you make the best choices.
- Facilitate communication with your insurance company or employer.
Coordinate the scheduling of needed home care therapies or home-health personnel.
- Monitor progress to receive high quality, expert care.
- Continue to follow up until you are on the road to recovery and have an effective treatment plan in place.

Case management programs offer you:

- Expertise, caring and understanding from trained professionals who can help to get you through difficult and confusing times.
- Additional information about the treatment choices identified by your doctor to help you make informed decisions about your health care.
- The peace of mind that comes from knowing that your case manager is working hard to get you access to the care you need so you can recover as soon as possible.

Case management programs only support participant and family decision-making. You need to make the right health care choices for you.

HEALTHCARE BENEFITS

Your rights under case management allow you to:

- Provide input into your case management plan;
- Refuse services, including case management services, and understand how this refusal may affect your eligibility for benefits and/or access to health information and assistance;
- Obtain information about the criteria for ending case management services;
- Receive notice and rationale if case management services are changed or end; and
- Have access to alternative service approaches if you or your family are not able to participate fully in assessing your needs;
- Understand the health plan's role in assisting with end-of-life and advance care directives, if applicable.

Your case manager is here to help and support you and your entire family during a difficult time. You and your doctor will always have the final say on any recommendations the case managers make. Case management is a voluntary program. Call your health plan's customer service number for more information.

Foreign Travel

All medical plans do not cover routine medical treatment outside of the United States. The medical plans only cover bona fide emergencies outside of the United States. You will have to pay the charges for bona fide emergencies up front and file for reimbursement of allowable fees.

If you are travelling abroad, you may want to consider purchasing special travel medical insurance. Immunizations required for foreign travel are not covered since they are not considered medically necessary or in accordance with established preventive care guidelines.

TYPES OF MEDICAL PLANS OFFERED

Employees are offered a choice between three medical plan models: HMO, EPO and POS.

- **What is Health Maintenance Organization (HMO)?**

A Health Maintenance Organization (HMO) is a medical benefits plan that provides access to certain doctors and hospitals within its network. Some HMO plans require you to select a primary care physician (PCP). Each family member may select their own PCP. If you do not select a PCP the HMO will assign one to you. Your PCP determines what treatment you need and will refer you to a specialist if deemed necessary. The specialist must also be in the designated network. Services are covered only if you see a provider within the HMO's network; unless you have a bona fide medical emergency.

- **What is an Exclusive Provider Organization (EPO)?**

An Exclusive Provider Organization (EPO) is a medical benefits plan that operates just like an HMO. You may still need to select a Primary Care Physician (PCP) who manages your healthcare needs depending upon the plan you select. Most services are covered in full with some requiring a co-payment. However, unlike an HMO, you do not need to get a referral from your PCP to see a specialist. Visits to a specialist are covered subject to the office visit co-payment as long as the specialist is a participating provider in the designated network. Services rendered by a specialist that is not participating in the designated network are not covered. There are no out-of-network benefits in an EPO, except for medical emergencies.

HEALTHCARE BENEFITS

- **What is a Point of Service (POS)?**

A Point of Service (POS) is a medical benefits plan that gives you the freedom to see any Physician or other health care professional in and outside of the network. You will receive the highest level of benefits when you seek care from a network provider, including specialists, as most services are covered in full or subject to a co-payment. If you seek care from an out-of-network provider, you will pay more out of pocket and the provider can bill you for any charges above what is normally paid in-network. This is known as balance billing. Whether you are in or out of the network, you do not need to select a Primary Care Physician (PCP) or get a referral from your PCP to see a specialist.

MEDICAL PLANS OFFERED

The Maryland National Capital Park and Planning Commission offers eligible active employees and their dependents and non-Medicare eligible retirees/dependents the following medical plans:

- Kaiser Permanente Health Maintenance Organization (HMO) with Prescription Drug Coverage
- UnitedHealthcare Exclusive Provider Organization (EPO)*
- UnitedHealthcare Preferred Point of Service (POS)*

Retirees (and their dependents) who are Medicare Eligible due to reaching age 65 or disability may elect enrollment in:

- UnitedHealthcare Exclusive Provider Organization (EPO)*
- Kaiser Permanente Medicare Complement Plan with Prescription Drug Coverage
- UnitedHealthcare Preferred Provider Organization (POS) Medicare Complement Plan*

**Prescription drug coverage is not included in the UnitedHealthcare plans. If you enroll in either of these plans and want prescription drug coverage, you must enroll in the separate Caremark Prescription Drug Plan.*

******* If you are an active employee and reach age 65, and become eligible for Medicare, you will be automatically enrolled in Medicare Part A, which is normally free. While an active employee, you do not have to enroll in Medicare Part B, since the Commission's medical plan is the primary insurer. When you retire, you will have a special enrollment period of eight months to sign up for Medicare Part B, without penalty. This does not apply to an employee that has retired and has been rehired as a seasonal or term-contract employee.***

A detailed comparison chart for the medical plans offered to employees/retirees and their eligible dependents is included in this section.

Before electing to participate in a plan, you should carefully review the plan's covered services, exclusions and participating doctors and hospitals. Please review the Summary of Benefit Coverage, which lists exclusions, for each plan medical plan and the Health & Benefits Enrollment Instructions Guide found at www.mncppc.org. For participating providers, visit the website for each plan or contact the plan directly.

Kaiser Permanente Health Maintenance Organization (HMO) with Prescription Plan

The Kaiser Permanente HMO covers most services in full with some requiring a co-payment. Your doctor, lab, pharmacy, x-rays and vision services are all in one convenient location. You must also select a Primary Care Physician (PCP) to direct your healthcare needs. If you do not choose a PCP, one will be assigned to you. A referral from your PCP is required if you need to see a specialist. There are no out-of-network benefits, except for bona fide emergencies, unless you are in another area such that you can obtain services from another Kaiser Permanente facility. If you are travelling or you have a student away at college in one of the areas below, call the toll-free number listed for a center near you. At the designated center(s), you will be covered for both routine, urgent and emergency care:

- California – 1-800-464-4000
- Colorado - 1-800-532-9700
- Northern Colorado - 1-844-201-5824
- Southern Colorado – 1-888-681-7878
- Georgia (Atlanta Metro Service Area) – 404-261-2590 (from Atlanta metro area) or 1-88-865-5813
- Hawaii – 1-808-432-5955 (from Oahu) or 1-800-966-5955 (from other areas)
- Oregon – 503-813-2000 (from Portland) or 1-800-813-2000 (from other areas)
- Washington State (Southwest area) – 1-800-813-2000

If you have a dependent attending college, living outside of the local Kaiser Permanente network, you may want to consider purchasing student insurance while your dependent is out of the area.

A Prescription Drug Plan is included in the Kaiser Permanente HMO plan. If you enroll in the Kaiser Permanente HMO (Kaiser Medicare Complement Plan), you cannot enroll in the Caremark Prescription Drug Plan (SilverScript Prescription Drug Plan).

Kaiser Permanente also provides additional services and programs to assist you in achieving and maintaining a healthy lifestyle:

- **Online tools** - Register at my.kp.org/mncppc and start taking advantage of the suite of online tools and mobile apps to take charge of your healthcare. At my.kp.org/mncppc you can:
 - Get lab results, order prescription refills, and email your doctor's office.
 - Access your digital membership card.
 - Make, change, or cancel appointments.
 - Read summaries of past visits with your doctor.
 - Manage the health care of a family member.
 - Checks costs and coverage.
- **Mobile Apps**
 - Set reminders when to take your meds and order prescription refills with the [My KP Meds app](#), which automatically connects to your electronic medical record.
 - Get moving with the [Every Body Walk! app](#). You can track your progress in real time as you set walking goals for distance, time, and calorie burn.

- **Healthy Extra Programs**

Find programs to help you maintain a healthy stance beyond the doctor's office at kp.org/healthylifestyles. Programs include:

- Weight and nutrition management
- Fitness
- Tobacco cessation
- Alternative medicine
- Diabetes care
- Heart health
- On-line programs, special rates and classes

The UnitedHealthcare Select Exclusive Provider Organization (EPO)

The UnitedHealthcare Select EPO is a medical benefits plan that operates just like an HMO. This plan is available to all eligible employees, retirees and survivors (under and over 65), including those who live out of the local area. Most services are covered in full with some requiring a co-payment. You do not need to select a Primary Care Physician (PCP) or get a referral from a PCP to see a specialist. Visits to a specialist are covered subject to the office visit co-payment as long as the specialist is a participating provider in the UnitedHealthcare Select EPO Network. The network of providers is national in scope providing access to doctors, hospitals and other health care facilities from coast-to-coast. There are no out-of-network benefits, unless due to a bona fide emergency.

Prescription drugs are not included in this plan. In order to obtain prescription drug coverage, you will need to enroll in the Commission's prescription plan.

The UnitedHealthcare Choice Plus POS

The UnitedHealthcare Choice Plus Point of Service (POS) is a medical benefits plan that gives you the freedom to see any Physician or other health care professional from a network of providers or choose to seek care outside of the network. This plan is available to all eligible employees, and retirees and survivors under the age of 65, including those who live out of the local area. You will receive the highest level of benefits when you seek care from a network provider as most services are covered in full or are subject to a co-payment. Visits to a specialist are covered subject to the office visit co-payment as long as the specialist is a participating provider in the UnitedHealthcare Choice Plus Network. In addition, you do not have to worry about any claim forms or bills if you seek care from a network provider. Unlike an HMO or EPO, there are out-of-network benefits. You do not need to select a Primary Care Physician (PCP) or get a referral from your PCP to see a specialist. The network of providers is national in scope providing access to doctors, hospitals and other health care facilities from coast-to-coast.

Prescription drugs are not included in this plan. In order to obtain prescription drug coverage, you will need to enroll in the Commission's prescription plan.

Both the UnitedHealthcare EPO and UnitedHealthcare POS provide additional services and programs to assist you in achieving and maintaining a healthy lifestyle:

- **Behavioral Healthcare**

UnitedHealthcare has developed its own behavioral service system called United Behavioral Health (UBH). You can access its website through a link on myuhc.com or by going directly to www.liveandworkwell.com. Prior notification to the UHC Select plan is required before seeking care by contacting UBH.

- **Nurse-Line Services and Personal Health Support**

Nurse-Line services using a toll-free number (1-800-603-4190), connects the member with a registered nurse who can assist with a wide range of health care questions and concerns 24 hours per day 7 days a week. Access is also provided to an audio health information library that provides more than 1,100 health and well-being topics, with 600 messages available in Spanish. Services are available to translate 140 languages and for callers with hearing impairments. Nurse-Line services can help members find a doctor or hospital that meet criteria for quality and efficiency, understand treatment options, ask medication questions, choose appropriate medical care and locate available resources, recognize urgent and emergency symptoms, understand medication interactions and how to reduce your prescription costs, connect with resources for pregnancy, cancer, diabetes, asthma, heart disease and more.

- **Wellness Programs** - The best health care keeps you and your family well.

- Start by taking a free health assessment at www.myuhc.com to identify your problem areas
- Search the online libraries where you'll find wellness articles that inspire the lifestyle changes to improve your health.
- Subscribe to the *Healthy Mind, Healthy Body* e-newsletter at www.uhc.com/myhealthnews and specify the content you'd like – whether articles on diet and exercise or fighting the flu
- Moms-to-be get special attention through our Healthy Pregnancy program from knowledgeable maternity nurses at www.healthy-pregnancy.com or calling Nurse-line Services
- Access a multicultural website for materials to address the health care needs of our diverse population at <https://www.uhc.com/health-and-wellness/family-health/multicultural-resources>
- Use UnitedHealthcare's <https://www.uhc.com/source4women.htm> as a resource you can turn to for information and support regarding your family's health. Source4women will give you answers to your health and wellness questions. It offers health tips, online seminars and more.
- Visit www.uhcpreventivecare.com to get a detailed list of guidelines to help you consider how often to see a doctor, when you should have a particular type of screening, when to get vaccinations and more.

- **Complementary Services** - These services are available at no additional cost and include:

- A personal health record that tracks doctor visits, shots, diagnoses, your health status and family medical history
- Preferred savings of up to 25% on laser vision correction services, making services such as LASIK more affordable
- Valuable discounts on products and healthcare services that may not be covered by your plan from nutrition supplements and fitness gear, to teeth whitening, and massage therapy
- Reduced membership fees for the National Fitness Network, a network of area health clubs, which offers members a convenient means of maintaining a healthy and fit lifestyle
- Health4Meapp for iPhones and Androids. Access your identification card wherever you are, locate providers, view your claims, track your personal health record, estimate costs of common procedures and conditions, and much more.

HEALTHCARE BENEFITS

Employee Medical Plans Comparative Summary At-A-Glance

Plan Feature	UHC Select EPO In-Network Only	UHC Choice Plus POS In-Network	UHC Choice Plus POS Out-of-Network	Kaiser Permanente HMO In-Network Only
Provider Network	Access to a national network of doctors, labs and facilities	Access to a national network of doctors, labs and facilities	Access to a national network of doctors, labs and facilities	Access to a local – DC, MD, VA, network of doctors, labs and facilities
Annual Deductible	N/A	N/A	\$250 Individual \$600 Family	N/A
Annual Out-of-Pocket Costs excluding deductible	\$1,100 Individual \$3,600 Family	\$600 Individual \$1,800 Family	\$600 Individual \$1,800 Family	\$1,100 Individual \$3,600 Family
Office Visit Copays	\$10 PCP \$10 Specialist	\$10 PCP \$10 Specialist	Covered at 80% of Plan Allowance after deductible	\$10 PCP (waived for children under age 5) \$10 Specialist
Inpatient Hospital/Facility	No Charge, covered 100%	No Charge, covered 100%	\$100 copay, then covered at 80% of Plan Allowance	No Charge, covered 100%
Outpatient/Facility	No Charge, covered 100%	\$10 Copay	Covered at 80% of Plan Allowance after deductible	No Charge, covered 100%
Outpatient/Labs and X-Rays	No Charge, covered 100%	No Charge, covered 100%	Covered at 80% of Plan Allowance after deductible	No Charge, covered 100%
Mental Health & Substance Abuse/Inpatient	No Charge, covered 100%	No Charge, covered 100%	Covered at 80% of Plan Allowance after deductible	No Charge, covered 100%
Mental Health & Substance Abuse/Outpatient	\$10 Copay	\$10 Copay	Covered at 80%	\$10 Copay/Individual \$5 Copay/Group
Emergency Room	\$50 Copay; waived if admitted	\$50 Copay; waived if admitted	\$50 Copay; waived if admitted	\$50 Copay; waived if admitted
Urgent Care	\$15 Copay	\$10 Copay	Covered at 80% of Plan Allowance after deductible	\$15 Copay
Out-of-Network Services' within the U.S.	Out-of-Network services covered for bona fide emergencies only.	Out-of-Network services covered for bona fide emergencies only.	Covered nationwide for routine and emergency services.	Routine and emergency services covered at Kaiser Permanente Centers in the states of California, Georgia (Atlanta), Hawaii, Oregon and Washington Out-of-Network services covered for bona fide emergencies only.

HEALTHCARE BENEFITS

Plan Feature	UHC Select EPO In-Network Only	UHC Choice Plus POS In-Network	UHC Choice Plus POS Out-of-Network	Kaiser Permanente HMO In-Network Only
Outside of the United States	Services covered for bona fide emergencies only. You may want to purchase travel medical insurance.	Services covered for bona fide emergencies only. You may want to purchase travel medical insurance.	Services covered for bona fide emergencies only. You may want to purchase travel medical insurance.	Services covered for bona fide emergencies only. You may want to purchase travel medical insurance.
Travel Immunizations	Not covered under medical; deemed not medically necessary.	Not covered under medical; deemed not medically necessary N/A	Not covered under medical; deemed not medically necessary N/A	Not covered under medical; deemed not medically necessary N/A
*Virtual Visits	Meet with a doctor, 24/7, by video conference for certain conditions: colds, flu, ear infection, allergies, joint aches and pains, and sore throat. Cost: F R E E	Meet with a doctor, 24/7, by video conference for certain conditions: colds, flu, ear infection, allergies, joint aches and pains, and sore throat. Cost: F R E E	Meet with a doctor, 24/7, by video conference for certain conditions: colds, flu, ear infection, allergies, joint aches and pains, and sore throat. Covered: 80% of Plan Allowance After Deductible	Meet with a doctor, 24/7, by video conference for certain conditions: colds, flu, ear infection, allergies, joint aches and pains, and sore throat. Cost: FREE
Prescription Drugs	Not included. Must enroll in CVS Caremark Prescription Drug Plan.	Not included. Must enroll in CVS Caremark Prescription Drug Plan.	Not included. Must enroll in CVS Caremark Prescription Drug Plan.	Included with your enrollment. (You cannot enroll in the Caremark Prescription Drug Plan.)
Dental Services	Not Included. Must enroll in the Delta Dental PPO or DeltaCare USA Plan.	Not Included. Must enroll in the Delta Dental PPO or DeltaCare USA Plan.	Not Included. Must enroll in the Delta Dental PPO or DeltaCare USA Plan.	Not Included. Must enroll in the Delta Dental PPO or DeltaCare USA Plan.
Vision Services	Not included. Must enroll in the EyeMed vision plan.	Not included. Must enroll in the EyeMed vision plan.	Not included. Must enroll in the EyeMed vision plan.	Limited Services. You can enroll in the EyeMed vision plan.

For more details on the medical plans refer to the detailed Medical Plan Comparison Charts on the following pages.

DETAILED COMPARISON CHARTS FOR MEDICAL PLAN OFFERINGS (Employees and Retirees)

EMPLOYEES/RETIREES/SURVIVORS/LONG TERM DISABILITY PARTICIPANTS (LTD) & Dependents

WHICH M-NCPPC MEDICAL PLAN ARE YOU ELIGIBLE FOR?

	UnitedHealthcare Select EPO	UnitedHealthcare Medicare Complement EPO	UnitedHealthcare Choice Plus POS	Kaiser Permanente HMO	UnitedHealthcare Medicare Complement	Kaiser Permanente Medicare Complement
Not Medicare Eligible	X		X	X		
Medicare Eligible		X			X	X

Note: If you are retired or on LTD and eligible for Medicare, you must enroll in both Medicare Part A (Hospital) and Medicare Part B (Medical). If your dependent becomes eligible for Medicare due to retirement or LTD, your dependent must also enroll in both Medicare Part A and Medicare Part B. Failure to do so will jeopardize your/your dependent’s continued enrollment in the medical plan.

For more details about each plan, please review the following comparison chart. This chart is a summary of the benefits under each plan and additional information is not all inclusive. For additional information, contact the plan directly using the phone number on the back of your Identification card. If there are any discrepancies between this document and the contract with the carrier, the contract will govern.

MEDICAL PLAN COMPARISON CHART for EMPLOYEES and RETIREES/SURVIVORS/LTD - NOT MEDICARE ELIGIBLE

<i>Plan Features</i>	<i>Kaiser Permanente HMO Plan</i>	<i>UnitedHealthcare Select EPO Plan</i>	<i>UnitedHealthcare (UHC) Choice Plus Point-of-Service (POS) Plan</i>	
			<i>UHC Choice Plus POS In-Network Benefits</i>	<i>UHC Choice Plus POS Out-of-Network Benefits</i>
<i>Annual Deductible</i>	No Deductible	No Deductible	No Deductible	\$250 Individual \$500 Two Member \$600 Family
<i>Annual Out-of-Pocket Limit (The limit on your out-of-pocket expenses, not including deductibles & disallowed charges)</i>	\$1,100 Individual \$3,600 Family Includes co-pay and co-insurance	\$1,100 Individual \$3,600 Family Includes co-pay and co-insurance	\$600 Individual \$1,200 Two Member \$1,800 Family Combined In and Out of Network Includes co-pay and co-insurance	\$600 Individual \$1,200 Two Member \$1,800 Family Deductible not included Combined In and Out of Network
<i>Lifetime Maximum</i>	Unlimited	Unlimited	Unlimited	Unlimited
<i>Pre-existing Condition Limitation</i>	No	No	No	No

Plan Features	Kaiser Permanente HMO Plan	UnitedHealthcare Select EPO Plan	UnitedHealthcare (UHC) Choice Plus Point-of-Service (POS) Plan	
			UHC Choice Plus POS In-Network Benefits	UHC Choice Plus POS Out-of-Network Benefits
Referrals Required	Yes, must be referred to specialists by your Kaiser Primary Care Physician.	No, but must use a UHC Select EPO provider	No, but must use a UHC Choice Plus POS provider	No

Plan Features	Kaiser Permanente HMO Plan	UnitedHealthcare Select EPO Plan	UnitedHealthcare (UHC) Choice Plus Point-of-Service (POS) Plan	
			UHC Choice Plus POS In-Network Benefits	UHC Choice Plus POS Out-of-Network Benefits
Pre-Authorization Required	N/A	<p>Yes, for all United Healthcare Plans.</p> <ul style="list-style-type: none"> All inpatient admissions and non-obstetric observation stays: Back surgery Biofeedback Dental services when done on an in-patient basis Durable medical equipment External Prosthetic Appliances Home Health Care/Home Infusion Therapy 	<ul style="list-style-type: none"> Injectable Drugs Maternity stays longer than 48 hours (vaginal delivery) or 96 hours (cesarean section) Mental Health & Substance Abuse Services MRIs/MRAs, CT Scans and PET Scans Nonemergency ambulance service Potentially experimental and investigational procedures Potentially cosmetic or reconstructive procedures 	<p>[In most cases it is the out-of-network provider's responsibility to obtain prior authorization, but it is in your best interest to ensure that this is done as coverage may be reduced or denied.]</p> <ul style="list-style-type: none"> Maternity stays longer than 48 hours (vaginal delivery) or 96 hours (cesarean section) Mental Health & Substance Abuse Services MRIs/MRAs, CT Scans and PET Scans Nonemergency ambulance service Potentially experimental and investigational procedures Potentially cosmetic or reconstructive procedures Speech Therapy Transplant Services Requests for in-network coverage of services from out-of-network health care professional

Plan Features	Kaiser Permanente HMO Plan	UnitedHealthcare Select EPO Plan	UnitedHealthcare (UHC) Choice Plus Point-of-Service (POS) Plan	
			UHC Choice Plus POS In-Network Benefits	UHC Choice Plus POS Out-of-Network Benefits
PREVENTIVE CARE				
Adult Physical Exams <i>*Charges may apply for diagnostic tests.</i>	\$0 co-pay	\$0 co-pay 1 exam every 12 months	\$0 co-pay 1 exam every 12 months	Covered 80% of allowed benefit (deductible applies) 1 exam every 12 months
Annual GYN Exam (including Pap test & related lab fees) <i>*Charges may apply for diagnostic tests.</i>	\$0 co-pay	\$0 co-pay	\$0 co-pay	Covered 80% of allowed benefit (deductible applies)
Flu Shots	\$0 co-pay	\$0 co-pay	\$0 co-pay	Covered 80% of allowable benefit, (deductible applies)
HPV Vaccine (Human papillomavirus) <i>For recommended age groups.</i>	\$0 co-pay	\$0 co-pay	Coverage only for at risk members Limitations apply \$0 co-pay	Coverage only for at risk members Limitations apply Covered 80% of allowable benefit, (deductible applies)
Immunizations	\$0 co-pay	Covered if recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control. \$0 co-pay	Covered if recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control. \$0 co-pay	Covered if recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control. \$0 co-pay

Plan Features	Kaiser Permanente HMO Plan	UnitedHealthcare Select EPO Plan	UnitedHealthcare (UHC) Choice Plus Point-of-Service (POS) Plan	
			UHC Choice Plus POS In-Network Benefits	UHC Choice Plus POS Out-of-Network Benefits
PREVENTIVE CARE (CONTINUED)				
Mammography (Over Age 40)	\$0 co-pay	Covered at 100%	Covered at 100%	Covered 80% of allowed benefit (deductible applies)
Preventive Care Infants to age 1 Toddlers Ages 1-2 Children Ages 3-18	\$0 co-pay	\$0 co-pay	\$0 co-pay	Covered 80% of allowed benefit (no deductible)
PSA Blood Serum Digital	\$0 co-pay	Member cost is based on the type of service performed and place where rendered	Covered 100% Limited to 1 per calendar year	Covered 80% of allowed benefit (deductible applies) Limited to 1 per calendar year
Zoster (a shingles vaccine) For age 60 and older only	\$0 co-pay	\$0 co-pay	\$0 co-pay	Coverage only for at risk members Limitations apply Covered 80% of allowable benefit, (deductible applies)
OFFICE VISITS, TESTING & THERAPY				
Allergy Injection Visits	\$0 co-pay	\$10 co-pay	Covered 100% Office co-pay applies if seen by doctor for an office visit	Covered 80% of allowed benefit (deductible applies)
Allergy Tests	\$0	\$10 co-pay	Covered 100% Office co-pay applies	Covered 80% of allowed benefit (deductible applies)

Plan Features	Kaiser Permanente HMO Plan	UnitedHealthcare Select EPO Plan	UnitedHealthcare (UHC) Choice Plus Point-of-Service (POS) Plan	
			UHC Choice Plus POS In-Network Benefits	UHC Choice Plus POS Out-of-Network Benefits
OFFICE VISITS, TESTING & THERAPY (CONTINUED)				
Diagnostic Lab & X-ray Services <i>(MRI, CAT Scan and Pet Scan require prior authorization)</i>	\$0 co-pay	100%	Covered 100% Office co-pay applies	Covered 80% of allowed benefit (deductible applies)
Habilitation Services (Benefits are limited to children under age 19. Require prior authorization and subject to case management.)	\$10 co-pay	\$10 co-pay	\$10 co-pay	Covered 80% of allowed benefit (deductible applies)
Office Based Surgery	\$10 co-pay	\$10 co-pay	Covered 100% Office co-pay applies	Covered 80% of allowed benefit (deductible applies)
Office Visits	\$10 co-pay PCP *PCP co-pay waived for child under age 5 if treated for injury or illness \$10 co-pay Specialist	\$10 co-pay	\$10 co-pay	Covered 80% of allowed benefit (deductible applies)
Rehabilitation: Physical, Occupational, Speech Therapy	\$10 co-pay Physical Therapy - 30 days per episode Occupational Therapy – 90 days per episode Speech Therapy – 90 days per episode	\$10 co-pay (Limited to 60 combined visits per year)	Covered 100% Limited to 90 days per year per type of treatment Combined In & out of network	Covered 80% of allowed benefit, 90 days per year per type of treatment (deductible applies) Combined in & out of network

Plan Features	Kaiser Permanente HMO Plan	UnitedHealthcare Select EPO Plan	UnitedHealthcare (UHC) Choice Plus Point-of-Service (POS) Plan	
			UHC Choice Plus POS In-Network Benefits	UHC Choice Plus POS Out-of-Network Benefits
EMERGENCY AND URGENT CARE				
Ambulance Services <i>(Non-emergency use requires prior authorization)</i>	\$0 co-pay for true emergency use only. This is for emergency services required to stabilize or initiate treatment in an emergency, not to transfer from one facility to another	Covered 100% For true emergency use only. This is for emergency services required to stabilize or initiate treatment in an emergency, not to transfer from one facility to another	Covered 100% For true emergency use only. This is for emergency services required to stabilize or initiate treatment in an emergency, not to transfer from one facility to another	Covered 80% of allowed benefit For true emergency use only. This is for emergency services required to stabilize or initiate treatment in an emergency, not to transfer from one facility to another (deductible applies)
Emergency Room use for a medical emergency <i>(Facility & Physician Charges)</i>	\$50 co-pay for emergency room. If admitted to the hospital from the emergency room, then the co-pay is waived Contact PCP before receiving care whenever possible	\$50 co-pay for emergency room. If admitted to the hospital from the emergency room, then the co-pay is waived Contact PCP before receiving care whenever possible	\$50 co-pay for emergency room. If admitted to the hospital from the emergency room, then the co-pay is waived Contact PCP before receiving care whenever possible	Covered at the In-Network level Contact PCP before receiving care whenever possible
Emergency Room use for a Non-Medical Emergency	Not Covered	Not Covered	Not Covered	Not Covered
Urgent Care Centers	\$15 co-pay	\$15 co-pay	\$10 co-pay	Covered 80% of allowed benefit (deductible applies)
IN-PATIENT & OUT-PATIENT HOSPITAL				
In-patient Diagnostic Tests <i>(Prior Authorization Required)</i>	Covered 100%	Covered 100%	Covered 100%	Covered 80% of allowed benefit (deductible applies) plus a separate \$100 in-patient deductible

Plan Features	Kaiser Permanente HMO Plan	UnitedHealthcare Select EPO Plan	UnitedHealthcare (UHC) Choice Plus Point-of-Service (POS) Plan	
			UHC Choice Plus POS In-Network Benefits	UHC Choice Plus POS Out-of-Network Benefits
IN-PATIENT & OUT-PATIENT HOSPITAL (CONTINUED)				
In-Patient Hospital Facility Charges (Overnight Stay) <i>(Prior Authorization Required)</i>	Covered 100%	Covered 100%	Covered 100%	Covered 80% of allowed benefit (deductible applies) plus a separate \$100 in-patient deductible
In-Patient Physician Visits	Covered 100%	Covered 100%	Covered 100%	Covered 80% of allowed benefit (deductible applies)
In-Patient Surgery <i>(Prior Authorization Required)</i>	Covered 100%	Covered 100%	Covered 100%	Covered 80% of allowed benefit (deductible applies) plus a separate \$100 in-patient deductible
Organ Transplant <i>(Prior Authorization Required)</i>	Covered 100% at a designated facility	Covered 100% at a designated facility	Covered 100%	Covered 80% of allowable benefit (deductible applies)
Out-Patient Surgery <i>(Prior Authorization Required)</i>	\$25 co-pay	\$25 co-pay (Facility) Covered 100% (Physician)	Office co-pay applies if done in the office Covered 100% if done at a facility	Covered 80% of allowed benefit (deductible applies)
In-Patient Professional Services (Such as anesthesiologists, radiologists and pathologists) when rendered in an in-network hospital	Covered 100%	Covered 100%	Covered 100%	Covered 80% of allowed benefit (deductible applies)

Plan Features	Kaiser Permanente HMO Plan	UnitedHealthcare Select EPO Plan	UnitedHealthcare (UHC) Choice Plus Point-of-Service (POS) Plan	
			UHC Choice Plus POS In-Network Benefits	UHC Choice Plus POS Out-of-Network Benefits
IN-PATIENT HOSPITAL ALTERNATIVES				
Home Health Care	\$0 co-pay limited to two (2) hours per visit Intermittent care not to exceed three (3) visits per day	Covered 100% 60 visits per calendar year Limitations apply	Covered 100% 90 visits per calendar year, max combined in & out of network	Covered 80% of allowed benefit (deductible applies), 90 visits per calendar year maximum combined in & out of network
Hospice Care	\$0 copay	Covered 100% Limited to 360 days during the time covered under the plan	Covered 100%	Covered 80% of allowed benefit (deductible applies)
Skilled Nursing Facility (Prior Authorization Required and Subject to case management)	Covered 100% Up to 100 days per calendar year	Covered 100% 60 days per calendar year	Covered 100% 100 Day Max/combined Subject to pre-authorization & case management	Covered 80% of allowed benefit 100-day Max/combined Separate \$100 per admission deductible Subject to pre-authorization & case management
MATERNITY & INFERTILITY				
Artificial Insemination (Prior Authorization Required and Subject to case management)	50% co-insurance \$100,000 per lifetime	50% co-insurance \$3,000 per lifetime	Covered 80% of allowed benefit 3 attempts per lifetime max. Combined in & out of network	Covered 60% of allowed benefit (deductible applies) 3 attempts per lifetime max. Combined in & out of network
Infertility Treatment and Testing	50% co-insurance	Member cost is based on the type and place of service	Covered 80% allowed benefit	Covered 60% of allowed benefit (deductible applies)

Plan Features	Kaiser Permanente HMO Plan	UnitedHealthcare Select EPO Plan	UnitedHealthcare (UHC) Choice Plus Point-of-Service (POS) Plan	
			UHC Choice Plus POS In-Network Benefits	UHC Choice Plus POS Out-of-Network Benefits
MATERNITY & INFERTILITY (CONTINUED)				
In Vitro Fertilization (Prior Authorization Required and Subject to case management)	50% co-insurance Limited to 3 attempts and a lifetime max of \$100,000. Limitations apply	Covered 50% of allowed benefit. Limited to 3 attempts and a lifetime max of \$100,000. Limitations apply	Covered 80% of allowed benefit 3 attempts per lifetime max. Combined in & out of network \$100,000 lifetime max. Limitations apply	Covered 60% of allowed benefit (deductible applies) 3 attempts per lifetime max. Combined in & out of network \$100,000 lifetime max. Limitations apply
Labor & Delivery	In-patient co-pay if applicable	Covered 100%	Covered 100%	Covered 80% of allowed benefit (deductible applies) plus a separate \$100 in-patient deductible
Prenatal and Postnatal Office Visits	No charge for routine prenatal care. Postnatal care subject to regular	\$10 co-pay initial visit, then 100%	\$10 co-pay initial visit, then 100%	Covered 80% of allowed benefit for initial visit (deductible applies)
Voluntary Sterilization (Reversal not covered)	Member cost is based on the type of service performed and place where rendered	Member cost is based on the type of service performed and place where rendered	Covered 100%	Covered 80% of allowed benefit (deductible applies)
MENTAL HEALTH & SUBSTANCE ABUSE				
Bereavement Counseling	Covered under Hospice benefit for family members up to one (1) year	Covered at 100% for short-term grief counseling as part of hospice care	Covered 100% \$200 maximum combined in & out of network for short-term grief counseling as part of hospice care	Covered 80% of allowed benefit after deductible, \$200 maximum combined in & out of network for short-term grief counseling as part of hospice care

Plan Features	Kaiser Permanente HMO Plan	UnitedHealthcare Select EPO Plan	UnitedHealthcare (UHC) Choice Plus Point-of-Service (POS) Plan	
			UHC Choice Plus POS In-Network Benefits	UHC Choice Plus POS Out-of-Network Benefits
MENTAL HEALTH & SUBSTANCE ABUSE (CONTINUED)				
In-Patient Hospital <i>(Prior Authorization Required and Subject to case management)</i>	Covered 100%	Covered 100%	Covered 100%	Covered 80% of allowable benefit, deductible applies plus separate \$100 in-patient deductible
Partial Hospitalization <i>(Prior Authorization Required and Subject to case management)</i>	Covered 100%	Covered 100%	Covered 100%	Covered 80% after deductible (60 days per year combined in & out of network) \$100 inpatient deductible
Out-Patient Treatment <i>(Prior Authorization Required and Subject to case management)</i>	\$5 co-pay group therapy \$10 co-pay individual therapy	\$10 co-pay per visit	\$10 co-pay per visit	Covered at 80%
ALTERNATIVE MEDICINE SERVICES				
Acupuncture	\$15 co-pay Limited to 20 treatments per year	\$10 co-pay Limited to 24 treatments per year	\$10 co-pay Limited to 24 treatments per year	Covered at 80% after deductible Limited to 24 treatments per year
Chiropractic	\$15 co-pay 20 visits per year	50% co-insurance Limited to 24 visits per calendar year	Spinal manipulation covered at 100%, subject to medical necessity guidelines	Spinal manipulation Covered 80% of allowable benefit (deductible applies) subject to medical necessity guidelines
Massage Therapy	Not Covered	Discount Program Contact UHC for details	Discount Program Contact UHC for details	Discount Program Contact UHC for details

Plan Features	Kaiser Permanente HMO Plan	UnitedHealthcare Select EPO Plan	UnitedHealthcare (UHC) Choice Plus Point-of-Service (POS) Plan	
			UHC Choice Plus POS In-Network Benefits	UHC Choice Plus POS Out-of-Network Benefits
HEARING AND VISION				
Hearing Tests	\$10 co-pay	\$10 co-pay	\$10 co-pay	Covered 80% of allowable benefit, deductible applies
Hearing Aids	1 hearing aid up to \$1,000 per ear every 36 months	80% covered every 36 months, up to \$3,600	80% covered every 36 months, up to \$3,600	80% covered every 36 months, up to \$3,600
Laser Vision Correction	Not Available	Discount Program Contact UHC for details	Discount Program Contact UHC for details	Discount Program Contact UHC for details
Mail Order Contact Lenses	Not Available	Not Available	Not Available	Not Available
Vision Annual Eye Exam Discount Plan (Does not qualify for retirement eligibility)	Eyeglass frames 25% discount Eyeglass lenses 25% discount Contact lenses 15% discount One refractive exam (pay Office Visit Copay) Separate vision benefit plan offered. See Vision Service Plan	Not covered. Separate vision benefit plan offered. See EyeMed Vision Service Plan	Not covered. Separate vision benefit plan offered. See EyeMed Vision Service Plan	Not covered. Separate vision benefit plan offered. See EyeMed Vision Service Plan

Plan Features	Kaiser Permanente HMO Plan	UnitedHealthcare Select EPO Plan	UnitedHealthcare (UHC) Choice Plus Point-of-Service (POS) Plan	
			UHC Choice Plus POS In-Network Benefits	UHC Choice Plus POS Out-of-Network Benefits
MISCELLANEOUS				
Durable Medical Equipment (DME)	Covered 100%	Covered 100%	Covered 100%	Covered 80% of allowed benefit – deductible applies
Prescription Coverage	<i>Included</i> Kaiser Pharmacy or Mail: \$7/15/30 Participating Pharmacy: \$10/20/35	<i>Not covered.</i> Separate prescription benefit plan offered through Caremark	<i>Not covered.</i> Separate prescription benefit plan offered through Caremark	<i>Not covered.</i> Separate prescription benefit plan offered through Caremark
Private Duty Nursing <i>(Subject to pre-authorization and case management)</i>	Covered under Home Health	Excluded	Covered 100% Subject to pre-authorization & case management	Covered 80% of allowed benefit Subject to pre-authorization & case management (deductible applies)
Surgery for Morbid Obesity <i>(Subject to pre-authorization and case management)</i>	Covered with eligibility requirements Pre-authorization required Member cost based on type and place of service.	Covered with eligibility requirements Pre-notification required	Covered with eligibility requirements Pre-notification required	Covered with eligibility requirements Pre-notification required
Virtual Visits (Telemedicine) Including Behavioral	FREE	FREE	FREE	Covered 80% of allowed benefit – deductible applies

MEDICARE COMPLEMENT PLAN COMPARISON CHART for **MEDICARE ELIGIBLE RETIREES/SURVIVORS/LTD**

Plan Features	Kaiser Permanente Medicare Complement Plan	UnitedHealthcare Select EPO Plan > 65	UnitedHealthcare (UHC) Medicare Complement Plan	
			Medicare Pays**	UHC Medicare Complement Plan Pays
Annual Deductible	No Deductible	No Deductible *You remain responsible for the Medicare Part A and Part B Annual Deductible.	Medicare Part A - N/A Medicare Part B – N/A	Deductible: \$1,676 \$257
Annual Out-of-Pocket Limit (The limit on your out-of-pocket expenses, not including deductibles & disallowed charges)	\$3,400 Includes co-pay and coinsurance	\$1,100 Individual \$3,600 Family Includes co-pay and co-insurance.	N/A	N/A
Lifetime Maximum	Unlimited	Unlimited	N/A	N/A
Pre-existing Condition Limitation	No	No	No	No
Referrals Required	Yes, must be referred to specialists by your Kaiser Primary Care Physician.	No, but must use a UHC Select EPO provider.	No, but Specialists must be enrolled in Medicare	No, but Specialists must be enrolled in Medicare

Plan Features	Kaiser Permanente Medicare Complement Plan	UnitedHealthcare Select EPO Plan > 65	UnitedHealthcare (UHC) Medicare Complement Plan	
			Medicare Pays**	UHC Medicare Complement Plan Pays
<p>Pre-Authorization Required</p> <p><i>This list does not include <u>all</u> services requiring pre-certification. These are only examples based on common procedures, treatments, and services. If your physician recommends an unusual procedure or service, you should contact your health plan's customer service for guidance.</i></p>	N/A	<ul style="list-style-type: none"> All inpatient admissions and non-obstetric observation Back surgery Biofeedback Dental services when done on an in-patient basis Durable medical equipment External Prosthetic Appliances Home Health Care/Home Infusion Therapy Injectable Drugs MRIs/MRAs,CT Scans and PET Scans Nonemergency ambulance service Potentially experimental and investigational procedures 	<p>Medicare Part B – 80%</p> <ul style="list-style-type: none"> Repetitive, scheduled non-emergent ambulance transport Hyperbaric oxygen (HBO) therapy demonstrations Custom wheelchairs 	<p>Remaining 20% of approved Medicare Part B amount</p>
PREVENTIVE CARE				
<p>Adult Physical Exams</p> <p><i>*Charges may apply for diagnostic tests.</i></p>	\$0 co-pay	<p>\$0 co-pay</p> <p>1 exam every 12 months</p>	<p>Medicare Part B - 80%</p> <p>*Yearly wellness visit covered every 12 months</p>	<p>Remaining 20% of Medicare approved amount</p>
<p>Annual GYN Exam (including Pap test & related lab fees)</p> <p><i>*Charges may apply for diagnostic tests.</i></p>	\$0 co-pay	\$0 co-pay	<p>Medicare Part B-80%</p>	<p>Remaining 20% of Medicare approved amount</p>
<p>Flu Shots</p>	\$0 co-pay	\$0 co-pay	<p>Medicare Part B- 80%</p> <p>100% if provider accepts Medicare assignment</p>	<p>20% of Medicare approved amount if provider does not accept Medicare assignment</p>

PREVENTIVE CARE (CONTINUED)				
Plan Features	Kaiser Permanente Medicare Complement Plan	UnitedHealthcare Select EPO Plan > 65	UnitedHealthcare (UHC) Medicare Complement Plan	
			Medicare Pays**	UHC Medicare Complement Plan Pays
HPV Vaccine (Human papillomavirus) For recommended age groups.	\$0 co-pay	\$0 co-pay	Medicare Part B- 100% if vaccine received with Pap test, age 30-65 and provider accepts Medicare assignment	20% of Medicare approved amount if provider does not accept Medicare assignment
Immunizations	\$0 co-pay	Covered if recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control. \$0 co-pay	Medicare Part B- 80% 100% for pneumonia and Hepatitis B vaccine if provider accepts Medicare assignment	20% of Medicare approved amount if provider does not accept Medicare assignment
Mammography (Over Age 40)	\$0 co-pay	Covered at 100%	Medicare Part B- 80% 100% if provider accepts Medicare assignment	20% of Medicare approved amount if provider does not accept Medicare assignment
Preventive Care Infants to age 1 Toddlers Ages 1-2 Children Ages 3-18	\$0 co-pay	\$0 co-pay	N/A	N/A
PSA Blood Serum Digital	\$0 co-pay	Member cost is based on the type of service performed and place where rendered	Medicare Part B One PSA free every 12 months for men over age	N/A
Zoster (a shingles vaccine) For age 60 and older only	\$0 co-pay	\$0 co-pay	Not Covered	Not Covered

Plan Features	Kaiser Permanente Medicare Complement Plan	UnitedHealthcare Select EPO Plan > 65	UnitedHealthcare (UHC) Medicare Complement Plan	
			Medicare Pays**	UHC Medicare Complement Plan Pays
OFFICE VISITS, TESTING & THERAPY				
Allergy Injection Visits	\$0 co-pay	\$10 co-pay	Medicare Part B if shot administered in doctor's office – 80% If not covered, Medicare Part D (SilverScript may cover)	Remaining 20% of Medicare approved amount
Allergy Tests	\$10 co-pay	\$10 co-pay	Medicare Part B-80% Only allergy skin tests are covered when you have an allergic history and show clinically significant allergic symptoms that can't be controlled by other means	Remaining 20% of Medicare approved amount
Diagnostic Lab & X-ray Services (MRI, CAT Scan and Pet Scan require prior authorization)	\$0 co-pay	100%	Medicare Part B-80%	Remaining 20% of Medicare approved amount
Habilitation Services (Benefits are limited to children under age 19. Require prior authorization and subject to case)	\$10 co-pay	\$10 co-pay	N/A	N/A
Office Based Surgery	\$10 co-pay	\$10 co-pay	Medicare Part B – 80%	Remaining 20% of Medicare approved amount
Office Visits	\$10 co-pay PCP \$10 co-pay Specialist	\$10 co-pay	Medicare Part B – 80%	Remaining 20% of Medicare approved amount

Plan Features	Kaiser Permanente Medicare Complement Plan	UnitedHealthcare Select EPO Plan > 65	UnitedHealthcare (UHC) Medicare Complement Plan	
			Medicare Pays**	UHC Medicare Complement Plan Pays
OFFICE VISITS, TESTING & THERAPY (CONTINUED)				

Plan Features	Kaiser Permanente Medicare Complement Plan	UnitedHealthcare Select EPO Plan > 65	UnitedHealthcare (UHC) Medicare Complement Plan	
			Medicare Pays**	UHC Medicare Complement Plan Pays
Rehabilitation: Physical, Occupational, Speech Therapy	\$10 co-pay no specific limit/Medicare guidelines	\$10 co-pay (Limited to 60 combined visits per year)	Medicare Part B – 80%	Remaining 20% of Medicare approved amount
EMERGENCY AND URGENT CARE				
Ambulance Services (Non-emergency use requires prior authorization)	\$0 co-pay for true emergency use only. This is for emergency services required to stabilize or initiate treatment in an emergency, not to transfer from one facility to another	Covered 100% For true emergency use only. This is for emergency services required to stabilize or initiate treatment in an emergency, not to transfer from one facility to another	Medicare Part B if medically necessary – 80%	Remaining 20% of Medicare approved amount
Emergency Room use for a medical emergency (Facility & Physician Charges)	\$50 per visit, anywhere in the world (waived if admitted) Contact PCP before receiving care whenever possible	\$25 co-pay for emergency room. If admitted to the hospital from the emergency room, then the co-pay is waived Contact PCP before receiving care whenever possible	Medicare Part B – 80%	Remaining 20% of Medicare approved amount
Emergency Room use for a Non-Medical Emergency	Not Covered	Not Covered	N/A	N/A
Urgent Care Centers	\$10 co-pay, anywhere in the world	\$15 co-pay	Medicare Part B – 80%	Remaining 20% of Medicare approved amount

IN-PATIENT & OUT-PATIENT HOSPITAL

Plan Features	Kaiser Permanente Medicare Complement Plan	UnitedHealthcare Select EPO Plan > 65	UnitedHealthcare (UHC) Medicare Complement Plan	
			Medicare Pays**	UHC Medicare Complement Plan Pays
In-patient Diagnostic Tests (Prior Authorization Required)	Covered 100%	Covered 100%	Medicare Part B – 80%	Remaining 20% of Medicare approved amount
In-Patient Hospital Facility Charges (Overnight Stay) (Prior Authorization Required)	Covered 100%	Covered 100%	Medicare Part A pays 100% of Days 1-60, All above specified copayment for Days 61+ \$0 of lifetime reserve days after exhaustion	Days 61-90 -\$419/day Days 91-150 - \$838/day for lifetime reserve days *Once lifetime reserve days are exhausted, you pay 100%
In-Patient Physician Visits	Covered 100%	Covered 100%	Medicare Part B – 80%	Remaining 20% of Medicare approved amount
In-Patient Surgery (Prior Authorization Required)	Covered 100%	Covered 100%	Medicare Part B – 100%	N/A
Organ Transplant (Prior Authorization Required)	Covered 100% at a designated facility	Covered 100% at a designated facility	Medicare Part A covers 100% of hospital costs Covers specific transplants: Heart, lung, kidney, pancreas, intestine, liver, Medicare Part B – 80% of doctor's services	Remaining 20% of Medicare Part B approved amount
Out-Patient Surgery (Prior Authorization Required)	\$25 co-pay	\$25 co-pay (Facility) Covered 100% (Physician)	Medicare Part B – 80%	Remaining 20% of Medicare approved amount
In-Patient Professional Services (Such as anesthesiologists, radiologists and pathologists) when rendered in an in-network hospital	Covered 100%	Covered 100%	Medicare Part A – 100%	N/A

IN-PATIENT HOSPITAL ALTERNATIVES

Plan Features	Kaiser Permanente Medicare Complement Plan	UnitedHealthcare Select EPO Plan > 65	UnitedHealthcare (UHC) Medicare Complement Plan	
			Medicare Pays**	UHC Medicare Complement Plan Pays
Home Health Care	\$0 co-pay limited to two (2) hours per visit Intermittent care not to exceed three (3) visits per day	Covered 100% 60 visits per calendar year Limitations apply	Medicare Part A – 100% Medicare Part B – 80% for durable medical equipment	Remaining 20% of Medicare Part B approved amount for durable medical equipment
Hospice Care	\$0 copay	Covered 100% Limited to 360 days during the time covered under the plan	Medicare Part A – 100%	5% of Medicare approved amount for inpatient respite care Up to \$5 copayment for each prescription for pain and
Skilled Nursing Facility <i>(Prior Authorization may be Required and Subject to case management)</i>	Covered 100% if Medicare would cover the stay or if medically necessary and Medicare would not cover the stay. Up to 100 days per calendar year	Covered 100% 60 days per calendar year	Medicare Part A pays 100% of Days 1-20, All above specified copayment for Days 21-99 \$0 after 99 days	Days 21-100 -\$209.50/day Days 101+ - you pay 100%
MATERNITY & INFERTILITY				
Artificial Insemination <i>(Prior Authorization Required and Subject to case management)</i>	50% co-insurance \$100,000 per lifetime	50% co-insurance \$3,000 per lifetime	Not covered	N/A
Infertility Treatment and Testing	Medically necessary services only Related prescription drugs: 50% co-insurance	Member cost is based on the type and place of service	Medicare Part B for reasonable and necessary services associated with treatment for infertility – 80%	Remaining 20% of Medicare approved amount

**MATERNITY & INFERTILITY
(CONTINUED)**

Plan Features	Kaiser Permanente Medicare Complement Plan	UnitedHealthcare Select EPO Plan > 65	UnitedHealthcare (UHC) Medicare Complement Plan	
			Medicare Pays**	UHC Medicare Complement Plan Pays
In Vitro Fertilization <i>(Prior Authorization Required and Subject to case management)</i>	Limited to 3 attempts and a lifetime max of \$100,000. Limitations apply	Covered 50% of allowed benefit. Limited to 3 attempts and a lifetime max of \$100,000. Limitations apply	Not covered	N/A
Labor & Delivery	In-patient co-pay if applicable	Covered 100%	Medicare Part A – 100% Hospitalization Medicare Part B- 80% Outpatient and Doctor's	Remaining 20% of Medicare approved amount
Prenatal and Postnatal Office Visits	No charge for routine prenatal care. Postnatal care subject to regular office co-payment	\$10 co-pay initial visit, then 100%	Medicare Part B – 80%	Remaining 20% of Medicare approved amount
Voluntary Sterilization <i>(Reversal not covered)</i>	Member cost is based on the type of service performed and place where rendered	Member cost is based on the type of service performed and place where rendered	Not Covered	N/A
MENTAL HEALTH & SUBSTANCE ABUSE				
Bereavement Counseling	\$10 copay	Covered at 100% for short-term grief counseling as part of hospice care	Medicare Part B -80% for grief counseling	Remaining 20% of Medicare approved amount
In-Patient Hospital <i>(Prior Authorization may be Required and Subject to case management)</i>	Covered 100%	Covered 100%	Medicare Part A pays 100% of Days 1-60, All above specified copayment for Days 61+ \$0 of lifetime reserve days after exhaustion	Days 61-90 - \$419/day Days 91-150 - \$838/day for lifetime reserve days *Once lifetime reserve days are exhausted, you pay 100%

MENTAL & SUBSTANCE ABUSE (Continued)				
Plan Features	Kaiser Permanente Medicare Complement Plan	UnitedHealthcare Select EPO Plan > 65	UnitedHealthcare (UHC) Medicare Complement Plan	
			Medicare Pays**	UHC Medicare Complement Plan Pays
Partial Hospitalization <i>(Prior Authorization may be Required and Subject to case management)</i>	Covered 100%	Covered 100%	Medicare Part B – 80%	Remaining 20% of Medicare approved amount
Out-Patient Treatment <i>(Prior Authorization may be Required and Subject to case management)</i>	\$10 co-pay individual therapy	\$10 co-pay per visit	Medicare Part B – 80%	Remaining 20% of Medicare approved amount
ALTERNATIVE MEDICINE SERVICES				
Acupuncture	\$15 co-pay Limited to 20 treatments per year	\$10 co-pay Limited to 24 treatments per year	Not covered	N/A
Chiropractic	\$15 co-pay 20 visits per year	50% co-insurance Limited to 24 visits per calendar year	Medicare Part B, if medically necessary for manipulation of the spine- 80%	Remaining 20% of Medicare approved amount
Massage Therapy	Not Covered	Discount Program Contact UHC for details	Not covered	N/A
HEARING AND VISION				
Hearing Tests	\$10 co-pay, routine and to diagnose hearing and balance issues	\$10 co-pay	Medicare Part B only for determination of need for medical treatment or for balance issues (If in hospital treatment, copayment applies.)	Remaining 20% of Medicare approved amount
Hearing Aids	1 hearing aid up to \$1,000 per ear every 36 months	80% covered every 36 months, up to \$3,600	Not covered	N/A

Plan Features	Kaiser Permanente Medicare Complement Plan	UnitedHealthcare Select EPO Plan > 65	UnitedHealthcare (UHC) Medicare Complement Plan	
			Medicare Pays**	UHC Medicare Complement Plan Pays
Laser Vision Correction	Not Available	Discount Program Contact UHC for details	Not covered	N/A
Mail Order Contact Lenses	Not Available	Not Available	Not covered	N/A
Vision Annual Eye Exam Discount Plan (Does not qualify for retirement eligibility)	\$10 per visit with an optometrist of ophthalmologist to diagnose and treat eye diseases. Eyeglasses or contact lenses after cataract surgery -You pay 20% coinsurance up to Medicare's limit and any amounts that exceed Medicare limit. Other eyeglasses or contact lenses – You pay 75% coinsurance for eyeglasses and 85% coinsurance for contacts. **You may also enroll in separate standalone Vision Service Plan (VSP).	Not covered. Separate vision benefit plan offered. See EyeMed Vision Service Plan	Medicare part B only for: <ul style="list-style-type: none"> • Glaucoma test every 12 months or more frequent if high risk – 80% • Annual test for diabetic retinopathy • Cataract surgery and cost of artificial lens and eyeglasses with standard frame Macular degeneration treatment	Remaining 20% of Medicare approved amount

MISCELLANEOUS

Plan Features	Kaiser Permanente Medicare Complement Plan	UnitedHealthcare Select EPO Plan > 65	UnitedHealthcare (UHC) Medicare Complement Plan	
			Medicare Pays**	UHC Medicare Complement Plan Pays
Durable Medical Equipment (DME)	Covered 100%, requires prior authorization	Covered 100%	Medicare Part B – 80%	Remaining 20% of Medicare approved amount
Prescription Coverage	<p><i>Included</i></p> <p><i>Preferred Pharmacy up to 60-day supply: \$10-preferred generic/generic or preferred/non-preferred brand and specialty tier and \$0 for vaccines</i></p> <p><i>Out-of-Network Pharmacy up to 30-day supply: \$7.50-preferred generic/generic or preferred/non-preferred brand and specialty tier and \$0 for vaccines</i></p> <p><i>Kaiser Mail Order up to 90-day supply: \$5.00-preferred generic/generic or preferred/non-preferred brand and specialty tier and vaccines not available.</i></p> <p><i>Participating Pharmacy: \$10/20/35</i></p> <p><i>If your copays reach \$5,000 in a year, you move to catastrophic coverage and pay \$2-generic/\$5-brand-name and \$0 for vaccines.</i></p>	<p><i>Not covered.</i></p> <p><i>Separate prescription benefit plan offered through Caremark</i></p>	<p><i>Medicare Part B – 80%, only for drugs you would not administered to yourself such as:</i></p> <ul style="list-style-type: none"> • <i>drugs administered in the doctor's office or hospital</i> • <i>Drugs used with an item of durable medical equipment such as a nebulizer or infusion pump</i> • <i>Some antigens</i> • <i>Injectable osteoporosis drugs</i> • <i>Erythropoiesis stimulation drugs for end-stage renal disease or anemia</i> 	<p>Remaining 20% of Medicare approved amount</p>

Private Duty Nursing <i>(Subject to pre-authorization and case management)</i>	Covered under Home Health	Excluded	Not covered	N/A
		MISCELLANEOUS (Continued)		

Plan Features	Kaiser Permanente Medicare Complement Plan	UnitedHealthcare Select EPO Plan > 65	UnitedHealthcare (UHC) Medicare Complement Plan	
			Medicare Pays**	UHC Medicare Complement Plan Pays
Surgery for Morbid Obesity <i>(May be Subject to pre-authorization and case management)</i>	Covered with eligibility requirements Pre-authorization required Member cost based on type and place of service.	Covered with eligibility requirements Pre-notification required	Medicare Part A for hospitalization for some procedures like gastric bypass, laparoscopic banding Medicare Part B – 80%Associated doctor's visits and outpatient care	Remaining 20% of Medicare approved amount
Dental Services	Comprehensive dental services through participating providers. Charges vary based on service.	Not covered.	Medicare Part A 100% - only for certain dental services when hospitalization is needed in an emergency or complicated procedure	N/A
Care outside of the United States	Bona fide emergencies covered worldwide	Bona fide emergencies covered worldwide	In most cases not covered.	N/A
Virtual Visits (Telemedicine) Including Behavioral	FREE	FREE	FREE	

**For more details on services covered under Medicare go to <https://www.medicare.gov/pubs/pdf/10050-Medicare-and-You.pdf>

PRESCRIPTION DRUG PLANS

There are two prescription drug plans offered to M-NCPPC employees. One is a standalone plan, CVS/Caremark with its Medicare Part D component through /SilverScript. The second is bundled with Kaiser Permanente HMO and the Kaiser Permanente Medicare Complement Plan. Your prescription plan options will be based on which medical plan you elect.

- If you elect the UnitedHealthcare EPO, UnitedHealthcare POS plan, or waive enrollment in a medical plan, you are eligible to enroll in the CVS/Caremark prescription drug plan.
- If you enroll in the Kaiser Permanente HMO, you will simultaneously be enrolled in the Kaiser Permanente prescription drug plan; it is a bundled plan.
- Since the Kaiser Permanente HMO and the Kaiser Permanente Medicare Complement Plans include prescription drug coverage, you cannot enroll in the Caremark/SilverScript Prescription Drug Plan.
- All prescription drug plans cover short-term drugs and long-term maintenance drugs. Short-term drugs include drugs that may be prescribed for a short period such as antibiotics, ear drops, antihistamines, anti-diarrheal, or acne medication. Long-term maintenance drugs are those that are taken for chronic conditions or long-term therapy such as for lowering cholesterol, high blood pressure, diabetes, diuretics and heart medication.

CVS/Caremark

Several programs under CVS/Caremark are designed to ensure that your medications are cost-effective and may include out-of-pocket savings as well. These programs are:

- **Maintenance Choice**

If you are taking a maintenance medication, you are allowed an initial fill and one refill up to a 34-day supply at the retail pharmacy. Thereafter, you should use the Maintenance Choice Program for any additional quantities of the same maintenance medication. *If you choose to obtain maintenance medication at a retail pharmacy other than CVS after the second fill, your copayment will double for additional refills or written prescriptions for the same drug.*

Under the Maintenance Choice Program, you have two options to fill maintenance medication up to a 90-day supply. The first option is at any CVS pharmacy. The second option is the CVS/Caremark Mail Service Pharmacy. No matter which option you choose, your copay will be no more than double the retail copay. If you receive a 90-day supply this will save you money since your copay at the most will be equal to two times the retail copay for a three-month supply versus three times the retail copay. Your physician must indicate 90 days on the prescription and can note up to three (3) refills, as appropriate.

You may refill a mail order prescription by calling the toll-free number on the back of your Caremark identification card or through the internet at www.caremark.com. You will need to set up a user ID and password prior to ordering by internet.

HEALTHCARE BENEFITS

- **Waiver of Copay for Diabetic Supplies**

In an effort to reduce the medical costs associated with the treatment of diabetes and improve patient medication adherence, the copay for test strips and lancets obtained through CVS Caremark's Mail Order service or Maintenance Choice programs will be waived.

- **Waiver of Copay for Certain Generic Medications**

In an effort to reduce the medical costs associated with the top three medical conditions affecting Commission employees and dependents, copays for generic anti-diabetic, anti-hyperlipidemic, and anti-hypertensive medications obtained through CVS Caremark's Mail Order service or Maintenance Choice programs will be waived.

- **Generic Step Therapy**

The Generic Step Therapy program is designed for people taking prescription drugs regularly for an ongoing condition like asthma, diabetes or high blood pressure. This program encourages the use of generic drugs or preferred brand drugs instead of non-preferred drugs that have a higher cost. It allows you and your family to receive the treatment you need while making prescription drugs more affordable for you. You can save money by using safe, effective generic medications when possible. Step Therapy targets single-source brand drugs (drugs that do not have a generic equivalent or generic alternative). You will be steered to use a generic or preferred brand drug before using a non-preferred drug. If you do not wish a generic or preferred brand drug you can pay out-of-pocket for the higher priced drug. If a lower-cost alternative is not clinically appropriate, your physician can contact CVS/Caremark to request a Prior Authorization.

When a prescription for a targeted single-source brand is presented to the pharmacy, the pharmacy will check for previous use of an appropriate generic or preferred select brand drug. If the member's claim history shows that a 30-day supply of an appropriate generic or preferred select brand has been tried within the last 180-185 days, depending on drug class, the plan will cover the targeted single-source brand and the claim will be paid.

However, if there is no evidence of prior use of an appropriate generic or preferred select brand as identified by the member's claim history, the claim will reject and a new prescription or an appropriate generic or select preferred brand must be obtained, or the member may pay out-of-pocket for the non-covered brand. The member may request that the physician call the Prior Authorization telephone number if a lower-cost alternative is not clinically appropriate.

- **PrudentRx**

You will be enrolled in the PrudentRx Copay Program if you use a specialty drug. When you fill at a CVS Specialty Pharmacy and are enrolled in the PrudentRx Copay Program, your copayment will be \$0 for specialty medications such as those for Hepatitis C, Autoimmune Conditions, Oncology and Multiple Sclerosis.

If you opt out or do not complete additional steps to enroll you will pay 30% of the drug cost. **DO NOT OPT OUT!**

- Enrollment in PrudentRx is FREE

- Call PrudentRx X today at 1-800-578-4403 to make sure they have your member information on file and register for any copay assistance available from drug manufacturers.
- Call CVS Specialty Pharmacy at 1-866-387-2573 if you have any questions about your specialty drugs.

The chart that follows will provide you with the copay structure under the CVS/Caremark prescription drug plan.

HEALTHCARE BENEFITS

	CVS/Caremark Pharmacy Participating Retail Pharmacy (Short-term medications up to 34-day Supply)*	CVS/Caremark Maintenance Choice: CVS Mail Order or CVS Pharmacy ONLY (Long-term maintenance medications up to a 90-day supply)
Tier 1- Generic Drugs Ask your doctor if a generic drug is available since these drugs cost less.	\$8.00 copay	\$16 copay
Tier 2 – Preferred Brand Name Drugs If a generic is not available ask your doctor to give you a prescription on the preferred drug list	\$16 copay	\$32 copay
Tier 3- Non-Preferred Brand Name Drugs These preferred drugs cost more than other preferred name-brand drugs that are therapeutically equivalent. You will pay the most for these drugs.	\$25 copay	\$40 copay
Tier 4- Lifestyle Drugs: cosmetic (anti-wrinkle or hair loss), erectile dysfunction, memory loss, weight loss and smoking cessation.	50% copay	50% copay
Fill limit for long-term maintenance medications	2 fills only. You will pay 100% of the cost for additional fills at a retail pharmacy.	No limit -Fill must be for 90-days at CVS Pharmacy or CVS Mail Order.
* You may only obtain up to a 34-day supply of any drug at a Retail Participating Pharmacy.		

It is important to note:

- There is a penalty if a generic is available and you request a name-brand drug (even if your doctor notes “Dispense as Written” (DAW) on the prescription). You will pay the normal generic drug copay in addition to the difference between the generic and the name brand drug. For example, if the name-brand drug costs \$100, the generic drug costs \$10, and the generic copay was \$8, you will pay \$98.

An exception will be made if your doctor contacts CVS/Caremark and certifies in writing, on letterhead, that a non-preferred brand name drug is medically necessary and not its generic equivalent. You will then be charged the brand name copay, without penalty.

- If you get a prescription filled at a non-participating pharmacy, you must pay the full cost and file for partial reimbursement. You will be reimbursed what would have been paid for the drug under your plan minus your copayment.
- **Diabetic medications and supplies must be filled through CVS Retail or CVS Mail Order.**

HEALTHCARE BENEFITS

To determine if your prescription is classified as a generic, preferred brand or non-preferred brand, view the CVS/Caremark Drug Formulary at www.caremark.com or you may call CVS/Caremark Prescription Services at 1-800-421-5501.

When You Become Medicare Eligible – Reach Age 65 or Are Approved for Long-Term Disability

When you become Medicare eligible either by reaching age 65 or meeting the criteria after approval for long-term disability, you will be transitioned from CVS/Caremark to the SilverScript prescription drug plan. SilverScript is a Medicare Part D plan marketed by CVS/Caremark. SilverScript will become your primary prescription drug plan and you will have additional coverage under Caremark for drugs that are not covered under Medicare Part D. ***You must submit a copy of your Medicare card confirming your enrollment in Medicare Part A and Medicare Part B to Health & Benefits in order to complete your enrollment in SilverScript.*** For more information, refer to the Retiree Enrollment Guide at www.mncppc.org.

You remain eligible for the benefits of the Caremark Extra Card when you become a member of SilverScript.

Kaiser Permanente Prescription Drug Plan

The Kaiser Permanente Drug Plan is included with your Kaiser Permanente medical plan and pays for prescriptions filled at either Kaiser Medical Center pharmacies, Kaiser Network Participating pharmacies or through Kaiser mail order pharmacy. Your copay will be more at a Kaiser Network Participating Pharmacy because Kaiser must pay an additional dispensing fee. The copayment for maintenance drugs through the Kaiser Mail Order pharmacy will be two times the retail copay for a 30-day supply and you get up to a 90-day supply.

The following chart summarizes the prescription drug copayment structure.

	Kaiser Permanente Pharmacy/ Kaiser Network Participating Pharmacy (Short-term medications up to 30-day Supply)*	Kaiser Permanente Mail Order Pharmacy/ Kaiser Network Participating Pharmacy (Long-term maintenance medications up to a 90-day supply)**
Tier 1- Generic Drugs Ask your doctor if a generic drug is available since these drugs cost less.	\$7/\$10 copay	\$14/\$20 copay
Tier 2 – Preferred Brand Name Drugs If a generic is not available ask your doctor to give you a prescription on the preferred drug list	\$15/\$20 copay	\$30/\$40 copay
Tier 3- Non-Preferred Brand Name Drugs These preferred drugs cost more than other preferred drugs that are therapeutically equivalent. You will pay the most for these drugs.	\$30/\$35 copay	\$60/\$70 copay
<p>* You may only obtain up to a 30-day supply of any drug at a Retail Participating Pharmacy. **Long-term maintenance medications up to a 90-day supply are only available through Kaiser Permanente Mail Order.</p>		

When You Become Medicare Eligible – Retired and Reach Age 65 or Due to Approval for Long-Term Disability

When you become Medicare eligible either by reaching age 65 or meeting the criteria after approval for long-term disability, you will be transitioned to the Kaiser Medicare Complement Plan which includes a Medicare Part D Prescription Drug Plan. You must be enrolled in Medicare Part A and Medicare Part B. For more information, including the formulary of drugs covered and excluded, log on to www.kp.org or call the Kaiser Customer Care line on 1-800-777-7902.

DENTAL PLAN - TWO PLANS TO CHOOSE FROM

Delta Dental PPO or DeltaCare USA

The Delta Dental PPO plan allows you to visit any licensed dentist or specialist nationwide. With the PPO plan you have access two dentist networks at once, the Delta Dental PPO network and the Delta Dental Premium network. Out-of-pocket expenses are lowest when you visit a dentist in the Delta Dental PPO network; deeper contract discounts apply. If you use a non-participating dentist, you can be balance billed, since Delta Dental has no contract with these dentists for discounts or fee limitations. Each year you must meet an annual deductible and there is a maximum annual benefit. Dentists in the Delta Dental PPO and Dental Premium networks will file your claim for you. Non-participating dentists may not file your claim.

DELTA DENTAL PPO PLAN		
Benefits and Covered Services* (Partial List)	In-Network**	Out-of-Network**
Annual Deductible	\$50 Person/\$150 Family	\$50 Person/\$150 Family
Maximum Annual Benefit	\$2,000	\$2,000
Diagnostic & Preventive Services		
Prophylaxis (Cleanings)	100%	100%
Oral Examinations	100%	100%
X-Rays	100%	100%
Basic Services		
Fillings	80%	80%
Endodontics (Root Canals)	80%	80%
Periodontics (Gum Treatment)	80%	80%
Oral Surgery	80%	80%
Major Services		
Crowns/Inlays/Onlays	60%	60%
Cast Restorations	60%	60%
Prosthodontics		
Bridges	60%	60%
Dentures	60%	60%
Implants	60%	60%
Orthodontics – Adults and Dependent Children		
Orthodontic Appliances, braces and treatment	60%	60%
Lifetime \$ Maximum	\$2,000	\$2,000

*Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

HEALTHCARE BENEFITS

DeltaCare USA Plan

If you choose the DeltaCare USA plan, you must select a Primary Care Dentist (PCD) in the DeltaCare USA network. The Primary Care Dentist will be responsible for coordinating your care and referring you to any specialists. You will be assigned a PCD if you do not select one. All services must be obtained from your designated network dentist except in an emergency or if services have been preauthorized in writing by Delta Dental. You can change your DeltaCare USA dentist at any time by calling DeltaCare Customer Service. You pay a set co-payment for each service. co-payment. There is no annual deductible or annual maximum amount of coverage. There are no claim forms that you have to deal with.

Please review the following comparative summary of the two plans before deciding which plan best fits the needs of you and your family.

	Delta Dental PPO	DeltaCare USA (Delta Dental HMO)
Annual Deductible	\$50 Per Enrollee/\$150 Per Family	No Deductible
Coinsurance/CoPayments	Covered services are paid based on a percentage. For example, preventive care is paid 100%, fillings are covered at 80% and you pay the remaining 20%.	While most diagnostic and preventive services are covered as 100%; if there is a copayment, you pay a fixed amount for each procedure. Your cost is always predictable.
Annual Maximum	\$2,000	No maximum
Dentist Network <ul style="list-style-type: none"> • Delta Dental PPO • Delta Dental Premier 	You can choose any licensed dentist. No referral necessary for a specialist.	If you do not select a primary care dentist, you will be assigned one. Primary care dentists will refer you to a specialist when necessary.
Out-of-Area Coverage	You can visit any licensed dentist.	If you have an emergency and are more than 35 miles from your primary care dentist, the plan pays up to \$100 per incident to relieve the pain until you can see your primary care dentist.
Transition of care from previous plan	Coverage is provided only for treatment started and completed after your effective date.	Coverage is provided only for treatment started and completed after your effective date.
Orthodontic Treatment-in-Progress	Delta Dental usually pays the remaining amount of the total case fee not paid by your prior dental plan. (Orthodontia has a \$2,000 lifetime limit per enrollee.)	If banding has taken place, you are eligible for continuous coverage and may continue to visit the same orthodontist. If banding has not occurred, you must obtain treatment from a DeltaCare USA network orthodontist. (Member responsible for \$1,000 copayment.)

+ If you obtain services under the Delta Dental PPO plan from Non-Delta Dental Provider, you will be balance billed You pay the difference between the Delta Dental allowance and the provider's billed charge.

HEALTHCARE BENEFITS

Other Important Information About Your Dental Plan

Provider Network

To find a participating provider visit Delta Dental's website at www.deltadentalins.com to access the Delta Dental PPO and DeltaCare USA provider directories or call customer service to obtain a personalized provider directory.

- Delta Dental PPO Customer Service - 800-932-0783
- DeltaCare USA Customer Service – 800-422-4234

Cards for the Dental Plan

You will receive a dental identification card in the mail at home for this plan only if you are a new enrollee or you are changing from single enrollment and adding dependents. All cards received will be in your name.

If you lose your identification card or need additional cards for family members, you can:

- Call Delta Dental Customer Service
- Visit deltadentalins.com
- Download the Delta Dental **App** (by the Delta Dental Plans Association) from **AppStore** or **Google Play**. Log in and select **My ID Card**.

Coordination of Benefits

Benefits are coordinated using the standard non-duplication of benefits calculation. When Delta Dental is the secondary carrier, they will pay only the **difference** between the amount paid by the primary carrier and Delta Dental's normal liability.

Non-Covered Services

It is important that you ask your dentist if a service is covered under the plan. If it is not and you choose to have the service performed, you will be responsible for all charges.

Predetermination of Benefits for Services Under the Delta Dental PPO Plan

If your dental services under the Delta Dental PPO Plan are expected to cost \$250 or more, ask your dentist to submit a predetermination of benefits. Delta Dental PPO will calculate how much of your dental services will be covered by the plan and what your will pay in out-of-pocket expenses.

Where Out-of-Network Claims Should Be Sent

The mailing address for Delta Dental PPO Out-of-Network claims:

Delta Dental
P.O. Box 2105
Mechanicsburg, PA 17055
717-766-8500 800-932-0783
TTY/TDD 888-373-3582

The mailing address for DeltaCare USA Out-of-Network claims:

DeltaCare USA
P.O. Box 1810
Alpharetta, GA 30023
800-422-4234

VISION PLANS

The Commission offers a comprehensive standalone vision plan through EyeMed. (Limited discounted vision benefits are bundled with the Kaiser Permanente plans.)

Those enrolled in a Kaiser Permanente Plan have the option to also enroll in EyeMed since the Kaiser Permanente Plans is not a comprehensive vision plan; only certain services are discounted.

EyeMed

EyeMed has an extensive nationwide network of doctors. The plan is designed to encourage members to maintain their vision through regular eye examinations and to help with vision care expenses for required glasses or contact lenses.

EyeMed covers routine eye exams, frames, and lenses or contact lenses in lieu of glasses. Members may use network or non-network opticians, optometrists and ophthalmologists.

You may choose from following three (3) options:

1. **Low Option** - an eye exam every plan year and frames, lenses or contact lenses every two plan years.
2. **Moderate Option** - an eye exam and lenses or contact lenses every plan year and frames every two plan years.
3. **High Option** – an eye exam, frames and lenses or contact lenses every plan year. In addition, the following enhancements are covered at 100%-you pay nothing:
 - Standard Anti-reflective coating,
 - Photochromic-adaptive lenses
 - Standard Progressive lenses
 - Tint (Solid/Gradient)

How Does the Plan Work When Using Participating Providers?

1. Locate a participating provider by contacting EyeMed or use the internet at www.eyemed.com,
2. Make sure you identify yourself as an EyeMed member when you call a participating provider to make an appointment,
3. The participating provider will contact EyeMed for eligibility and plan coverage information
4. Go to your appointment for your exam or for your eye evaluation,
5. The provider's staff will take care of everything from here. You pay for any copays and any amount over the allowance, if applicable.

If My Doctor Is Not In the EyeMed Network, How Do I Get Reimbursed?

Complete an Out-of-Network (OON) claim form and send it to EyeMed and they will reimburse you for the allowed benefit. Contact EyeMed Customer Service or go to www.eyemed.com to obtain the OON claim form.

Mail the completed OON claim form to:

**First American Administrators, Inc.
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111**

Laser Surgery Discounts

- You'll save 15% off the regular price at contracted laser centers, or 5% off the center's promotional price – which could add up to hundreds of dollars in savings.
- EyeMed discounts may not apply to some laser center promotional programs.
- To learn more about laser vision correction, how to find a participating surgeon or how to access the procedures, visit the website or call EyeMed's customer service department.

Identification Cards for the Vision Plan

You do not need any card for this plan. When you go to a network provider, you should give the following information:

- Your name and date of birth
- The name of the Commission (M-NCPPC)
- The employee's Social Security number

The provider will call EyeMed to verify your benefit eligibility.

Even though you do not need an identification card, you can go online at www.eyemed.com and access a print-on demand card.

Retail Chain Affiliate Providers

- Retail chain affiliate providers give added convenience and additional retail locations.
- EyeMed has an arrangement with LensCrafters®, Target Optical®, Sears Optical®, JCPenney Optical®, Pearle Visio®, America's Best and MyEyeDr.

EyeMed Providers In or Outside of Network

Members have the freedom to choose a provider in or outside of the EyeMed network. Providers can contact EyeMed directly to check eligibility and submit claims on an employee's or dependent's behalf.

If you select an out-of-network provider, your benefit may differ from the coverage you would receive with an EyeMed network doctor.

Additional Benefits

- **Discounts through an EyeMed Access Network provider:**
 - 40% off unlimited additional eyeglasses after initial benefit is exhausted
 - 20% discount on remaining frame balance (once allowance has been applied) and 15% discount on any balance over the conventional contact lens allowance
 - 15% savings off retail price of LASIK – or 5% off promotional pricing
 - 15% off any balance over the conventional contact lens allowance
 - 40% off hearing exams and discounted, set pricing on hearing aids
 - 20% off any non-covered item
- **International Travel Solution** provides 24/7 international support if you have a vision emergency while traveling abroad. Temporary, adjustable eyewear delivered next day.
- **Order frames and lenses on-line from in-network providers**

Kaiser Permanente Discount Vision Plan

Kaiser Permanente medical plans include discount vision plans. This plan provides a discount on eyeglass frames, contact lenses and an annual eye exam.

Retirees should note that discount vision plans that are offered bundled with a medical plan, such as Kaiser Permanente will not be considered for retiree vision benefit eligibility in meeting the 36-month rule.

Since this plan is only a discount vision plan, you may enroll in the EyeMed vision plan for more comprehensive coverage.

HEALTHCARE PLAN IDENTIFICATION CARDS

When You Enroll

If you enroll in a new medical plan, the dental plan, the vision plan or the prescription plan during open enrollment, you should receive your cards by the end of the second week in January. New hires should receive cards for the medical, prescription and dental plans no later than 10 business days after the effective date of your coverage.

If you misplace your medical, prescription, or dental cards you may contact the plan's customer service to request new cards. If you misplace your EyeMed vision plan, DeltaDental or UnitedHealthcare identification card, you may go to the applicable website (after member log in) to print an electronic version:

- www.eyemed.com
- www.deltadentalins.org
- www.myuhc.com

If You Change Plans

When you enroll in a new plan, to be safe, do not schedule any routine doctor visits or routine lab work during the first two weeks of the new plan year. Since you may not have your cards, you eliminate the stress of trying to ensure that your new doctor will treat you.

If You Need Your Benefits Before Your Cards Arrive

You may need to use your benefits before you receive your cards. Please call the plan to make sure that you and your dependents are enrolled. If you are enrolled, you can have the provider call the plan to confirm your eligibility, and you should be able to receive services without your card.

Check with the plan to see if you can print out temporary identification cards at their website or access your identification card via a mobile app. If you call the plan to verify that you and your dependents are enrolled and the plan cannot confirm your enrollment, call the Health & Benefits Office immediately so your enrollment can be expedited.

LIFE INSURANCE PLANS



LIFE INSURANCE PLANS

Many people do not think about the financial consequences their families would face in the event of their death. For most people, savings alone would not be enough to pay the bills if an income was suddenly lost. The Commission’s life insurance programs can help.

- All group life insurance plans are voluntary (except the Basic and AD&D which are automatic with an opt-out provision).
- You must complete an application form for the Spouse/Dependent and Supplement Life Plans.
- You must enroll in the Basic Life Insurance Plan in order to select either the Spouse/Dependent Plan or the Supplement Life Insurance Plan.
- Each plan provides death benefit coverage during a fixed period or “term”, which is the length of your employment at the Commission. Term life insurance has no cash or surrender value.
- If you are approved for Long Term Disability, you can continue your coverage as long as premiums are covered either through a waiver of premium or direct payments.

If you leave the Commission, your basic term life insurance ends. You may convert some or all of your basic life insurance to an individual policy when you terminate your employment or retire. You may also convert dependent and spousal coverage once you terminate your employment or retire.

Life insurance benefits will not be paid for loss of life due to, but not limited to the scenarios below:

- Services in the armed forces of any country, except in the United States National Guard;
- Operating, learning to operate or a crew member of an aircraft; while in any aircraft operated under any military authority; or while in an experimental aircraft;
- Death occurring within two (2) years after the effective date of the insured’s coverage as a result of suicide while sane or insane;
- Death occurring as a result of suicide while sane or insane within two (2) years of the effective date of an increase in an insured’s coverage that required the submission of evidence of insurability.

Please see your Certificate of Coverage booklet for more information on coverage exclusions.

Basic Life Insurance and Accidental Death & Dismemberment

Amount of Coverage Available

- Basic Life Insurance (Automatic with Opt-Out Provision)

<i>Benefits</i>	<i>Benefit Levels</i>
Basic Life Insurance	
Coverage Level	2.0 x (base salary rounded up)
Maximum Coverage	\$200,000

Basic Life Insurance is two times your base annual salary rounded up to the next higher thousand, up to a maximum of \$200,000. **Base pay does not include overtime, bonuses, shift differential or other compensation.**

If you die while employed by the Commission, the Plan will pay your beneficiary an amount equal to two times your annual base salary, rounded up to the next \$1,000 to a maximum benefit of \$200,000. For example, your annual salary of \$37,265 times two is \$74,530. When rounded to the next higher \$1000, your coverage amount becomes \$75,000. This is the amount that would be paid to your beneficiary.

LIFE INSURANCE PLANS

- Accidental Death & Dismemberment (Automatic with Opt-Out Provision)

Benefits	Benefit Levels
Accidental Death & Dismemberment (AD&D)	
Coverage Level	2.0 x (base salary rounded up)
Maximum Coverage	\$200,000
If on Long Term Disability	\$0 on or after age 65

When you are enrolled in the basic term life insurance benefit, the Commission also automatically enrolls you in the accidental death and dismemberment insurance. Accidental Death & Dismemberment coverage has the same value as the Basic Life Insurance. If your death is due to an accident, this amount is paid to your designated beneficiary, in addition to any proceeds due from the Basic Life Insurance plan. Conversion is not available if you leave the Commission.

If you are dismembered due to an accident, you are paid for your loss. In the event of your death due to an accident, benefits are paid to your beneficiary(ies). Benefits will be paid according to the following schedule of benefits.

IF YOU LOSE:	YOUR BENEFIT WILL BE THIS PERCENTAGE OF YOUR BASIC LIFE INSURANCE COVERAGE AMOUNT: *
Your Life	100%
Both Hands or Both Feet or Sight of Both Eyes	100%
One Hand and One Foot	100%
One Foot or One Hand plus Sight of One Eye	100%
One Hand or One Foot	50%
Speech or Hearing	50%
Hemiplegia	50%
Thumb and Index Finger of One Hand	25%

No more than 100% of the covered amount will be paid for all losses sustained in any one accident. AD&D benefits will not be paid if losses were caused by:

- Suicide or willful self-injury;
- Illness or disease;
- War or any act of war;
- Any criminal act.

Separate Supplemental AD&D for Park Police

An additional \$50,000 AD&D benefit is provided at no cost to Park Police Officers.

LIFE INSURANCE PLANS

What You Pay

All eligible employees, including FOP, pay 20% of the premium for Basic Life Insurance.

Coverage for Part-Time Employees

For this benefit, the Commission considers an employee part-time if they are scheduled for 20 hours per week regardless of actual hours worked. Life and AD&D benefits are prorated; based on 20 hours per week times your hourly rate of pay rounded to the next higher thousand.

Imputed Income

Under Internal Revenue Code 79, you are not taxed on the value of the first \$50,000 of group term life insurance coverage provided by the Commission. The value of coverage in excess of \$50,000 is "imputed income" and is included in your gross earnings. The value depends on the excess coverage amount and your age. Imputed income is subject to Social Security and Medicare taxes.

Late Enrollment for Basic Life Insurance and AD&D

If you do not elect to have Basic Life Insurance and AD&D coverage within 45 days of your date of hire, you are required to demonstrate evidence of good health or insurability when you later decide to enroll. You may also be required to have a medical exam at your own cost and share those results with the insurer.

Deductions will not be taken for late enrollments until your coverage has been approved. For a copy of the Evidence of Insurability form, please visit www.mncppc.org or contact the Health & Benefits Office.

Beneficiary Form

If you enroll in Basic Life Insurance plan you will need to provide beneficiary information. Your designated beneficiaries for the basic life insurance plan will be the same for your AD&D and supplemental plan, if elected. Changes in beneficiary designation by someone other than the employee will not be honored unless a power of attorney form specifically states that someone other than the employee may change the beneficiary(ies). If a change in beneficiary is made close to the employee's death, when the employee may have been on medications, a doctor's certification or power of attorney may be required to ascertain that the employee was of sound mind to make a beneficiary change. Changes in beneficiaries will become effective the date the Health & Benefits Office receives the change form, not the date signed by the employee.

Accelerated Benefit Option (ABO)

If you are terminally ill and your treating physician certifies in writing that you will die within the next twelve (12) months, you may apply for up to 100% of your death benefit to pay for bills, treatment etc. Please contact the Health & Benefits Office for the forms to be completed by you and your physician.

When Your Benefits End

Your Basic Life insurance and AD&D plans end when you terminate your employment with the Commission. You may choose to convert to an individual policy at that time.

Conversion Available Upon Termination

When you terminate your employment with the Commission, you may convert your group term coverage to an individual whole life policy within 31 days of your termination date. You may elect an amount up to the amount of insurance you had at the Commission prior to your termination. Please contact the Health & Benefits Office for an application. Individual rates will apply based on your age at the time you apply. Both the application and your premium must be received within 31 days of your termination date.

LIFE INSURANCE PLANS

Supplemental Life Insurance

In addition to Basic Life Insurance benefits, you may purchase extra life insurance for yourself. You must be enrolled in the Basic Life Insurance plan in order to elect coverage under the Supplemental Life Insurance plan.

Eligibility

This benefit is available to you if you are in an eligible class of employees (see chart in the beginning of this book) and if you are actively at work on the day that your coverage is scheduled to begin. If you are not actively at work due to layoff, leave of absence or disability, your coverage or increased benefit amounts will only become effective on the day you return to active work.

Amount of Coverage Available

You may elect coverage for yourself of one to eight times your base salary rounded to the next higher \$1,000 not to exceed \$750,000 for supplemental life insurance. You must first be enrolled in the Basic Life Insurance Plan before you are eligible to participate in this plan. Coverage may be subject to evidence of insurability.

Guaranteed Issue Amount

If you enroll when you first become eligible, within your first 45 days of hire, you will be able to select one or two times your salary rounded to the next higher \$1,000 up to a maximum of \$300,000, without showing evidence of insurability/good health. This is called your "guaranteed issue amount".

If you enroll when you first become eligible and elect three to eight times your base salary, you will have to submit evidence of insurability. Supplemental coverage at these levels is subject to the approval/denial of the carrier. If coverage at these levels is denied, you will receive coverage in the amount of two times your base salary, up to a maximum of \$300,000.

Late Enrollment for Supplemental Life Insurance

If you do not elect Supplemental Life Insurance coverage, within 45 days of your date of hire, you are required to demonstrate evidence of good health or insurability when you later decide to enroll. You may also be required to have a medical exam at your own cost and share those results with the carrier.

If the carrier approves coverage, deductions will be taken the first of the month following carrier approval.

Total Maximum Coverage Available Combining Basic and Supplemental Plans

Your total maximum available amount of coverage between basic life insurance and supplemental life insurance is \$950,000 (\$200,000 of basic coverage + \$750,000 of supplemental coverage).

Requesting Subsequent Increases in Supplemental Coverage

Once enrolled in Supplemental Coverage, any subsequent request for an increase in coverage will require evidence of good health or evidence of insurability. Any increase in coverage will be subject to the approval/denial of the carrier. Payroll deductions will not be taken for increased coverage until the increase has been approved by the carrier. If approved, deductions become effective the first of the month following carrier approval.

If the carrier does not accept your evidence of good health as satisfactory, the amount of your supplemental life coverage will not be more than the greater of:

- The amount of supplemental life benefits for which you were covered immediately prior to the date on which any such increase would have become effective, or
- Two times your basic annual earnings not to exceed \$300,000.

LIFE INSURANCE PLANS

Who Pays for Coverage

Supplemental group term life insurance coverage is offered at low group insurance rates and paid 100% by you. When you participate in the plan, your premiums are paid through convenient payroll deductions. The group rates can be found in the Open Enrollment Guide. Your rates will increase in the year you attain the next age range.

When Coverage Ends

Coverage under the Supplemental Term Life Insurance Plan will end:

- If you stop making the required contributions,
- Thirty-one days after you terminated your employment for any reason if you do not elect to continue your coverage,
- When this Plan ends, if you do not convert to an individual policy,
- If a specific class of employees is no longer included in the coverage described in this section and does not convert to an individual policy, or
- When you retire.

Spouse and Dependent Life Insurance

You must be enrolled in the Basic & AD&D Life Insurance Plan in order to elect coverage for your spouse and dependent(s). Dependents may be covered up to age 26. If dependent is disabled, coverage may continue beyond age 26-contact the Health & Benefits Office 30 days prior to the 26th birthday. There are three different levels of coverage available as indicated in the chart below. You pay 100% of the premium for spouse and dependent life insurance coverage.

Spouse & Dependent Life Insurance Coverage
<ul style="list-style-type: none">• \$10,000 spouse/\$5,000 each child;• \$20,000 spouse/\$10,000 each child; or <ul style="list-style-type: none">• \$30,000 spouse/\$15,000 each child- <i>Spouse must provide Evidence of Insurability</i>

Double Coverage Exclusion

If your spouse is also a Commission employee, your spouse may be covered as a dependent as long as he/she has not elected his/her Basic Life Insurance coverage through the Commission.

Late Enrollment for Spouse Life

If you do not elect spousal life within 45 days of your initial hire or within 45 days of marriage, your spouse must complete an Evidence of Insurability. Coverage is subject to approval/denial by the carrier.

*Evidence of Insurability is not required for dependent children.

Beneficiary

If you enroll in dependent life insurance you will be the beneficiary for coverage for your spouse and your dependent(s).

LIFE INSURANCE PLANS

Exclusions

Life insurance benefits will not be paid for loss of life due to, but not limited to the scenarios below:

- Services in the armed forces of any country, except in the United States National Guard
- Operating, learning to operate or a crew member of an aircraft; while in any aircraft operated under any military authority; or while in an experimental aircraft
- Death occurring within two (2) years after the effective date of the insured's coverage as a result of suicide while sane or insane
- Death occurring as a result of suicide while sane or insane within two (2) years of the effective date of an increase in an insured's coverage that required the submission of evidence of insurability.

When Coverage Ends

Coverage under the Spouse and Dependent Life Plan will end:

- If you stop making the required contributions,
- Thirty-one days after you terminated your employment for any reason if you do not elect to continue your coverage,
- When this Plan ends, if you do not convert to an individual policy,
- If a specific class of employees is no longer included in the coverage described in this section and does not convert to an individual policy, or
- When you retire.

FLEXIBLE SPENDING ACCOUNTS

- ***HEALTHCARE***
- ***DEPENDENT CARE***



FLEXIBLE SPENDING ACCOUNTS

GENERAL INFORMATION

The Flexible Spending Account (FSA) lets you save taxes on money you spend for certain health care and dependent care expenses. Voya administers our flexible spending accounts program. Through the FSA, you may set aside money in one or both of the following accounts:

- **The Health Care Account** covers unreimbursed health related expenses such as but not limited to medical, dental, and vision expenses not eligible for reimbursement through another source, such as your medical, dental, or vision plan(s).
- **The Dependent Care Account** covers eligible expenses for the care of a child or an adult dependent physically or mentally incapable of caring for himself or herself while you work.

How the FSA Works

With the FSA, you select an amount from each paycheck to pay eligible expenses you have during the year. When you get a bill, you pay it as usual then submit a claim for reimbursement. You save money with the FSA because you pay no federal income or Social Security taxes on amounts deposited or withdrawn from your accounts. However, the Internal Revenue Service (IRS) restricts the use of the FSA. For example, if you do not have enough eligible expenses during the year to use all of the funds in one or both accounts, the amount left over at the end of the year cannot be returned to you.

Estimate your health care and dependent care expenses carefully before deciding if the FSA can save you money. If you have eligible expenses, your savings will be well worth the time spent planning.

Who Is Eligible

You are eligible for the FSA accounts if you are a career employee, appointed official, or term-contract employee, receiving a paycheck from the Commission. Retirees are not eligible for this plan. Eligible dependents include your spouse and your dependent children who meet the eligibility criteria for our medical plans; they do not have to be actually enrolled in our health plans.

When You May Set Up the FSA Accounts

New Employee -- As a new employee, you may elect to have one or both accounts start based on when the Health & Benefits office receives your form. This election will remain in effect until December 31 of the year in which you join the Commission. You must then re-enroll for each subsequent year.

Re-enrollment -- Each year, during the annual open enrollment period, you must re-enroll in the FSA for the next calendar year. When you re-enroll, you can continue or change your current contribution amount. You must complete a new FSA enrollment form each year even if electing the same annual contribution amount.

Direct Deposit of Reimbursement

If you want your reimbursement checks deposited directly in your checking account, you must complete the Direct Deposit authorization online at www.voya.com/. All you need is your Bank Name, Routing Number (ABA) and Account Number (DDA). Benefit Strategies can deposit to Checking or Savings Accounts. If you do not have access to the internet, please contact Benefit Strategies Customer Service (888-401-3539) for online assistance. To change your bank account, you will need to perform the same process described above. For disenrollment, you can terminate the Direct Deposit (EFT) online or call the Plan's Customer Service number and follow their directions.

FLEXIBLE SPENDING ACCOUNTS

About Your Contributions

You fund your FSA accounts with contributions from your paycheck which are deducted each payday in equal amounts throughout the year. You pay no federal income or Social Security taxes on these contributions. State taxes apply in some states.

You may elect to contribute up to:

- \$3,200 a year into a Health Care Account. (Indexed annually.)
- \$5,000 a year into a Dependent Care Account (\$2,500 if you are married and file a separate income tax return).

The minimum you may deposit in a single account is \$52 a year (\$2.00 per pay period).

- *Potential restrictions on contributions by highly compensated employees* -- Tax law may limit the maximum deductible contribution for certain highly compensated employees depending on the total contribution made by all employees. You will be notified if this situation arises.

YOUR FSA HEALTH CARE ACCOUNT

Your Health Care Account may be used to pay health care expenses that are not covered by any other source and are tax deductible according to IRS guidelines.

In general, you may use your Health Care Account to pay:

- Co-payments for office visits and prescriptions;
- Annual deductibles under your family's medical and dental plan(s);
- Coinsurance (your share of expenses after you meet your deductible);
- Charges not covered by any plan (such as routine medical checkups or tests, school physicals, dental expenses in excess of benefit limits);
- Over the Counter (OTC) medications; and menstrual care products;
- COVID: Personal Protective Equipment (PPE) -masks, sanitizer and also home test kits; and
- Eligible vision and hearing expenses.

Eligible Expenses

A limited list of eligible expenses is provided at the end of this benefit section followed by a list of ineligible expenses. A final determination of what expenses are eligible rests with the IRS. More information is available in IRS [Publication 502 - Medical/Dental Expenses](#) and IRS Publication 969 – Health Savings Accounts and Other Tax-Favored Health Plans. Although eligible expenses are tax deductible, expenses reimbursed by your Health Care Account cannot be claimed as a deduction on your income tax return. You may use your Health Care Account for expenses for you and your eligible dependents. Your dependents do not have to be covered under the Commission's health plans to claim Health Care Account funds, but you must claim them as dependents on your tax return.

Eligible Medical Expenses of Dependents

You may submit eligible medical expenses for dependents as defined according to IRS tax guidelines. See Publication 502 – "What Medical Expenses Can You Include". You may also submit eligible medical expenses for young adult dependents age 23 and less than 26 or a disabled dependent over age 26.

Expenses Must Be Incurred Before Reimbursement

If fees are prepaid, such as orthodontic work, reimbursement cannot be made until the expense has been incurred – that is not until the medical care is provided.

Health Care Accounts Cannot Reimburse Insurance Premiums

Your monthly portion of the health benefit premium cannot be reimbursed through a health FSA. If fees are for 'qualified long-term care expenses' or if they function essentially as life insurance premiums, a health FSA cannot reimburse them.

Over-The-Counter Drugs and Health Care Reform

Over the counter (OTC) medications are not reimbursed under the Health Care Spending account, unless prescribed by a physician.

Under the Patient Protection and Affordable Care Act (PPACA), in order to claim reimbursement for all over the counter (OTC) medications and drugs (except insulin), you must have a prescription. A "prescription" is defined as a written or electronic order for a medicine or drug that meets the legal requirements of a prescription in the state in which the medical expense is incurred and that is issued by an individual who is legally authorized to issue a prescription in that state. Supporting documentation required to substantiate a prescription includes a customer receipt issued by a pharmacy that identifies the name of the purchaser (or the name of the person for whom the prescription applies), the date and amount of the purchase, and the Rx number.

You must also submit a letter of medical necessity with your claim for reimbursement.

Letter of Medical Necessity

The letter of medical necessity must state that the person has a specific medical condition and the OTC drug is recommended to treat the condition for the expense to be reimbursed. A letter of medical necessity will remain on file and valid for the lesser of 12 continuous months starting at any time or the length of time stipulated on the doctor's letter.

Debit Card Program

Health plan participants are eligible to voluntarily participate in the debit card program. By making an election each year to participate in this part of the FSA program, you will receive a debit card with your annual dollar amount you elected for the plan year. This card will pay for such items as:

- Co-pays
- Deductibles
- Eligible medical expense items (see the list)

There are, however, certain requirements if you choose this option:

- The card must only be used for healthcare expenses for you and your eligible family members.
- Claims must not be submitted for reimbursement to any other payer.
- Use of the card is limited to authorized providers and participants.
- **You must retain receipts in the event the administrator requires substantiation of items purchased.**

Currently when submitting claims for reimbursement, supporting documentation is required before a claim will be paid. However, no further documentation is required if:

- The claim amount matches the plan co-payment.
- The claim amount matches the amount for a previously approved charge (e.g., a prescription refill) by the same provider.

FLEXIBLE SPENDING ACCOUNTS

The Internal Revenue Service (IRS) also provides the following safeguards against misuse of the card:

- The employee must repay the employer for any ineligible expenses.
- The amount of ineligible expenses may be withheld from the employee's paycheck or used to offset any future claims.
- Employees who do not repay the employer may be denied use of the card.
- The card is cancelled upon the employee's termination of employment.

Additionally, any ineligible expenses that are not reimbursed to the Commission will prevent an employee from receiving any retiree benefits once that employee retires.

Participation in the Debit Card Program

When you enroll in the FSA program, you will automatically receive a debit card. If you are not interested in using the debit card, call Benefit Strategies and they will cancel your participation in the debit card program. They will ask you to destroy your card. You will not need to return the debit card to Benefit Strategies.

Cost of Additional Debit Cards

The Commission will pay for the cost of the first debit card that you receive. Please call Benefit Strategies if you lose or want additional cards. If you request a card for your spouse or child, your spouse or child's name will be placed on the card.

How Your Debit Card Works

When Benefit Strategies receives your enrollment, your annual health account balance is allocated to your card. As you use your card, the annual amount is updated nightly with the new balance.

When your card is "swiped" you should select **credit** only when prompted. No personal identification number (PIN) is assigned with the debit card. You will need to sign the receipt just as you would with a credit card.

You cannot use your card to withdraw cash from an ATM, nor can it be used at unapproved service provider locations, including restaurants and home-improvement centers. The card will be rejected when used at ineligible locations.

Coordination of Debit Card Eligible Expenses and Over-The-Counter-Expenses

When you use your debit card at qualified card locations where VISA debit cards are accepted, such as in your doctor's office or a facility rendering a service where you would be required to pay a co-pay, deductible or coinsurance, the card administrator will verify the location where the expense is being charged. The business location, not the item or service that is being purchased, is verified as an eligible location.

Even if your card can be used to purchase eligible items, you may still be required to submit receipts to Benefit Strategies documenting your purchases. For example, if you have both a prescription costing \$40 and some over the counter items totaling \$7.50, you will want to use the debit card twice rather than combining the purchases. Your prescription should not require further proof of payment eligibility.

FLEXIBLE SPENDING ACCOUNTS

Ineligible Purchases Made With the Debit Card

If you are able to purchase items for which you do not later provide a receipt or the items are not eligible purchases through the FSA plan, Benefit Strategies will notify you that you must reimburse the plan by sending a check to Benefit Strategies for the amount of the ineligible purchases. If you fail to reimburse the plan, Benefit Strategies will offset the amount you received against a future payment or will reduce the amount of your eligible plan balance. If you have ineligible purchases at the end of the plan year, Benefit Strategies will require you to return the reimbursements to Benefit Strategies for services that were not supported with satisfactory documentation.

If Your Debit Card Does Not Work

Your debit card may not work for one or more of the following reasons:

- The merchant is not a qualified service provider, such as a convenience store.
- You don't have sufficient funds in your account to cover the purchase
- The merchant is having a problem, such as difficulties with the card-reader or network connection.
- Your card has been suspended temporarily due to problems validating certain expenses you've paid with the card.

If you are unable to use the card for your purchase, you may pay for the expense with another form of payment and then file a claim for reimbursement.

If the amount of the expense is greater than your available account funds and your transaction is denied, you can split the expense using the debit card for the available amount in your account and pay the remaining balance with another form of payment. You can also pay the entire amount with another payment method and file a claim for reimbursement.

Purchasing Items through Mail Order

You may use your card to purchase items, such as prescription drugs and contact lenses, by mail order or online. Simply enter your card number on the order form as you would when purchasing online with a credit card.

Proof of an Eligible Expense

Although this debit card program is designed to reduce the number of transactions that require proof of payment and eligibility, Benefit Strategies may still require some proof. You must therefore, keep your receipts for the plan year of the purchase/service date.

Debit Card Expiration

Your debit card has an expiration date located on the front side of card. Your debit card will be valid until the expiration date on the front of card is reached or employment is terminated, whichever is earlier. New cards are not issued each year; only when the current card reaches the expiration date.

FLEXIBLE SPENDING ACCOUNTS

YOUR FSA DEPENDENT CARE ACCOUNT

The Dependent Care Account reimburses you some or all of your eligible expenses for the care of a qualifying child or relative while you work. If you are married, your spouse must also work or be a full-time student in order for you to use the Dependent Care Account.

You may use the Dependent Care Account to cover the cost of care for a qualified dependent. In general, a qualifying child or relative would be:

- Your spouse;
- Qualifying children under age 13 or who is disabled
- Your spouse or other qualifying relative regardless of age, who is physically or mentally incapable of self-care, resides with you for more than half the year and does not have annual income greater than \$4,400.00.

The relationships that satisfy the IRS definition of a qualifying child or relative include your:

- Child, grandchild, stepchild, foster child, or adopted child;
- Spouse;
- Brother, half-brother or stepbrother; sister, half-sister, or stepsister; nephew or niece;
- Child or grandchild or any of the relatives above;
- Father, grandfather, stepfather, mother, grandmother or stepmother;
- Uncle or aunt; or
- Son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law.

If you provide more than 50% of a person's support for the calendar, and they are not a qualifying child or relative of any other person, that person is considered your eligible dependent.

Qualifying dependents must:

- Reside with you for more than half the year. (This does not include temporary absences such as illness, education, vacation, or business as long as the qualifying dependent is expected to return after the absence.)
- Regularly spend at least eight hours a day in your home.
- Not file a joint tax return with his/her spouse for the calendar year (unless the qualifying relative is your spouse).
- Not be claimed by any other person as a qualifying child for the calendar year.
- Be a citizen, national or resident of the US; or a resident of Canada or Mexico (unless the person is an adopted child).
- Be considered a qualifying child or relative on a daily basis.

You may use your Dependent Care Account to cover expenses for:

- Care provided inside or outside your home (care provided outside your home for a dependent who is age 13 or older and incapable of self-care is eligible for reimbursement only if the dependent spends at least eight hours a day in your household);
- Before and after school care; and
- Nursery school or Pre-school (but not kindergarten) tuition. Before and after care costs, if broken out from the basic tuition, may be reimbursed.

FLEXIBLE SPENDING ACCOUNTS

- Summer day camp for qualifying child under age 13
- Eldercare day care for an incapacitated adult who lives with you at least eight hours a day in your home
- Cost of a housekeeper whose duties include the care of a qualifying dependent

You may not use your Dependent Care Account to cover expenses for:

- Money paid to your spouse, your child under age 19, a parent of your child who is not your spouse, or a person who you or your spouse can claim as a personal tax exemption as a dependent
- Expenses related to care for a disabled spouse or tax dependent living outside of your home, unless they reside in your home at least eight hours each day
- Overnight camp
- Educational expenses (such as summer school and tutoring programs)
- Tuition for kindergarten and above
- Placement fees for finding a dependent care provider (example: au pair)
- Sports lessons, field trips, clothing or transportation

Dependent care fees paid to family members are not eligible for reimbursement unless the family member is over age 19 and not claimed as a dependent on your federal income tax return. The maximum amount you may be reimbursed for dependent care expenses each year is the *lowest* of the following:

- \$5,000 (\$2,500 if you are married and file a separate income tax return),
- Your taxable income, or
- Your spouse's taxable income.

If your spouse has no income because he or she is a full-time student or is mentally or physically incapable of self-care, the IRS still permits you to use a Dependent Care Account to pay dependent care expenses of up to \$250 a month for the care of one dependent and up to \$500 a month for the care of two or more dependents.

Rules for Married, Divorced or Separated Parents

The following rules apply if you are married, divorced or separated:

- If you are married and both you and your spouse are both eligible to contribute to an FSA Dependent Care account through your employer, you both may not contribute the \$5,000 maximum and claim it as a deduction on your tax filing.
 - If you are married and file a joint return, you can claim a combined \$5,000 as a deduction on your tax filing. If you exceed this amount, consult your tax advisor.
 - If you are married and file separate tax returns, the maximum is \$2,500.
 - The reimbursed amount must be lower than either you or your spouse's earned income
- If you are divorced, your eligibility to claim dependent care expenses is based on whether or not you are the custodial parent:
 - If you are the custodial parent, you can be reimbursed under the FSA Dependent Care account for expenses incurred for care for your qualifying child even if you don't claim that child as a tax dependent.
 - If you are not the custodial parent, you cannot be reimbursed under the FSA Dependent Care account even if you claim your child as a tax dependent.

FLEXIBLE SPENDING ACCOUNTS

IRS Rule Regarding Dependent Care Claim Processing Rule

Dependent care claims cannot be processed for future dates of service. For example:

You pay for total day care expenses for January on the 2nd of January and file a claim for total expenses on January 20th. The claim will be processed for expenses incurred up to the date of the claim form signature. The balance will be denied. A new claim form will need to be submitted at end of month, January 31st or later in order for balance (January 21st to January 31st) to be paid out. To lessen confusion, it is recommended that dependent care claims be filed at the end of each week or at the end of each month for reimbursement.

Reimbursement of Your Dependent Care Claims

You may only be reimbursed for the total amount that has been deducted from your paycheck. No expenses are reimbursed prior to the payroll deduction being made. The amount that is available for reimbursement is your total payroll deduction to date less all reimbursements for the plan year.

Dependent Care Account vs. Income Tax Credit

Your eligible dependent care expenses are the same ones that qualify for a federal income tax credit. However, you cannot take a tax credit for dependent care expenses reimbursed through a Dependent Care Account. Although the Dependent Care Account typically offers greater tax savings than the tax credit, you may want to check with a tax advisor before making your decision.

ADDITIONAL INFORMATION YOU NEED TO KNOW ABOUT FSA ACCOUNTS

Period of Coverage for Eligible Expenses

To be reimbursed from your FSA accounts your eligible expenses must be incurred during a "period of coverage." A period of coverage begins the *later of*:

- January 1 of each calendar year;
- The date you become enrolled in the FSA if you are a new employee;
- The effective date of an account you set up as the result of a qualified life event.

A period of coverage ends the *earlier of*:

- March 15th following the plan year; or
- The end of the month in which contributions stop.

Extension of Plan Year- Grace Period

If you have any funds remaining on December 31st in your health care and dependent care accounts, you will have a two-and-a-half-month grace period, between January 1st and March 15th of the following year, to incur additional qualified expenses. The grace period extends the plan year from a 12 month claim period to a 14 ½ month claim period.

All claims must be filed no later than March 31st for consideration. You may also use your FlexExpress debit card during this period. Eligible expenses incurred during the grace period will be applied to your unused funds from the previous year first. Once your funds from the previous year have been exhausted, any claims incurred during the grace period will be applied to your current year account balance.

If you have any eligible health care or dependent care expenses incurred between January 1st and December 31st of the previous plan that you did not submit a claim, you may file a claim by March 31st for consideration.

If you still have funds from the previous plan year remaining in your health care or dependent care account on March 31st, the funds will be forfeited.

FLEXIBLE SPENDING ACCOUNTS

Account Restrictions

The IRS restricts the FSA accounts in several important ways.

- *No transfers* -- You cannot transfer dollars from one account to another. The accounts are separate, and the money you contribute for one type of expense cannot be used to pay for another.
- *The IRS "use it or lose it" rule* -- You contribute funds to the FSA accounts to pay expenses you expect to incur during the year. If you don't have eligible expenses that are at least equal to this amount, you forfeit the money left over in your FSA account(s). All health care and dependent care expenses you have in a calendar year must be submitted for reimbursement by March 31 of the following year. Under current IRS rules, you lose any money left in your account after this date.
- *No changes in the FSA contributions* -- You cannot stop, increase or decrease your FSA contributions until the next annual enrollment period. However, an exception is made if you have a qualifying life event and submit proof to request the change within 45 days.

Making Changes Due to Qualifying Life Events

The IRS allows changes in the FSA contributions when the following qualifying events occur:

- Your marriage or divorce,
- Your dependent or child's marriage,
- A birth, adoption, or change in custody of a child or gain of a disabled adult dependent,
- A change in your or your spouse's employment status, including part-time and retirement,
- An unpaid leave of absence by you or your spouse,
- Your dependent child ceases to be a dependent,
- The death of your spouse or other dependent; or
- You change daycare providers (change in rates)

A new election must be consistent with the reason or appropriate as a result of the status change. Such changes must be accompanied by documentation sufficient to verify the event. Contact the Health & Benefits Office to change your FSA contributions, if you have a qualifying life event. Your request must be made within 45 days of the qualifying event. Any change in your FSA contributions will become effective the first of the month after your form has been received by the Health & Benefits Office.

Account Balances

You'll receive quarterly statements showing your account activity and balance. Statements will be forwarded by email if you have an email address on file with Benefit Strategies. You can also view your account activity and balance at any time through the VoyaConsumer Portal www.voya.com/.

Impact on Other Benefits

Your participation in the FSA won't affect most other salary-related benefits, such as life insurance, disability and retirement. For example, if you earn \$20,000 a year, and put \$1,000 into the FSA account, your taxable income will be \$19,000. However, your life and disability benefits will still be based on your \$20,000 salary.

Possible Impact on Social Security Benefits

If you contribute to the FSA and your earnings are less than the Social Security taxable wage base, your Social Security taxes will be reduced. As a result, your Social Security benefits may be slightly lower when you retire or if you become disabled.

For example, suppose you are age 35 and earn \$25,000. If you contribute \$500 a year to the FSA accounts until you retire, and you remain under the taxable wage base, your monthly Social Security benefit when you reach age 65 will be about \$5 less than if you had not contributed to the FSA. The amount of benefit reduction will depend on the amount of your FSA contributions and how long you participate in the FSA between now and when you retire.

If You Are on an Approved Leave of Absence

If you are approved for a leave of absence such as LTD, you may still pay your elected salary reduction amount on an after-tax basis in order to remain eligible in the plan. If you are terminated from the plan for non-payment, you will not be able to submit any expenses that were incurred after your plan termination date. You will not be eligible to re-enroll in the plan until the next open enrollment following your return to active work status. If you return to work after a leave of absence or disability within the same calendar year, your before-tax contributions will be adjusted to meet your annual pledge.

- You may not make additional contributions to continue coverage. If you are not working, you cannot use the dependent care account.

In the Event of Your Termination or Retirement

If you terminate employment you have 90 days from your termination date to request reimbursement for eligible expenses incurred while an active employee.

In the Event of Your Death

If you die while participating in the FSA, your eligible dependents and spouse may withdraw funds in your accounts for expenses incurred up until the date of your death. Your family may be reimbursed for health care expenses incurred *after* the date of your death by continuing to make Health Care Account contributions on an after-tax basis.

How to File a Claim

To be reimbursed from the FSA account for an eligible expense you should:

- Pay the bill or, in the case of covered medical or dental expenses, submit the bill to your medical/dental plan(s) first.
- Complete the appropriate reimbursement form and attach a copy of the itemized bill(s) and Explanation of Benefits (EOB) form. Reimbursement forms are available online at www.voya.com/.
- Send your reimbursement form with the appropriate documentation attached directly to the FSA administrator. Dependent Care Account claims must include your caregiver's taxpayer ID or Social Security number. Health Care Account claims for expenses submitted to your spouse's medical or dental plan should include an Explanation of Benefits (EOB) form from that plan.

If the reimbursement is from your Health Care Account, the check will equal the lesser of the:

- actual amount of your claim, or
- total amount of contributions you have elected to put in the Health Care Account for the year, less any reimbursement you have already received.

If the reimbursement is from your Dependent Care Account, the check will equal the lesser of the:

- actual amount of your claim, or
- amount of your account balance at the time the reimbursement is made with no future expense dates reflected on the claim form.

Timing for Reimbursement

Reimbursements are processed weekly. Your claims may take 7-10 business days from the date filed to be processed and for you to receive reimbursement through direct deposit or by mail. The Health & Benefits Office will not investigate any reimbursement until this time has passed.

FLEXIBLE SPENDING ACCOUNTS

If Your Claim for Benefits Is Denied

If any claim for the FSA account benefits is denied, in whole or in part, you will receive a written explanation of the denial within 90 days explaining:

- The specific reason for the denial,
- Reference to the plan provisions on which the denial is based,
- A description of any additional material or information required to substantiate your claim and an explanation of why it is necessary, and
- A description of the appeals procedure.

You may file an appeal within 45 days of the date you receive the denial notice. During that time, you or your representative may also review and submit any additional documentation in support of your claim

A decision will be made on your appeal within 60 days of your request for review and you will be informed in writing. Under special circumstances, this decision process may take up to 120 days.

Eligibility Disclaimer

Each year the IRS publishes Bulletins which provide up to date changes in eligible and ineligible items. Please refer to this document or the Commission's current FSA Administrator for current rulings.

A list of eligible and ineligible Health Care FSA expenses follows.

FLEXLE SPENDING ACCOUNTS

Eligible health care expenses are expenses incurred for medical care, including amounts paid for the diagnosis, care, mitigation, treatment or prevention of disease or illness and for treatments affecting any part or function of the body.

ELIGIBLE HEALTH CARE ACCOUNT EXPENSES

Professional Services

Chiropracist
Chiropractor
Dermatologist
Dentist
Gynecologist
Neurologist
Nursing
Obstetrical
Oculist
Optician
Optometrist
Orthopedist
Osteopath
Pediatrician
Physician
Physiotherapist
Podiatrist
Psychiatrist
Psychoanalyst
Psychologist
Registered nurse
Surgeon (except for cosmetic surgery)

Hospital Services

Anesthetist
Oxygen mask, tent
Use of operating room
X-ray technician

Medical Treatments

Acupuncture
Blood transfusion
Bone marrow transplants
Diathermy
Electric shock treatments
Fertility enhancement
Hearing services
Injections
Insulin treatments
LASIK or PRK surgery
Nursing
Organ donor costs associated with transplant
Patterning exercise therapy
Pre-natal and post-natal care
Psychotherapy
Radiation
Radial keratotomy
Radium therapy
Speech therapy
Sterilization
Surgery
Ultra-violet ray treatments
Vasectomy
Vision correction surgery
X-ray treatments

Equipment and Supplies

Abdominal supports
Air conditioner if necessary
for relief from allergy or
difficulty in breathing, less
home improvement value
Ambulance hire
Arches
Artificial teeth, eyes
Auto device for handicapped
person, but not for travel to work

FLEXIBLE SPENDING ACCOUNTS

ELIGIBLE HEALTH CARE ACCOUNT EXPENSES *continued*

Equipment and Supplies (Continued)

Back supports
Braces
Contact lenses & contact lens solutions
Cost of installing specialized equipment
Cost of installing stair-seat
COVID: masks and sanitizer
COVID: Home test kits
Diabetic supplies
Elevator (in home) for disabled)
Crutches
Elastic hosiery
Eyeglasses
Fluoridation unit in home
Hearing aids
Heating devices
Household visual alert system for hearing impaired persons
Invalid chair
Iron lung
Orthopedic shoes
Prescriptions
Reclining chair if prescribed by physician
Repair of telephone equipment for the deaf
Sacroiliac belt
Special mattress and plywood bed boards for relief of spinal arthritis
Specialized equipment for disabled persons
Splints
Truss
Wheelchairs
Wig if advised by physician because of hair loss from disease

Laboratory Exams/Tests

Blood tests
Cardiographs
Metabolism tests
Spinal fluid tests
Sputum tests
Stool examination
Urine analyses
X-ray examinations

Dental Services

Cleaning teeth
Dental X-rays
Filling teeth
Gum treatment
Oral surgery
Orthodontia (unless only for cosmetic purposes)

FLEXIBLE SPENDING ACCOUNTS

ELIGIBLE HEALTH CARE ACCOUNT EXPENSES *continued*

Miscellaneous

Alcoholism inpatient care	Lead based paint removal
Birth control pills or other birth control items prescribed by a physician	Legal fees for guardianship of mentally ill spouse where commitment was necessary for medical treatment
Braille books (excess cost of braille works over cost of regular editions)	Nurse's board and wages, including Social Security taxes you pay
Child birth preparation classes	Nutritionist/Nutritional Counseling**
Clarinet lessons if advised by a dentist for treatment of tooth defects	Over the counter drugs (see special section) and menstrual needs
Computer storage and medical records	Prescribed vitamins
Convalescent home if for medical treatment	Routine physical exam
Copayments and coinsurance	Remedial reading for child with dyslexia*
Deductibles	Sanitarium and similar institutions
Drugs and medicines obtained over the Counter, only if prescribed by a physician	School costs for physically and mentally handicapped children
Drug treatment center - inpatient care	Seeing-eye dog and its maintenance
Fees paid to health institute if services are prescribed by a physician to alleviate a physical or mental defect or illness	Smoking Cessation program cost*
Guide for visually or hearing-impaired person	Special devices (tape recorder, typewriter) for visually impaired person
Hair transplant operation if a result of an accident or injury to return a person to their prior state	Support hose*
Kidney donor's or possible kidney donor's expenses	Telephone-teletype costs and television adaptor for closed caption service for deaf person
	Transplant associate donor costs
	Travel expenses related to medical treatment
	Weight reduction programs undertaken to treat a specific ailment*
	Whirlpool baths*
	Other health expenses not paid by a health plan

***Medical Necessity Required for Certain Eligible Expenses**

Some expenses must be accompanied by a doctor's certification indicating

- the specific medical disorder
- the specific treatment and
- how this treatment will alleviate the medical condition

****Nutritional Counseling/Nutritionist**

If a condition is partially covered by your medical plan, you may submit a copy of the Explanation of Benefit (EOB). If a nutritionist is not covered under a medical plan, you must have the doctor write a letter of medical necessity stating a diagnosis of obesity and submit this paperwork along with the paid expenses for a nutritionist. Only the cost for the nutritionist is eligible. Any food or nutritional products are not eligible.

FLEXIBLE SPENDING ACCOUNTS

INELIGIBLE HEALTH CARE ACCOUNT EXPENSES

Athletic or health club expenses to maintain or improve physical fitness	Nicotine patches and gum
Babysitting expenses incurred while you go to the doctor	Patent medicines
Boarding school fees paid for child while parent is recuperating from illness	Scientology fees
Bottled water	Tattooing
Cosmetic expenses and related medications	Toothpaste
Dance lessons, even if advised by physician	Transportation costs of a disabled person to and from work
Diaper service	Travel for reasons of health, even if prescribed by physician
Divorced spouse's medical bills	Tuition and travel expenses to send a child to a particular school for a beneficial change in environment
Domestic help -- even if needed because of spouse's illness	Veterinary fees
Expenses claimed on your income tax return	Vitamins, tonics, etc., even if prescribed by a physician
Expenses reimbursed by other sources such as insurance companies	Weight reduction or programs for general well-being
Ear piercing	
Food or beverage substitutes, except cost of special foods over what would have ordinarily been spent on food is deductible if necessary because of allergy	
Hair transplants	
Illegal operations, treatments and drugs – (Drugs from Canada are considered illegal by the FDA, therefore are ineligible by the IRS for reimbursement)	
Insurance premiums	
Marriage counseling or legal fees for divorce	
Maternity clothes	

INCOME REPLACEMENT PROGRAMS

- LONG_TERM DISABILITY
- SUPPLEMENTAL LONG-TERM DISABILITY
 - SICK LEAVE BANK
- SICK LEAVE DONOR PROGRAM
- WORKERS' COMPENSATION



If you are in a union and covered by a collective bargaining agreement, you must review your agreement for specific benefits in these areas.

WORKERS' COMPENSATION

Workers' Compensation is a state-mandated, Commission-paid program, which provides payment for lost wages as well as reasonable medical expenses incurred as a result of a work-related injury or illness. These benefits are regulated by the State. Managed Care Innovations, L.L.C. provides total program management, partnering with Corvel Corporation as the claims administrator.

What to Do If You Are Injured On the Job

Notify your supervisor immediately if you have an injury or illness on the job. If your supervisor isn't available, notify the designated person in charge. Your supervisor will arrange for medical assistance for you and will also report the injury or illness to the Commission's workers' compensation carrier. In the case of an emergency, you should go to the nearest hospital emergency room for initial treatment.

Compensability Decisions

Compensability decisions for lost time and medical treatment are determined by Corvel. Records for medical care (e.g., documentation/bills) and documentation for injury related absences (disability certificates) must be submitted in a timely manner to Corvel for consideration and payment. Untimely submission of documentation will result in delayed compensability decisions and delayed reimbursements to employees.

If Your Claim Is Found to Be Non-compensable

If your supervisor filed a claim with the program administrator and a determination is made that your claim is not compensable, your services are covered up to the denial date.

Benefit Eligibility

If you are a Merit system employee, you may be eligible for payment of two-thirds of your average weekly wage during the period of incapacity. However, the Commission provides full (100%) wage protection for the period of documented disability, up to a maximum amount of time, through Disability Leave. When an employee receives Disability Leave, it is in lieu of the state mandated two-thirds average weekly wage. When an employee has exhausted the maximum Disability Leave, wages are paid at two-thirds of the average weekly wage up to the state mandated maximum. See Merit System Rules and Regulations and/or applicable collective bargaining agreements for details.

CoreCare Pharmacy Program

The Commission's claims administrator uses the CoreCare Pharmacy Program for pharmacy benefits. By using this program, the injured worker has no out-of-pocket expenses. The network includes most major chains such as CVS, Eckerd's, Rite Aid, Walgreen's, K-Mart, Wal-Mart, Target, etc. Mail order is also available where longer periods of treatment are needed.

CoreCare Provider Network

Corvel Corporation uses the CoreCare PPO Network to provide medical care for occupational injury and disease claims. Doctors and facilities in this network are committed to providing proper care and are under contractual obligation for negotiated amounts and timely billing.

INCOME REPLACEMENT PROGRAMS

Medical Bills Related to Workers' Compensation

Corvel Corporation will process medical bills related to your workers' compensation claim. A claim number is not required for bill submission. Request that your medical provider submit the bill to Corvel Corporation, P.O. Box 43600, Baltimore, MD 21236.

Applying for Long Term Disability (LTD) Benefits

Once your claim has been filed by your supervisor, if you know that you will be out for more than 60 days, you will need to apply for Long Term Disability (LTD). Failure to apply for LTD timely will limit the amount of Workers' Compensation Disability Leave for which you are entitled.

Refer to the Section on Long Term Disability for information on the coordination of LTD benefits with Workers' Compensation (page 64).

Health Benefits While You Are on Workers' Compensation

During the period of Workers' Compensation Disability Leave, you will continue to receive a paycheck. Health insurance premiums continue to be deducted directly from the paycheck.

Return to Work

When your doctor states, in writing, that you are able to return to full-duty work or to work with medical restrictions, you will be required to have a return-to-work physical by the Commission's medical doctor. Medical restrictions should be provided prior to returning to work in order to discuss them with your manager or Division Chief. Once you return to work in any capacity, no lost time wage replacement is available for physical therapy and other medical appointments.

LONG-TERM DISABILITY PLAN

The sudden loss of an income would mean an enormous financial burden for most people. That is why it is so important to protect your income if an illness or injury prevents you from working. When you have been disabled for 120 calendar days, you may be eligible for long-term disability (LTD) benefits.

Benefit Eligibility

This is a mandatory benefit for career employees. The Commission pays 80% of the premium and you pay 20%.

Determining Your Benefit

The LTD Plan pays 66 2/3% of your basic monthly earnings, up to a maximum monthly benefit of \$6,000. For example, an employee who earns \$1,500 a month would be eligible for an LTD benefit of \$1000 a month, calculated as: $66 \frac{2}{3}\% \times \$1,500$ salary. Park Police must refer to their collective bargaining agreement to determine their maximum benefit under this plan.

For purposes of the LTD Plan, your basic monthly earning is your base rate of pay prior to becoming disabled. It does not include overtime, bonuses, shift differential, or other additional forms of pay.

Applying for LTD Benefits

You must submit a claim for disability benefits by either calling the LTD carrier or submitting a paper application. The carrier determines whether you are eligible for benefits. This process takes anywhere from six to eight weeks. To ensure that you continue to receive income, you should file your application after being disabled for 60 days. Please contact the Health & Benefits Office for an LTD application packet. You must return all completed forms to the Health & Benefits Office.

INCOME REPLACEMENT PROGRAMS

If you have been disabled or expect to be disabled for more than 120 days, you must apply for Long Term Disability. If you do not apply before 60 days have lapsed, you may not be eligible for other income programs such as Sick Leave Bank or the Commission's Disability Pay program for work related injuries or illnesses. Once the LTD carrier has received your application and associated documents, the carrier generally takes 6-8 weeks to review your case and may request any additional information to help them make a reliable determination. Please be sure to submit LTD paperwork as soon as you know that you will be disabled for more than 120 days.

Coordination of Sick Leave Bank Benefits with LTD

Once you have been approved for LTD, you will no longer be able to use your accrued leave or the Sick Leave Bank. The Health & Benefits Office will coordinate the start of your LTD leave with your department.

Coordination of LTD Benefits with Workers' Compensation

If you are injured on the job and you are eligible for workers' compensation benefits, you may also apply for LTD. Even though your workers' compensation may be approved, and you may be receiving workers' compensation benefits and possibly Commission disability benefits, in order to receive LTD benefits.

If you are approved for both workers' compensation and LTD, your workers' compensation claim will pay benefits first and your LTD claim will pay benefits second. You will be eligible to receive a benefit from both plans. The LTD carrier will make sure that their portion of the benefit plus what you receive through Workers' Compensation is no greater than 66 2/3% of your pre-disability pay or \$100, whichever is greater.

You must apply for LTD benefits by contacting the Health & Benefits Office.

You must fully cooperate with Workers' Compensation in order to remain eligible for LTD. If for example, you are scheduled for an independent medical exam (IME) and you fail to appear for it two times, you may be considered as not cooperating with Workers Compensation. The LTD carrier may do at least one of the following:

- Terminate LTD benefits; or
- Continue coordinating against the last known Workers' Compensation benefit you received.

Coordination of Other Income with LTD

You are required to report any other wages or income that you received at least 6 months prior to your disability and during your disability. Your failure to report earned income may be considered fraud with disciplinary action up to and including termination.

If You Are Not Totally Disabled

If you are not able to perform the substantial and material duties of your regular occupation on a full-time basis, but are able to earn at least a portion of your pre-disability salary by working on a partial or part-time basis, you may be eligible for a residual disability benefit. The residual disability benefit is a portion of your total disability benefit.

Leave Without Pay Status

While you are receiving LTD benefits, you will be placed in a Leave Without Pay Status (LWOP). If your LTD benefits end and you do not return to work at the Commission:

- Your health and other benefits will end after you have been on LWOP for 6 months.
- You may be terminated after being on LWOP for 12 months or before.

If you appeal the decision to terminate your LTD benefits, the Commission may not terminate you, if you provide a timely copy of the denial letter and a copy of your appeal paperwork.

LONG-TERM CARE

As of January 1, 2018, the Long-Term Care program through Acsia Partners LLC was closed to new enrollees. Participants may contact Acsia directly at 844-250-5228 if they have questions about their plan.

Note: As of June 30, 2013, the long-term care plan offered through Prudential was frozen to new members. If you have questions about your existing plan, please contact Prudential directly at 800-732-0416.

INCOME REPLACEMENT PROGRAMS

Benefits While You Are On Long Term Disability

While you are disabled and receiving LTD income replacement benefits, you may continue your Commission sponsored health and welfare benefits as long as you continue to pay your portion of the monthly premiums. Your portion of the premiums is the same as an actively-at-work employee. You will continue to receive materials for and be able to make benefit changes during the Open Enrollment period.

If your LTD benefits end and you do not continue to pay for your health benefits, you may not be able to show 36 months of continuous coverage in each plan prior to your retirement, in order to remain eligible for the Commission's retiree benefits. A break in health coverage will make you ineligible for retiree health benefits. If you do not retire before the Commission terminates your employment status, you may also become ineligible for retiree benefits.

Life insurance and Accidental & Death (AD&D) coverage will end after you have been on LTD for 12 months. Basic and supplemental life insurance may be continued as long as you pay your portion of the premium. Premiums are usually waived when you are considered to be totally and permanently disabled. You must apply for a waiver of premium if you are considered totally and permanently disabled or coverage may be terminated.

Your life insurance benefits end once you are terminated and may be converted to an individual policy through the carrier. Life insurance is not eligible for conversion while an appeal to extend LTD benefits is in process.

Payment of Benefit Premiums Disability

If you are on Long Term Disability, you will be required to pay your portion of health benefits through the Self-Pay program. You will not be required to pay any LTD premiums or make any contributions to the Employee Retirement System (ERS) while you are totally disabled.

Payment of Benefit Premiums during Partial Disability

If you remain on LTD part-time and work part-time, you must continue to pay your portion of your benefits through payroll deduction. If you do not have enough income for all of your benefits to be deducted, you may accrue premium deductions until you do have enough income or you may be placed on the Self-Pay program at the discretion of the Health & Benefits office.

Social Security Disability Approval & Medicare Enrollment

You are required to apply for Medicare Part A and Part B benefits if you are approved for disability for any occupation even if you have not reached age 65.

Sworn Park Police officers who were hired or rehired after March 31, 1986 can enroll in Medicare even if they are not eligible for Social Security benefits. Sworn Park Police officers hired before April 1, 1986, are not eligible for Social Security or Medicare benefits. These officers will not be required to enroll in Medicare and may remain in their currently enrolled medical plans.

Once you are approved for Social Security Disability Income, you will become eligible for Medicare benefits, 29 months after your initial disability date. In order to continue to be eligible for any Commission benefit plans after you are eligible for Medicare, you must enroll in both parts of Medicare (A & B). Medicare will become your primary coverage and Commission coverage will be secondary. You must provide the Health & Benefits Office with a copy of your Medicare card to confirm enrollment in Medicare.

INCOME REPLACEMENT PROGRAMS

If you are enrolled in the UnitedHealthcare Point-Of-Service (POS) plan, you will no longer be eligible for this plan. Instead, you must enroll in a Medicare Complement plan or the UnitedHealthcare Exclusive Provider Organization Plan (EPO) offered by the Commission. It is your responsibility to change your enrollment. If you do not change your plan enrollment, your claims will be rejected through the POS and you will be responsible for those claims.

In the event you are not granted Social Security Disability Insurance (SSDI) benefits but have fully cooperated with the LTD carrier in applying and appealing for SSDI benefits, you will be permitted to remain in the plan elected. If you have not fully cooperated with the LTD carrier in applying and appealing for SSDI benefits, when you are on LTD for 30 months, your benefits will end because you must be enrolled in Medicare by the 30th month of disability in order to continue benefits (some Park Police who are not eligible for Social Security and Medicare are exempt from this requirement).

COLA Adjustments

Cost-of-living adjustments (COLAs) are calculated on the LTD benefit that you are receiving. However, it does not apply to the maximum monthly benefit or the minimum \$100 monthly benefit.

ERS Service Accrues While You Are On LTD

While you are on LTD, the full months in which you were on LTD prior to your normal retirement date will be considered credited ERS service. Once an employee reaches his/her normal retirement date in the applicable ERS retirement plan, the employee is no longer eligible for free credited service. You will be able to receive credit for unused sick leave toward your ERS credited service.

Two-Year Benefit Limitation for Your Own Job

Your LTD benefits will continue for the first 24 months for your own job or occupation so long as you remain disabled. After 24 months, you must be unable to do any job based on education, training and experience, in order for LTD benefits to continue. Park Police must refer to their collective bargaining agreement.

Return to Work

The Commission will try to return employees to work as quickly as possible subject to medical clearance and job availability. Before you can return to work, you must be scheduled for the appropriate fitness for duty examinations, based on your disabling injury or illness. Any medical restrictions and their expected duration must be clearly stated in writing by your treating doctor before you can be returned to a job. Medical restrictions should be provided three to five business days prior to being released to return to work. The Health & Benefits Office will provide a form for your doctor to complete. If your own job is no longer available, you will be considered for other open available positions within the Commission. While every attempt will be made to find you another position within the Commission, the Commission does not guarantee you another position.

Accepting a Different Job While On LTD

If you are totally disabled from your own position and you are offered a position in another line of work, with or outside of the Commission for the first 12 months of your disability, LTD will coordinate their payments with what you earn at your new job. During the first 12 months you can collect up to 100% of your pre-disability pay between the LTD benefit and your earnings at your new job. After 12 months and before the 25th month, your benefit would be offset by 50% of your new job earnings and you would be allowed to earn up to 80% of your pre-disability earnings. No benefit is available beyond the 24th month of disability. All benefits are subject to Normal Retirement limitations for your employee class.

INCOME REPLACEMENT PROGRAMS

When Your LTD Benefits End

If you remain disabled after the end of the 24-month period for your own job, but you are able to do any other job, your LTD benefits end. If at the end of the 24-month period, you are unable to perform your job or any other job for which you are educated and trained to do, LTD benefits will continue until you are no longer totally disabled, but not to exceed the maximum period in the table below (depending on the age when your disability began).

If Your Disability Begins:	Your Benefits Will Continue Up to a Maximum of:
On or before age 62	Up to Age 65
Age 63	36 Months
Age 64	30 Months
Age 65	24 Months
Age 66	21 Months
Age 67	18 Months
Age 68	15 Months
Age 69+	12 Months

Impact on Employment and Healthcare Benefits

If you are unable to return to a Commission job for any reason, you will be terminated for disability reasons.

Your healthcare benefits will end and you will be offered COBRA continuation coverage. If you are eligible to retire when LTD ends, it is important for you to consider retirement in order to remain eligible for retiree health benefits. If you are no longer considered disabled by the LTD carrier and you notify the Health & Benefits Office of your intent to appeal, you may continue employment as an inactive employee, if you appeal within 180 days of your denial. Otherwise steps will be taken to terminate your employment.

Tax Information

If you are approved for LTD, the insurance carrier will withhold state and federal taxes if you request. Your monthly benefit will also be subject to any local taxes. At year-end you may receive several W2 forms including one from the LTD carrier. The Commission's portion of your premium (currently 80% for non-FOP employees) becomes the percentage of the monthly LTD benefit that is taxable to you. FOP members pay 100% of the LTD benefit premium and do not pay taxes on any portion of the benefit.

SUPPLEMENTAL LONG-TERM DISABILITY PLAN

If you earn less than \$108,000 annually, you will receive 66 2/3% of your salary under the basic LTD plan, or up to the maximum of \$6,000. If you earn more than \$108,000 annually, the Commission offers a voluntary supplemental LTD plan to eligible employees to cover 66 2/3% of their earnings in excess of \$108,000 up to \$216,000. The maximum benefit under the supplemental LTD plan is \$6,000/month. Employees pay 100% of the premium.

If you earn exactly \$216,000 annually, and enroll in the supplemental LTD plan, you will receive \$6,000/month under the basic LTD plan and an additional \$6,000/month under the supplemental LTD plan, for a total of \$12,000/month. If you earn between \$108,000 and \$216,000, your total benefit will be between \$6,000 and \$12,000/month.

INCOME REPLACEMENT PROGRAMS

Eligible new hires or eligible employees who exceed the \$108,000 annual salary threshold due to promotion, reclassification, merit increase, or COLA have 45 calendar days following hire date or change in base salary to enroll. Please contact the Health & Benefits Office to obtain enrollment forms and cost information. If an election form is not received in the Health & Benefits Office during the initial 45 days, an employee who later applies for this benefit will be required to submit medical information and be subject to underwriting approval.

Your Supplemental LTD benefits end in accordance with the same schedule for regular LTD benefits.

LTD Disclaimer

In the event of a discrepancy between this handbook and the LTD certificate issued by the carrier, the carrier's certificate will govern. For more information, please refer to the LTD certificate that can be found at www.mncppc.org.

SICK LEAVE BANK

The Sick Leave Bank (SLB) is a voluntary, short-term, income-replacement disability plan designed to provide income if you have exhausted all of your accrued leave (except for 80 hours of annual leave) and are unable to perform your job. It is designed to pay up to 80% your income when you need it most:

- In the event of your own serious illness (including pregnancy) – Income replaced for up to 688 work hours for full-time employees (344 hours for part-time employees)
- Illness of a family member – Income replaced for up to 160 work hours (80 hours for part-time employee), or
- Parental responsibilities (birth, adoption, foster care) - Income is replaced for up to 480 work hours (240 hours for part-time employees).

Eligibility

You may join the plan if you are a full-time or part-time career employee within 60 days of your date of hire or during the annual open enrollment period. You will not need to re-enroll every year.

The following employees are **not eligible** to enroll in the SLB Program:

- Employees who participate in the Municipal and County Government Employees' Organization (MCGEO) union's Sick Leave Donor Program. These employees may not participate in both the agency's and the MCGEO's programs at the same time.
- Employees represented by the Fraternal Order of Police (FOP), as they have their own SLB Program. Union members of FOP Lodge 30 are not eligible for the Sick Leave Bank.

When SLB Payments Begin

There is no waiting period for benefits to begin. You must actively at work on the last scheduled workday before taking time off.

INCOME REPLACEMENT PROGRAMS

Contributions Required for Membership

Employees must contribute the required hours of sick leave as designated each year for membership in the SLB. Typically, the requirement is 8 hours for full-time employees and 4 hours for part-time employees but is subject to change based on the balance of hours in the bank.

Advice to Pay

All requests for use of the Sick Leave Bank will be evaluated to determine if you are disabled from performing your job. You will be required to provide medical information to substantiate your claim. Additional detailed medical certification will be required if it is determined that you may exceed expected recovery time based on your injury/illness and the physical nature of your job. If you have not recertified your continuing illness before you have exhausted your SLB hours, you are not permitted to use SLB for the period of time that you did not provide timely medical certification.

If Your Doctor Charges for Completing Forms

You are responsible for all fees your doctor may charge for completing medical forms. You may want to schedule an extended office visit to allow the doctor to complete the forms during the office visit.

LTD Approval & Denial

If you are using the Sick Leave Bank (SLB) program, once you have been approved for LTD, your SLB benefits ends. If you are denied LTD, you are no longer considered eligible for SLB for that disability, since SLB is a short-term income replacement plan designed to cover you until you are either approved or denied for LTD. If you apply and are denied LTD, you may decide to appeal the decision. The Commission may extend your SLB while an appeal decision is rendered. If, however, the appeal decision is to uphold the denial your SLB may be reversed.

Workers' Compensation Approval & Denial

If you are denied Workers' Compensation and you are enrolled in the Sick Leave Bank, you may apply for Sick Leave Bank benefits. If you were approved for Workers' Compensation benefits and exhausted the 4 or 6 months of Commission Workers' Compensation Disability Leave, you are not eligible for Sick Leave Bank. If you were approved for Workers' Compensation benefit and are later denied benefits beyond a certain date, you are not eligible for Sick Leave Bank benefits; you must apply for Long Term Disability. As long as you have an approved worker's compensation claim SLB benefits are not available. For further details on this program, please refer to the Sick Leave Bank Administrative Procedure.

Donation of Unused Sick Leave to the Sick Leave Bank Upon Separation of Employment

Upon separation from employment, you may donate up to forty (40) hours of accrued sick leave to the Sick Leave Bank. The amount donated may not be reinstated if you return to a Merit System position at a later date.

If Your Claim Is Found to Be Non-compensable

If your supervisor filed a claim with the program administrator and a determination is made that your claim is not compensable, your services are covered up to the denial date.

INCOME REPLACEMENT PROGRAMS

SICK LEAVE DONOR PROGRAM

Participation by Non-Union Employees

Unused sick leave is not paid upon termination from employment. Unused sick leave is not paid upon termination. Employees may donate up to forty (40) hours of accrued sick leave to the Employees' Sick Leave Bank. These hours will not be reinstated if the employee returns to a Merit System position.

Employees must submit a request for sick leave bank donation to the Health & Benefits Office at least 14 days before their termination of employment/retirement.

Participation by Union Members (MCGEO AND FOP)

Both unions in the Commission offer a Sick Leave Donor Program. If you are a member of the Fraternal Order of Police (FOP) you may only join the union donor plan. If you are a member of the Municipal and Organization/United Food and Commercial Workers (MCGEO) union, you may choose whether to join the union's donor program or the Commission's Sick Leave Bank plan. MCGEO union members that join the Sick Leave Bank may not donate time to participants in the donor program except under special circumstances listed in the union contract.

For more details regarding these plans, please refer to the respective collective bargaining agreements.

LONG-TERM CARE



EMPLOYEE ASSISTANCE PROGRAM



EMPLOYEE ASSISTANCE PROGRAM

EMPLOYEE ASSISTANCE PROGRAM

What is an Employee Assistance Program?

The Employee Assistance Program (EAP) provides support, resources and information for personal and work-life issues. The services are provided in confidence at no charge to employees. It offers assessment, brief counseling and referrals to a wide variety of services including marital and family concerns, substance abuse issues, planning a wedding or vacation and eldercare. This service is available to the Commission's full-time and part-time employees as well as their household members.

With ComPsych Guidance Resources, the Commission's EAP provider, you have an important resource for virtually any type of problem that may be affecting your home or work life. The EAP is a personal and confidential counseling service designed to offer caring, professional help with a broad range of concerns, from routine challenges to serious issues. The primary goal of the EAP is to help employees and family members balance the demands of work and personal life.

How an EAP Works

You or your household members may call ComPsych 24 hours a day, seven days a week using the toll-free number 855-286-1678 for immediate assistance or to schedule an appointment.

You will reach an EAP consultant who specializes in employee assistance. The EAP toll free line provides access to a network of professional, licensed clinicians, 365 days a year. When you call, you can talk in complete confidence with a professional, experienced counselor. When appropriate, employees and family members receive a referral for in-person sessions with an EAP counselor conveniently located near their home or work. Employees and household members are eligible for up to eight (8) in person sessions per year per issue and unlimited telephone consultations.

During the initial phone call, the EAP specialist will work with you to determine which services you require to help you with your concerns. If a referral to a counselor is appropriate, you will be given the name of several local EAP counselors to contact in order to schedule an appointment. A person who calls for EAP services may not select the counselor even if the person is a prior participant in the EAP program and wants the same counselor as before.

While most clients call with routine requests, in rare instances an individual may experience a crisis. If this occurs, contact the EAP through the toll-free number and push the option for emergencies.

Who Pays for the EAP?

The Commission pays 100% of the cost of participation in the plan for you and your eligible dependents. If a referral is needed outside the EAP, and you decide to have additional care or treatment, the EAP counselor will make the referral and you will be responsible for the cost of any additional services. However, these costs may be covered by your medical plan.

Confidentiality

Use of the EAP is voluntary and confidential. No one at the Commission will know about your use of the EAP. While the EAP will provide the Commission with statistical information about how the program is being used, (for example, number of phone calls received) no information about an individual will be released. In other words, no one from the Commission will know which employees access the program. An EAP clinician may be required to break confidentiality and notify local authorities as required by law (for example cases involving child abuse).

EAP Services

The EAP has a proven record of helping employees and family members. Household members are encouraged to seek assistance even if they think the situation is not serious. You and your household members can receive up to eight (8) prepaid counseling sessions per issue per year.

Common referrals to the EAP include:

- Relationships
- Parenting and family
- Substance abuse (i.e.: alcohol & drugs)
- Depression
- Emotional problems
- Stress
- Work related issues
- Legal and financial issues
- Childcare and Eldercare Resource and Referral

EAP on the Internet

The EAP offers information through their website at www.guidanceresources.com . Individuals can explore their own issues or those of their family in an anonymous, confidential and secure manner 24 hours a day. Simply go to www.guidanceresources.com and enter the company access code: MNCPPC.

Childcare and Eldercare Resource and Referral

Balancing work and family life is increasingly difficult. The EAP will provide up-to-date, carefully screened, national resources and referrals for a range of childcare and eldercare needs including but not limited to:

- Home-Based Services: Nutrition, Meals on Wheels, Cleaning, Repair
- Transportation Services
- Before and After-School Programs
- Family Day Care Homes and Group Homes
- Emergency and Back-Up Care
- Nurseries and Preschools
- Nanny and Au Pair Services
- Summer Camps
- Adoption and Special Needs
- In-Home Care: Medical, Nursing
- Geriatric Specialists
- Rehabilitation Services
- Screening Clinics
- Older Adult Support Services: Adult Day Care, Volunteer Opportunities, Support/Advocacy Groups and Senior Citizen Centers

If you are interested in accessing this program, you will be asked questions regarding your needs. A counselor will conduct research to identify resources to fit the dependent's need, such as service providers. Whenever possible, you will be provided with names and telephone numbers of at least three available options, suitable for the dependent's age, and in locations and with hours of operation as convenient as possible for your family. These referrals will usually be provided within three working days after receiving your initial call.

EMPLOYEE ASSISTANCE PROGRAM

Legal Support and Resources

The EAP offers the following legal services as a part of your EAP plan:

- Unlimited telephone consultations without limit on the number of separate legal issues.
- Legal consultation – If you require legal representation, you will be referred to a qualified attorney for a free 30-minute consultation.
- Discounted rate (25%) if you choose to retain an attorney in the network.
- Quality assurance system – telephone follow-up to ensure satisfaction with services.

Financial Information and Resources

If you are facing a financial issue, the EAP can offer support and resources. Services include unlimited telephone access to Certified Public Accountants and Certified Financial Planners on a wide range of financial issues, including, but not limited to:

- Getting out of debt
- Credit card or loan problems
- Tax questions
- Retirement Planning
- Estate Planning
- Saving for College

EAP Recommended Medical Treatment

The EAP professional may refer you or your eligible family member to your doctor or to a psychiatrist or psychologist. When an EAP professional suggests a psychotherapist, your problems may take more time than you have available through your EAP benefit. The EAP counselor will make every effort to refer you to community resources, providers covered by your insurance, and other cost-conscious resources. You will be responsible for any fees for these services. Since the EAP is primarily for short-term issues, the counselor may not refer the employee to himself or herself once EAP sessions have been completed. The counselor must refer an employee to another provider for ongoing services.

Mandatory Management Referral

Occasionally a supervisor or manager makes a mandatory referral to the EAP to help an employee address issues or concerns impacting work performance or to address a personal issue. This referral may be a condition of continued employment however it does not automatically guarantee continued employment. After an employee signs a release of information, the EAP can provide the following information to the supervisor:

- If and when the appointment was made
- Whether the appointment was kept
- Whether you as the employee are compliant with the treatment plan or recommendations.

Critical Incidents

If you believe that an employee is a danger to him/herself or another employee or Commission patron, please contact the Department of Human Resource Management Employee Relations or Health & Benefits office for guidance.

EMPLOYEE ASSISTANCE PROGRAM

Administrative Leave for Appointments

Employees are eligible to participate in the program for up to eight (8) in person sessions per year per issue and unlimited telephone consultations. Upon approval of your supervisor, you will receive administrative leave during regular working hours*:

- Not more than two (2) hours per in-person visit with the EAP counselors. Includes time for 45 minute in-person meeting and travel;
- If visit is virtual, requiring no travel, one (1) hour of administrative leave is sufficient
- *If you want to keep your visits confidential you may choose not to use administrative leave.
- To receive administrative leave, you will be required to provide your supervisor documentation confirming the length of each visit with the EAP counselor. Bargaining unit members may have different provisions in their contract. When you contact the EAP provider for services, let them know that you will need proof of your visits. You will need to have the provider sign a form, available on line at www.mncppr.org/275 confirming your visit.

PREPAID LEGAL PLAN



PREPAID LEGAL PLANS
Prepaid Legal Plan

Two prepaid legal plans are available to eligible M-NCPPC employees and retirees, Legal Resources and U.S. Legal Services. Participants can get high quality advice, consultation and courtroom representation for commonly used legal services. This service may not be used for any Commission related lawsuits.

Benefit Eligibility

If you are a career or appointed employee, retiree or a Commissioner, you may enroll in this benefit. Both plans cover attorney’s fees at 100% for services including, but not limited to:

- Legal advice and consultations
- Will preparation
- Divorce (some limitations may apply)
- Adoptions
- Consumer Relations
- Landlord/tenant matters

These are just a few of the legal services offered. Many other services are included for your monthly fee (active employees pay this fee on a bi-weekly basis and retirees pay monthly). Other services are covered at a discount.

Once you enroll, you will be automatically re-enrolled each calendar year, unless you decide to terminate your coverage. You may terminate benefits only during open enrollment provided you have been covered for at least 12 months.

Plan Summary - deleted US Legal

Legal Resources
Who is covered.....
You, your spouse and your dependent children up to age 19, or up to age 23 if a full-time student. *Your parents will receive a 25% discount for services including advanced medical directives, power of attorney, estate advice/probate, living wills, will revisions, and housing and care.
Attorney Assignment...
You must select one participating firm for all of your legal needs.
Legal Consultation Services
Unlimited in-person or telephone advice and consultation for fully covered services.
Other Services
Offered at 25% discount.

If You Leave the Commission

You can continue the benefit after you retire or end employment with the Commission. Please contact the Health & Benefits Office for more information.

For more information contact:

- Legal Resources - www.legalresources.com (1-800-728-5768)

FAMILY SECURITY AND SURVIVOR BENEFITS



FAMILY SECURITY and SURVIVOR BENEFITS

What are Family Security and Survivor Benefits?

Family Security and Survivor benefits extend health coverage to your surviving dependents in the event of your death. When you die, your spouse and eligible dependents may continue the health plan coverage they had at the time of your death. The duration and cost of continued coverage depends on whether you were retired, or if active, whether you were or were not eligible to retire at the time of death.

The Family Security benefit provides free medical and prescription coverage for the six months following your death. Survivor Benefits provide coverage during your spouse's lifetime and for dependent children until they no longer meet the Commission's eligibility requirements. The following describes the benefits available for dependents depending on your status at the time of your death.

Active Employee Not Eligible to Retire

If you were actively employed and not eligible to retire at the time of your death, your dependents are eligible for the Family Security benefit. The Consolidated Omnibus Budget Reconciliation Act (COBRA) provides that your eligible dependents will be offered temporary continuing health coverage for up to 36 months following your death, provided they pay the required premiums, which is typically 102% of the full cost with no contributions from the employer. However, the Family Security benefit helps with the COBRA cost for the first 24 months.

Your covered dependents will have the following COBRA benefits:

- The first 6 months of medical and prescription coverage would be at no cost to the spouse and/or dependents. The Commission would pay 100% of the premium for benefits already elected. The spouse and/or dependents would be required to pay the current rates that active employees pay for dental and vision coverage if previously enrolled in these plans.
- The next 18 months of coverage would be paid at the same rates as active employees for medical, prescription, dental and vision coverage.
- After this period of 24 months, the cost for the next 12 months would be at the normal federally allowed COBRA percentage, which is currently 102% of the full premium.

In summary, your dependents are entitled to up to a total of 3 years of continuous COBRA coverage.

Benefits may be terminated if premiums are delinquent for more than 30 days. The Family Security benefit will end for each participant on the earlier of the following:

- Your surviving spouse reaches age 65 (becomes Medicare eligible) or
- Your spouse remarries or
- Dependents become ineligible through plan eligibility requirements
- At the end of the 24-month subsidized premium period

Active Employee Eligible to Retire

If you die before you retire and you are eligible to retire as of the date you die, your spouse and dependents are eligible to continue the benefits they were enrolled in at the time of your death. Dependent children are covered until they no longer meet the Commission's eligibility requirements. Upon your death, your spouse and dependents are considered as "Survivors".

Your covered surviving dependents will have the following Family Security and Survivor benefits:

- The first 6 months of medical and prescription coverage would be at no cost to the spouse and/or dependents. The Commission would pay 100% of the premium for benefits already elected.
- After this 6-month period, the spouse and/or dependents would be required to pay the current rates that retired employees pay for medical and prescription coverage

FAMILY SECURITY AND SURVIVOR BENEFITS

- The spouse and/or dependents would be required to pay the current rates that retired employees pay for dental and vision coverage if previously enrolled in these plans.
- If your surviving spouse is eligible for Medicare either by age or through a disability, your surviving spouse must enroll in Medicare to be eligible for the medical plan.

Retired Employee

- **Continuation of Healthcare Benefits**

If you are retired when you die, your spouse and/or dependents are eligible to continue those benefits elected at the time of your death at the same premium sharing percentage with the Commission as a retired employee.

- **Post Retirement Death Benefit**

Your designated beneficiary(ies) will receive \$10,000.

Spouse is Also Employee

If both you and your spouse work for the Commission and one of you dies, the survivor is eligible for family security and/or survivor benefits if the spousal healthcare benefits were obtained through the deceased employee.

Payment of Premiums

If eligible for continued healthcare benefits, your dependents may continue benefit premium payments through the Employee Retirement System retirement annuity. If you are not eligible for an annuity or the annuity amount is insufficient to cover the monthly premiums, payments must be made through the Commission's Self-Pay Program.

Future Plan Changes for Survivors & Dependent Eligibility

During each subsequent open enrollment, your spouse or dependents may make changes in the plan. However, no new dependents may be added. If a dependent is dropped, the dependent may not be added at a later open enrollment. If your spouse elects to discontinue coverage in any of the plans, your spouse may not re-enroll in those plans at a later open enrollment. For example, if your spouse has dental but decides to discontinue coverage, your spouse may not re-enroll in the dental plan during a later open enrollment.

When Survivor Health Benefits End

Survivor benefits will end for survivors of

- A retiree, or
- An active employee who was eligible to retire at the date of the employee's date of death,

When:

- A dependent becomes ineligible through plan eligibility requirements
- The survivor remarries
- The survivor (spouse or any eligible dependent child) dies
- The deceased employees and/or survivor's portion of the premiums are not paid timely
- The Commission makes any changes in benefit eligibility that limits or terminates any portion of or all benefits.

Your survivors are subject to any changes the Commission makes to premium co-pays, co-insurance structures, benefit plan design, and eligibility changes. Your survivor may not add any new dependents. The Family Security and Survivor benefit is subject to changes that may be made by the Commission in the future.

TUITION ASSISTANCE PROGRAM



TUITION ASSISTANCE PROGRAM

The Tuition Assistance Program is available to Merit System Career employee; both full-time and part-time. New hires must first successfully complete their probationary period. Tuition Assistance is on a semester/session basis and if approved is funded in the following order:

- Courses that enable you to perform more effectively in your present job are funded first;
- Courses that are for career development or different responsibilities within the Commission are funded second.

If and when funds are available, the maximum benefits per fiscal year are below:

- Full-time Merit System career employees may receive up to \$2,200 per fiscal year;
- Part-time Merit System career employees may receive up to \$1,100 per fiscal year.

Employees must abide by the following conditions:

- In general, courses must be taken during off duty hours. In certain instances, the Department Head or designee can grant administrative leave for course attendance during work hours;
- If an employee receives education benefits from the Veterans Administration or other governmental education benefits; the Commission will only pay the difference between such benefits and the total cost of the course(s) up to the fiscal maximum designated by the Commission;
- Employees must submit three (3) copies of the application to participate in the Tuition Assistance Program to their supervisor.

Employees will be notified of the approval/denial of the application by the Department Head or Designee in writing. For detailed information, please refer to Tuition Assistance Program Administrative Procedures No. 03-06 (Last Amended 9/20/2024). The application can be found at www.mncppc.org/275.

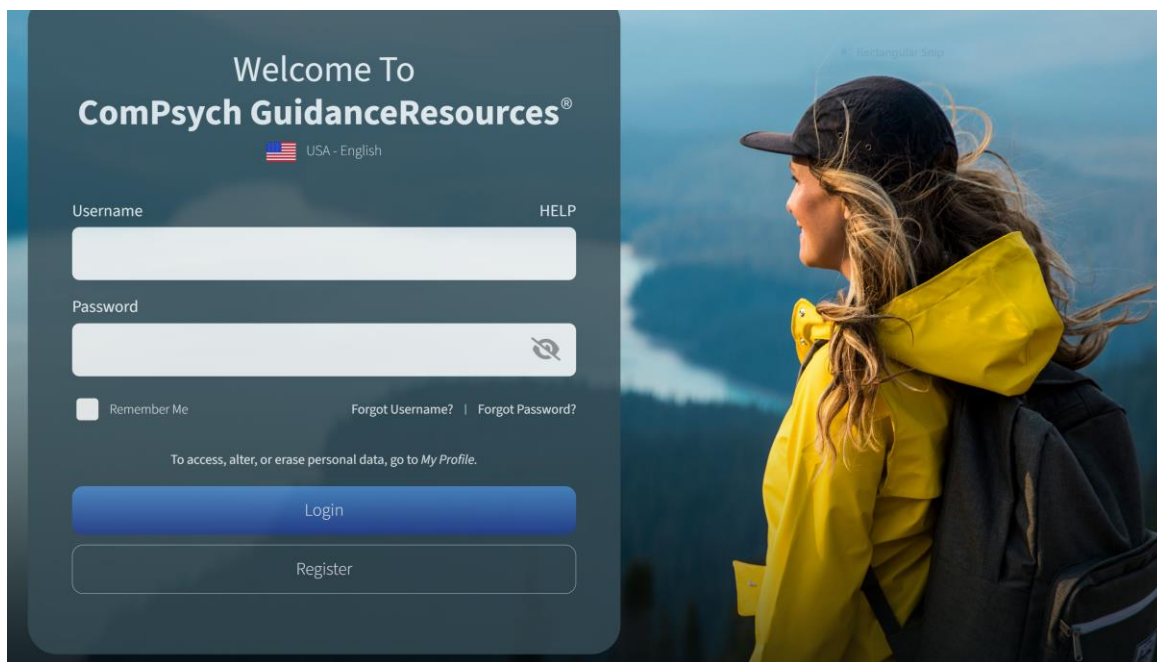
M-NCPPC WORKPLACE WELLNESS PROGRAM



M-NCPPC WORKPLACE WELLNESS PROGRAM

M-NCPPC WORKPLACE WELLNESS PROGRAM

The mission of the Commission's Wellness Program is to empower employees to take advantage of tools, opportunities, and resources provided in the workplace to enhance their well-being. This mission is carried out through wellness activities sponsored by the Commission's Employee Health and Wellness Committee. Activities include 'lunch and learn' seminars, health screenings, aerobics, weight loss programs, free annual flu shot clinic, walking groups and an annual Employee Health & Fitness Week. Some activities require a nominal fee however the majority of them are free. You are welcome to participate in any offered activities. If an activity requires your supervisor's approval to leave your work site, you are responsible for obtaining the approval. Administrative leave is generally given for most activities. Sometimes employees must use their own leave.



- Go to www.guidanceresources.com.
- Enter our Web ID: MNCPPC.
- Register your user name and password and log in.
- **Navigate Your Workplace Wellness Program.** You are in the driver's seat.
 - Research Wellness Topics such as Fitness & Nutrition, Personal Safety, Stress Management and Personal Growth.
 - Check out Wellness Life Events including Eating Better and Developing Positive Habits.
 - Sign up for Telephonic or Online Coaching to help you attain and maintain a healthy lifestyle.
 - Find a Lawyer, Certified Financial Planner, Child Care or Elder Care Provider.
 - Check out discounts and offers to save you money on entertainment events and online shopping, Petco products for your pet or a USA Today print subscription.
 - You may also call and speak to a guidance counselor at 855-286-1678.

M-NCPPC WORKPLACE WELLNESS PROGRAM

Work Well. Do Well. Live Well. Take part in the M-NCPPC Workplace Wellness Program.

- **Annual Wellness Incentive** - Complete preventive screenings, exams, and participate in wellbeing offerings and earn up to \$300 each year. Record and track your progress online.



M-NCPPC Employee Health & Fitness Week

The month of May is designated as National Employee Health & Fitness Month. This is an international and national observance of health and fitness in the workplace, created by two non-profit organizations, the National Association for Health and Fitness, and ACTIVE Life. Employers and employees all over the world implement and participate in healthy activities conveniently at the workplace and within their communities. The goal is to raise awareness about the important role physical activity plays in maintaining good health. Most of us recognize that there are great benefits to being physically active.

In recognition of National Employee Health and Fitness Month, the Commission designates one week in May as Employee Health and Fitness Week. During this week, the Workplace Wellness Program partners with the Parks and Recreation Department to host various activities. With supervisor's approval employees (Merit/Career/Term-Contract) are granted up to 10 (ten) hours of administrative leave to participate in sponsored health and fitness activities held at various M-NCPPC locations throughout Prince George's County and Montgomery County, plus up to 4 (four) hours of administrative leave to donate blood at the Blood Drive. Seasonal/Intermittent employees may participate with supervisor's approval. A sample week includes:

- Bike/Run/Walk Day: biking/running/walking, reflexology, and urban line dancing
- Great Outdoors/Water Day: archery, biking, pickleball, fishing, paddle boating, pontoon boat rides, canoeing/kayaking, self-guided nature walks, skate mobile and tree planting
- Blood Drive Day
- Mind, Body & Soul Day: get fit mobile, arts and crafts, yoga, dog walking, drum circle, healthy cooking, meditation, pick-up basketball, quick start tennis, self-guided walk or run
- Inner-Divisional Competition Day and Vendor Fair: brain games, health screenings, massages, swimming, and Olympic-style games

Look out for the Health & Fitness Week announcement in April. Come and join us! There is something for everyone, including fun.



M-NCPPC Passport to Wellness

The M-NCPPC Passport for Wellness is an employee fitness initiative for career employees. The passport provides access to fitness rooms, adult drop-in gym time and aquatic facilities (pools only), at various M-NCPPC Prince George's County sites. Pools are available at the Sports and Learning Complex and the Fairland Sports and Aquatics Complex and Southern Regional Technology and Recreation Complex.

Go to or call 301-699-2255 if you have any questions.

M-NCPPC WORKPLACE WELLNESS PROGRAM

For up to date information on M-NCPPC wellness information, resources and activities, visit:

[M-NCPPC Workplace Wellbeing SharePoint Website](#) or Scan QR Code Below!



Government Regulated Benefits and Required Notices



GOVERNMENT REGULATED BENEFITS AND REQUIRED NOTICES

FAMILY MEDICAL LEAVE ACT

There may be times when you will need time off for medical reasons or to care for a family member who needs help with medical care. The Family Medical Leave Act (FMLA) is a federal program that provides eligible employees with up to 12 workweeks of unpaid leave during a 12-month rolling “look back” period for FMLA approved situations. The 12-month period is measured backward from the date of the employee’s most recent FMLA leave request.

Who Is Eligible

You are eligible if you have:

- worked at the Commission for at least 12 months;
- worked for at least 1,250 hours during the 12 months immediately preceding the start of the FML and;
- you have not used your full 12-week FML entitlement in the previous 12 months.

Reasons for Taking Leave

You are entitled to family and medical leave for one of the following reasons:

- Your child’s birth and care for your newborn;
- To bond with a child (leave must be taken within 1 year of the child’s birth or placement);
- Placement of a child for adoption or foster care with your family;
- To care for a spouse, child or parent with a serious health condition;
- A serious health condition that makes you unable to perform the essential functions of your job;
- Qualifying exigency for a military service person;
- To care for a sick or injured military service person.

Note: A child is defined as being 18 years of age and under or can be over 18 years of age if incapacitated due to a mental or physical disability.

Serious Health Condition

You may take leave to care for a dependent’s or your own serious health condition. The FMLA defines serious health condition as an illness, injury, impairment, or physical or mental condition that involves:

- Inpatient care in a hospital, hospice, or residential medical care facility; or
- Continuing treatment by a health care provider. Continuing treatment involves:
 - Treatment two or more times by a health care provider, by a nurse or physician’s assistant under direct supervision of a health care provider, or by a provider of health care services under orders of, or on referral by a health care provider; or
 - Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider.

Your Benefits During Your Leave

While you are on leave, the Commission will continue your elected benefits at the same level and cost as if you had continued to work. If you terminate employment after your full use of FML, you will be entitled to 15 additional months of COBRA coverage for a total of 18 months of leave and continuation coverage. You are responsible for paying any health care premiums through the Commission’s self-pay program.

GOVERNMENT REGULATED BENEFITS AND REQUIRED NOTICES

Eligibility for FMLA-LWOP, Depending on Type of Qualifying FMLA Event

Types of FMLA Qualifying Events	Sick Leave	Compensatory Leave	Annual Leave	Personal Leave
Employee's Own Illness/Injury	Must exhaust all hours ¹	Must exhaust all hours ²	May use hours ³	May use hours ⁴
Illness/Injury of a Family Member, as defined in Merit Rules § 1470.1	Must use up to 480 hours, when available ⁵	Must exhaust all hours ⁶	Must exhaust all hours ⁷	May use hours
Parental Responsibilities (Birth, Adoption, Foster)	Must use up to 240 hours, when available ⁸ (480 hours maximum) ⁹	Must use up to 240 hours, when available ¹⁰	May use hours	May use hours
Care or Comfort of a Military Service Member	No ¹¹	May use hours ¹²	May use hours ¹³	May use hours

¹ See: Merit Rules, § 1642.3.

² *Id.*

³ *Id.*, at § 1624.1

⁴ *Id.*

⁵ *Id.*, at § 1642.2.

⁶ *Id.*

⁷ *Id.*

⁸ *Id.*, at § 1633(2)(a).

⁹ *Id.*, at § 1470(3)(b).

¹⁰ *Id.*, at § 1633(2)(a).

¹¹ *Id.*, at §§ 1470.2 and 1470.3

¹² *Id.*, at § 1621.5, *et seq.*; see also: § 1624.

¹³ *Id.*

You will be required to use your sick leave and compensatory leave for your illness toward your FMLA leave (except where parental leave is a maximum of 240 hours). You may use up to 80 hours (10 days) of your sick leave for the illness of an eligible family member. In the above chart, the word exhaust means you **must** exhaust all designated leave before unpaid leave may be used. See Merit Rules 1633 and 1642.

If you and your spouse are both employed by the Commission, the total number of weeks to which both of you are entitled for birth, placement for adoption or foster care, or illness of a parent (not an in-law) is limited to 12 weeks during the calendar year.

Leave on an Intermittent or Reduced Schedule Basis

Leave taken because of your own serious health condition, or your child's, spouse's, or parent's, may be taken on a reduced or intermittent schedule when medically necessary. The Commission may require you to transfer temporarily to an alternative available position with equivalent pay and benefits that better accommodates recurring periods of leave. You may use up to 480 hours as your 12-week allotment.

When you return from your leave, you will be able to return to your same job or a job with equivalent status, pay, benefits, and other employment terms, provided you are able to perform the essential functions of the job. You must furnish the Commission with a certification from your health care provider stating you are able to resume work. If you do not return from leave, you must repay the Commission for health insurance

GOVERNMENT REGULATED BENEFITS AND REQUIRED NOTICES

premiums that the Commission paid to maintain your coverage while you were on leave, unless your failure to return from leave is due to the continuation, recurrence, or onset of your own serious health condition or other circumstances beyond your control.

Extended FMLA Leave for Military Personnel

Family members of military personnel can take up to 26 weeks of unpaid leave, in a single 12-month period, to care for service members suffering from serious injury or illness. The law also entitles an eligible employee who is the spouse, son, daughter, or parent of a service member who is on active duty (or has been notified that he or she will be called to active duty in the near future) to 12 weeks of FMLA leave. This leave would be available in cases of any “qualifying exigency.” For more information, please refer to the Commission’s FMLA packet.

How to Apply for Benefits

You are required to provide 30 days notice that you are requesting family leave when the need for leave is foreseeable. If your circumstances do not allow 30-day notice, you must provide notice as soon as practicable. Your request for leave should be made on the appropriate application form and directed to your Department Head. FMLA packets which include a summary of the Act, directions for applying, and forms are available through the Health & Benefits Office and the Commission’s internet site. After receipt, you will usually be notified within two business days whether your leave qualifies as FMLA leave.

If your leave is for a serious health condition of yours or a parent, spouse, or child you will also be required to provide a Medical Certification Form. Re-certification of a serious medical condition will be required every 30 calendar days, if you are using any kind of paid leave. You will also be required to report periodically to your department regarding the status of the medical condition and your intent to return to work. Exceptions may be considered on a case-by-case basis; however, leave may be denied if the above conditions are not met.

NOTE: FMLA forms can be found at www.mncppc.org/275

Health Insurance Portability and Accountability Act

HIPAA NOTICE

An Important Notice About Your Privacy

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health plans protect the confidentiality of your private health information. The Plan uses health information about you and your covered dependents only for the purposes of providing treatment, paying claims, and related functions. To protect the privacy of health information, access to your health information is limited to such purposes. In addition, effective April 14, 2003, the Plan complies with the applicable health information privacy requirements of federal regulations issued by the Department of Health and Human Services. The Plan's privacy policies are described in more detail in the Plan's privacy notice. You may contact the Commission's Health & Benefits Office if you would like to receive another copy of the HIPAA notice.

An Important Notice About ePHI Security

Each plan will operate in accordance with the HIPAA security law and regulations as set forth in 45 CFR Parts 160 and 164, and as they may be amended (collectively, "HIPAA"), and with respect to electronic protected health information ("ePHI") as that term is defined therein. The Plan Administrator and/or his or her designee retain full discretion in interpreting these rules and applying them to specific situation. All such decisions shall be given full deference unless the decision is determined to be arbitrary and capricious.

An Important Notice About ePHI Security

As a condition of the Commission possibly receiving ePHI from each plan, the Commission has agreed to:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of each plan;
- Ensure that the adequate separation between each plan and the Commission, required by the applicable section(s) of the Plan relating to the sharing of PHI with the Commission, is supported by reasonable and appropriate security measures;
- Ensure that any agent, including a subcontractor, to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect the information; and
- Report to each plan any security incident of which it becomes aware.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY.

BACKGROUND: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires health plans to notify plan participants and beneficiaries about its policies and practices to protect the confidentiality of their health information. This document is intended to satisfy HIPAA's notice requirement with respect to all health information created, received or maintained by M-NCPPC's group health plan (the Plan) as sponsored by M-NCPPC (the Company).

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M-NCPPC's Pledge Regarding Health Information Privacy

The privacy policy and practices of the Plan protects confidential health information that identifies you or could be used to identify you and relates to a physical or mental health condition or the payment of your health care expenses. This individually identifiable health information is known as "protected health information" (PHI). Your PHI will not be used or disclosed without written authorization from you, except as described in this notice or as otherwise permitted by federal and state health information privacy laws.

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information;
- Give you this notice of our legal duties and privacy practices regarding health information about you;
- Follow the terms of our notice that is currently in effect.

For Treatment. The Plan may disclose your PHI to a health care provider who renders treatment on your behalf. For example, the Plan may disclose -PHI to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. The Plan may use and disclose PHI so that -claims for health care treatment, services and supplies you receive from health care providers may be paid according to the Plan's terms. For example, the Plan may receive and maintain information about a surgery you received to enable the Plan to process a hospital's claims for reimbursement of surgical expenses incurred on your behalf.

For Health Care Operations. The Plan may use and disclose your PHI to enable it to operate, operate more efficiently or make certain all of the Plan's participants receive their health benefits. For example, the Plan may use your PHI for case management or to perform population-based studies designed to reduce health care costs. In addition, the Plan may use or disclose your PHI to conduct compliance reviews, audits, actuarial studies and/or for fraud and abuse detection. The Plan may also combine health information about many Plan participants and disclose it to M-NCPPC in summary fashion so it can decide what coverage the Plan should provide. The Plan may remove information that identifies you from health information disclosed to M-NCPPC so it may be used without M-NCPPC learning who the specific participants are.

For Administrative Duties. The Plan may disclose your PHI to designated M-NCPPC personnel so that they can carry out their Plan-related administrative functions, including the uses and disclosures described in this notice. Such disclosures will be made only to M-NCPPC's Plan Administrator and/or designated members of M-NCPPC's Health and Benefits Department. These individuals will protect the privacy of your health information and ensure it is used only as described in this notice or as permitted by law. Unless authorized by you in writing, your health information: (1) may not be disclosed by the Plan to any other M-NCPPC employee or department and (2) will not be used by M-NCPPC for any employment-related actions and decisions or in connection with any other employee benefit plan sponsored by M-NCPPC.

GOVERNMENT REGULATED BENEFITS AND REQUIRED NOTICES

To a Business Associate. Certain services are provided to the Plan by third-party administrators known as “business associates”. For example, the Plan may input information about your health care treatment into an electronic claims processing system maintained by the Plan’s business associate so that your claim may be paid. In doing so, the Plan will disclose your PHI to its business associate so it can perform its claims payment function. However, the Plan will require its business associates, through contract, to appropriately safeguard your health information.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. The Plan may use and disclose PHI to contact you to remind you that you have an appointment with us. The Plan also may use and disclose PHI to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, The Plan may share PHI with a person who is involved in your medical care or payment for your care, such as your family or a close friend. The Plan also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, the Plan may use and disclose PHI for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before the Plan uses or discloses PHI for research, the project will go through a special approval process. Even without special approval, the Plan may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any PHI.

SPECIAL USE and DISCLOSURE SITUATIONS:

As Required by Law. The Plan will disclose your PHI when required to do so by international, federal, state or local law, including those that require the reporting of certain types of wounds or physical injuries.

To Avert a Serious Threat to Health or Safety. The Plan may use and disclose PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Organ and Tissue Donation. If you are an organ donor, the Plan may use or release PHI to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, the Plan may release PHI as required by military command authorities. The Plan also may release PHI to the appropriate foreign military authority if you are a member of a foreign military.

Workers’ Compensation. The Plan may disclose your PHI to the extent authorized by, and to the extent necessary to comply with Worker’s Compensation laws and other similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. The Plan may disclose PHI for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. The Plan will only make this disclosure if you agree or when required or authorized by law.

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Health Oversight Activities. The Plan may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. The Plan may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, the Plan may disclose PHI in response to a court or administrative order. The Plan also may disclose PHI in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. The Plan may release PHI if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. The Plan may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Plan also may release PHI to funeral directors as necessary for their duties.

National Security and Intelligence Activities. The Plan may release PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others. The Plan may disclose PHI to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plan may release PHI to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO AGREE OR OBJECT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, the Plan may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, the Plan may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. The Plan may disclose your PHI to disaster relief organizations that seek your PHI to coordinate your care or notify family and friends of your location or condition in a disaster. The Plan will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

GOVERNMENT REGULATED BENEFITS AND REQUIRED NOTICES

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your PHI will be made only with your written authorization:

1. Uses and disclosures of PHI for marketing purposes; and
2. Disclosures that constitute a sale of your PHI

Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose PHI under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding PHI we have about you:

Right to Inspect and Copy. You have a right to inspect and copy PHI that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this PHI, you must make your request, in writing, to:

William Spencer, Privacy Officer
Department of Human Resources and Management
6611 Kenilworth Avenue, Suite 404
Riverdale, MD 20737

The Plan has up to 30 days to make your PHI available to you and may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. The Plan may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. The Plan may deny your request in certain limited circumstances. If the Plan does deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and the Plan will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your PHI is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. The Plan will make every effort to provide access to your PHI in the form or format you request, if it is readily producible in such form or format. If the PHI is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. The Plan may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured PHI.

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Right to Amend. If you feel that the PHI we have is incorrect or incomplete, you may ask the Plan to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to:

Jennifer McDonald
The Maryland-National Capital Park and Planning Commission
Department of Human Resources and Management
6611 Kenilworth Avenue, Suite 404
Riverdale, MD 20737

To request an amendment, you must provide the reason(s) to support your request. The Plan may deny your request if you ask the Plan to amend health information that was accurate and complete; not created by the Plan; not part of the health information kept by or for the Plan; or not information that you would be permitted to inspect and copy.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of PHI for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to:

Jennifer McDonald
The Maryland-National Capital Park and Planning Commission
Department of Human Resources and Management
6611 Kenilworth Avenue, Suite 404
Riverdale, MD 20737

Your request must state a time period, which may not be longer than six years prior to the date the accounting was requested.

Right to Request Restrictions. You have the right to request a restriction or limitation on the PHI we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the PHI we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to:

Jennifer McDonald
The Maryland-National Capital Park and Planning Commission
Department of Human Resources and Management
6611 Kenilworth Avenue, Suite 404
Riverdale, MD 20737

You must advise: (1) what information you want to limit; (2) whether you want to limit the Plan's use, disclosure or both; and (3) to whom you want the limit(s) to apply.

The Plan is not required to agree to your request unless you are asking the Plan to restrict the use and disclosure of your PHI to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If the Plan agrees, we will comply with your request unless the information is needed to provide you with emergency treatment.

GOVERNMENT REGULATED BENEFITS AND REQUIRED NOTICES

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your PHI with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that the Plan communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that the Plan only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to:

Jennifer McDonald
The Maryland-National Capital Park and Planning Commission
Department of Human Resources and Management
6611 Kenilworth Avenue, Suite 404
Riverdale, MD 20737

Your request must specify how or where you wish to be contacted. The Plan will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

To obtain a paper copy of this notice, you may email Jennifer McDonald at jennifer.mcdonald@mncppc.org.

CHANGES TO THIS NOTICE:

The Plan reserves the right to change this notice and make the new notice apply to PHI we already have as well as any information we receive in the future. The Plan will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the privacy officer in writing by contacting:

William Spencer, Privacy Officer
Department of Human Resources and Management
6611 Kenilworth Avenue, Suite 404
Riverdale, MD 20737

All complaints must be made in writing. You will not be penalized for filing a complaint.

GOVERNMENT REGULATED BENEFITS AND REQUIRED NOTICES

Health Benefits While On Military Duty (USERRA)

The federal Uniformed Services Employment and Reemployment Act of 1994 provides certain rights and responsibilities to employees who are called to service in the Uniformed Services. For Uniformed Service of less than 30 days, you may not be required to pay more than the employee's share of coverage you have elected. For Uniformed Service of more than 30 days, the Commission has the right to charge you up to the normal COBRA percentage of 102% of the monthly premium. If you and/or your dependents elect COBRA, your right to coverage ends on the day after the deadline for you to apply for re-employment or 24 months after your absence from the Commission, whichever comes first. The Human Resources Director will, however, evaluate individual circumstances regarding the tour of duty to determine what portion of the monthly premium may become the Commission's responsibility.

When you are reinstated upon successful completion of military service with an honorable discharge from military service, no waiting period may be imposed that would not have been imposed had you not taken military leave. No new waiting periods or exclusions for pre-existing conditions may be imposed except that coverage for military service-related medical conditions will be excluded. Your benefits will become active on the first day you are actively at work. Your return to Commission employment is based on the following chart for eligible USERRA service:

Length of Military Service	Reemployment Deadline
Less than 31 days	1 day after discharge (allowing 8 hours for travel)
31 through 180 days	14 days after discharge
More than 180 days	90 days after discharge

You must notify the Health & Benefits Office within 45 days of return from active military status in order to re-enroll. Otherwise, you must wait until the next open enrollment to enroll for the following plan year. Upon your return, in order to continue to be eligible for the Commission's health benefits you are required to provide a copy of your military medical release form that indicates your medical condition upon your discharge from the service.

Depending on your tour of duty, you may also be eligible for supplemental pay as provided for in the Merit Rules Section 1255, 1538.1, 1538.2, 1621.5, and 1627. After the first 30 days of absence, the Commission pay is coordinated with military pay. Monthly payments will be made upon Commission receipt of copies of the employee's military leave and earnings statements. The Commission will attempt to collect medical premiums from the wages. Should the Commission wages be insufficient to pay the benefit premiums, you must pay premiums through the Commission's Self-Pay program, to maintain the benefits. Please contact the Health & Benefits Office for further information.

For more information on USERRA you may go to www.dol.gov/vets/programs/userra/poster.pdf.

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Reasonable Accommodation- Americans with Disabilities Act

If you are a qualified individual with a disability as defined and amended by the Americans with Disabilities Act (Amendment Act ADAAA), as long as you can be reasonably accommodated, you can work and your benefits will continue.

If you believe that you can continue to do your essential job duties with accommodation, you may contact the Recruitment Office for a packet that will be sent to your supervisor/manager. Information is required from you, your treating doctor and your supervisor/manager. Some questions that you are required to answer include:

- Describe your impairment
- What activities does the impairment limit
- To what extent does the impairment(s) limit your ability to perform the activity or activities
- Are there certain conditions under which you can do the activities you have listed
- What job duties are you unable to perform
- What accommodations would you recommend so you may continue to work or return to work and perform the essential functions of your job?

If you are unable to perform the essential duties of your job and you are on any of the following income replacement plans, medical benefits continue as long as you continue to pay your portion of the premiums:

- Sick leave
- Annual leave
- Sick leave bank
- Long-term disability (LTD) – (self-pay program for medical premiums)

GOVERNMENT REGULATED BENEFITS AND REQUIRED NOTICES

COBRA - Continuing Coverage for Health Benefits

The Consolidated Omnibus Budget Reconciliation Act (COBRA) provides that you and your eligible dependents will be offered temporary continuing medical coverage when you terminate your employment with the Commission. Your coverage ends on the last day of the month when you leave the Commission. You and your dependents may be eligible to continue coverage under COBRA for a specified period of time. Your dependents may be eligible for COBRA coverage for reasons such as divorce or your death. You will be responsible for making monthly payments for the full costs of coverage plus a small administrative fee, for a total of 102% of the normal total monthly premium. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the law. (Both you and your spouse should take the time to read this notice carefully.)

- You and/or your dependents may elect to continue coverage for 18 months if you have terminated employment with the Commission or have had a reduction in hours;
- You and/or your dependents may elect to continue coverage for up to 29 months if you lose coverage because of a disability, as defined by Social Security. In this case, you pay the full cost of coverage plus a higher premium. Your disability must have begun at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must present a copy of your Social Security Disability letter to the Health & Benefits Office during the 18-month continuation period. If you fail to do so, you will not be eligible for the additional months.
- In general, a dependent is eligible for COBRA if covered under a group health plan on the day before the event that causes a loss of coverage (such as a termination of employment, or a divorce from or death of the covered employee). There is an exception for newborns and adoptions. A child born to an employee while covered under COBRA or adopted/placed for adoption with the covered employee, will also be eligible for coverage during the COBRA continuation period.

Your enrolled dependents may elect continued coverage for up to 36 months if they lose coverage due to any of the following qualifying events:

- Your death as an employee or as a COBRA participant,
- A divorce or legal separation,
- Your child no longer qualifies as a dependent, or
- You become eligible for Medicare (under Part A, Part B, or both) less than 18 months before you end employment or incur a reduction in hours of employment

For example, if you become entitled to Medicare 8 months before the date on which you terminate employment, COBRA continuation coverage for your spouse and children can last up to 28 months after the date of your Medicare entitlement (36 months less 8 months).

If you go on a non-medical leave of absence and do not return to work, but instead elect a voluntary termination, your qualifying event will be considered to be the end of the month following the date of your leave of absence in counting toward your continuation coverage.

If you or your dependents become eligible for continuation of healthcare coverage, Benefit Strategies, the Commission's third-party administrator for the COBRA program, will provide information about the cost of coverage and payment method. Continued coverage must be elected within 60 days of either the qualifying event or the date of the continuation notice, whichever is later. If the employee or dependent waives COBRA coverage but revokes the waiver within the 60-day election period, coverage begins from the day the waiver

GOVERNMENT REGULATED BENEFITS AND REQUIRED NOTICES

is revoked - not from the date of the qualifying event. If you decide to continue coverage, 45 days will be allowed from the election date to pay back premiums. Your first payment, including any back payments, must be received within 45 days from the date you signed the election form.

You or your covered dependents must contact the Heath & Benefits Office in writing within 60 days of the qualifying event if your dependents lose coverage because you become legally separated or divorced, or a child ceases to qualify for dependent coverage. You or your covered dependents must pay the full cost of coverage, as well as the administrative cost. If you or your dependents do not notify the Health & Benefit Office in writing and complete the appropriate paperwork within 60 days, you and/or your dependents waive the right to continuation coverage.

Continued coverage will stop before it is scheduled to end if:

- You or your dependents become covered under another group plan without a pre-existing condition clause or become enrolled in Medicare;
- The required premiums are not paid before the end of the 30-day grace period. A COBRA premium payment is "made" on the date it is sent. Since checks are generally mailed, the postmark date will be the date sent;
- The Commission no longer provides health care coverage for its employees;
- You extended coverage for up to 29 months due to your disability and there has been a final determination that you are no longer disabled;
- You stop payment on a check regardless of the reason and do not replace the amount due before the end of the 30-day grace period.

Payment of COBRA Premiums

The Commission has contracted with a third-party vendor, Benefit Strategies, to administer our COBRA program. If your coverage is terminated due to late or no payment, as with active employees, your coverage will be retroactively terminated back to the end of the month in which the last payment was made, received and accepted. If you stop payment on a check or a check bounces, you may be required to make future payments with a money order or bank check. A request to delay deposit of a payment may not be made. All payments will be deposited on the date received or the following business day. If you have a bad check or stopped payment on a check or other form of payment, your subsequent payments will apply to the earliest outstanding premiums.

Newborns' and Mothers' Health Protection Act of 1996

This law includes important protection for mothers and their newborn children with regard to the length of hospital stays following the birth of a child. The law stipulates that “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 48 hours (or 96 hours as applicable). In any case, plans and issuers may not under Federal law require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay less than 48 hours (or 96 hours).

Women's Health and Cancer Rights Act of 1998

This law requires group health plans that provide coverage for medically necessary mastectomies to also provide coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to provide a symmetrical appearance; and
- Protheses and the treatment of physical complications during all stages of the mastectomy.

The Commission's plans cover mastectomies and the benefits required by this act. If you would like more information on WHCRA benefits, call the Health & Benefits Office at 301-454-1694.

RETIREMENT PLANNING



RETIREMENT PLANNING

Retiree Health Coverage

Benefit Eligibility

If you are eligible to retire on the date you terminate from the Commission (including an early or reduced benefit) and you or your survivor begins to receive a retirement annuity immediately following active Commission employment, you are eligible for retiree healthcare coverage if you meet the 36-month rule (see below). Once you retire, when you reach age 65, you must enroll in parts A and B of Medicare in order to remain eligible for the Commission's benefits in which you are enrolled.

Available Benefits during Retirement

You may elect any benefits listed for retirees in the Benefit Eligibility Chart found under General Employee Benefit Information earlier in this Handbook, provided you meet the 36-month rule. During open enrollment, you may make changes to your benefit elections. However, if you drop the medical, dental, prescription, and/or vision plans, you may not later re-enroll unless you show proof of coverage with a similar plan during the time you were not covered under the Commission's plan. See Opt-in/opt-out provisions discussed later in this section.

36-Month Rule for Retiree Coverage

To be eligible for retiree health benefits (medical, dental, prescription, and vision), an employee and eligible dependents must provide proof of qualifying prior coverage for **each** plan elected. Qualifying prior coverage is 36 months of continuous coverage in a Commission or other insured plan immediately prior to retirement with the Commission. You as the employee are eligible as a dependent on your spouse's plan under this rule. You do not need to be in the same health plan for the entire 36-month period. You must show proof of continuous health insurance coverage and similar benefits during the period of coverage with another carrier. Benefits including deductibles and out-of-pocket maximums must be similar.

Many medical plans offer discounted plan features such as dental and vision or may have bundled prescription drug plans. Discounted dental and vision features do not qualify as comprehensive health plans and will not be considered as qualifying coverage under the 36-Month Rule.

The 36-Month Rule does not apply to the prepaid legal plan, which is 100% retiree funded.

Dependent Eligibility

Your eligible dependents are eligible for the same plans that you are, provided they meet the 36-month rule for each benefit. This 36-month evaluation of your dependents must occur at the time that you retire. You must provide satisfactory documentation of your dependent's coverage according to the 36-month rule. However, you may not enroll a dependent in any plan in which you are not also enrolled. If your spouse is still working, he/she may defer enrollment in the Commission plans until he/she stops working. This becomes a qualifying event to enroll your spouse in your elected plans when he/she retires. You and any Medicare eligible dependent must be enrolled in both parts of Medicare (A and B) in order to be eligible for Commission health benefits. Dependent children are subject to all regular dependent eligibility requirements. If your spouse or other dependents become eligible for other coverage including Medicare, you must notify the Health & Benefits Office within 45 days of the initial coverage effective date.

Dependent Coverage

Following your retirement, changes may be made to your benefits during each subsequent open enrollment. However, after you retire, new dependents are not eligible for coverage under the medical, dental, prescription or vision plans. You may not add a new spouse if you marry or re-marry after retirement. Newborn, adopted children and children for whom you obtain legal custody after you retire, also are not eligible to be covered under your plan.

Only those dependents that were evaluated for eligibility at the time you retired are eligible for coverage. For example, your spouse may have similar coverage under another plan at the time you retire. As long as you have had the Health & Benefits Office analyze your spouse's eligibility under the 36 Month Rule **at the time you retire** and your spouse is determined to be eligible, then you may add your spouse after you retire, provided he/she can provide proof of continuous coverage and similar benefits during the period of coverage with another carrier. A HIPAA certificate will generally be considered acceptable for proof of coverage. This certificate can be requested from the other plan administrator. If the Health & Benefits Office does not already have a copy, you must provide a copy of your marriage certificate, your spouse's birth certificate and your spouse's Social Security card.

Delayed Enrollment

The employee and all dependents must be qualified for retiree coverage in each plan, **at the time the employee retires**, regardless of whether the employee and/or dependent(s) will initially be enrolled or defer enrollment because they are enrolled in the spouse's plan. If the employee defers enrollment for himself or herself and spouse, then later decides to enroll, proof of continuous coverage must be provided for the period of time not covered under the Commission's plans. An employee who is retiring, may add a spouse who is not currently enrolled in a Commission health benefit plan(s) at the time of retirement, so long as the spouse can meet all requirements of the 36-month rule. Delayed enrollment may be for one or more plans.

Benefit Premium Payments for Continued Healthcare

When you retire, your premium payments will be deducted from your monthly annuity check. If your annuity amount is not sufficient to cover all of your benefit premiums, you will be set-up for the Self-Pay Program. Under the Self-Pay program, you make payments directly to Benefit Strategies, the Commission's third-party administrator.

Benefit Changes When You Initially Retire

When you retire this becomes a qualifying event for you to elect retiree coverage or move to your spouse's plan(s). If both of you work for the Commission, you may elect to move to your spouse's plan.

Changing Healthcare Plans

Retirees can make changes to their medical, dental and vision plan elections at any time throughout the year. (Exception: If you enroll in the Prepaid Legal Plan, during any Plan Year (Jan 1 – December 31), you must remain enrolled until the end of that Plan Year, i.e., December 31 before cancelling.)

After you retire, you may not add any benefit plans for which you were not eligible at retirement.

Employees Eligible to Retire On Their Date of Termination and Receive or Defer Annuity

You and your eligible dependents may elect retiree benefits as of your retirement annuity commencement date, providing you meet all requirements of the 36-Month Rule and you are eligible to retire (either a normal or early retirement) as of the date of your termination with the Commission. You will not be eligible for retiree benefits during the period of time you have chosen to defer or postpone your retirement and therefore your annuity payments. You must secure health coverage either through COBRA or another source during this time in order to satisfy the 36 month and continuous coverage requirement.

Opt-In / Opt-Out Provision

The Commission allows covered retirees and their dependents to cancel their existing Commission health insurance coverage and re-enroll at a later date if the retiree and dependents can show proof of comparable continuous health insurance coverage and benefits during the period of coverage with another carrier.

Comparable, continuous coverage does not include Medicare. The federal Medicare plan is not a comparable medical plan, since the Commission does not offer Medicare.

Re-enrollment can occur at anytime with the exception of a qualifying event (i.e.: loss of spousal coverage, divorce etc.). Benefits, including deductibles, must be similar. For example:

- If a catastrophic coverage plan with a high deductible (i.e.: \$5,000) was offered by the Commission, a plan would not be considered high deductible if the deductible for an individual does not exceed \$3,000.
- Discount or limited dental and vision plans offered and bundled with a medical plan are not the same as fully insured or self-insured plans that are separate from medical plans. If a dental or vision plan is not a standalone plan it will not be considered for retiree dental or vision benefit eligibility.

If you are eligible to retire when you terminate your employment with the Commission, you may postpone receiving your annuity to avoid age reduction. You will be eligible to enroll for retiree benefits when you begin to receive your postponed annuity, if you were eligible to continue the retiree coverage in retirement. You must meet the 36 month and continuous coverage rule when you retire and again when you begin to receive your annuity.

Post-65 (Medicare Eligible) Retirees

When you reach age 65 or become Medicare eligible, you are required to sign-up for Medicare Part A and Part B in order to be eligible for Commission benefits. Your spouse and any disabled dependents must also enroll in Medicare parts A and B after becoming eligible. You and your Medicare eligible dependents must show proof of enrollment in Medicare once eligible. Medicare will become the primary payer and the Commission's medical plan will be the secondary payer. You and your dependents must provide a copy of your Medicare card to the Health & Benefits Office confirming your enrollment in Medicare Part A and Part B. Periodically you and all family members may be required to show continuing proof of Medicare enrollment. If you are eligible for Medicare and do not enroll in Medicare Parts A and B you and your dependents are not eligible for coverage in any medical plan.

If your spouse or your Medicare eligible dependents do not enroll in Medicare Parts A and B, those who are not enrolled are no longer eligible to continue enrollment in any Commission benefit plans. If you or your dependents disenroll from Medicare after you have proven enrollment to the Health & Benefits Office, you may become responsible for the entire cost of the monthly premiums for the period that you were not enrolled in Medicare.

If you are over age 65 or are Medicare eligible, and you elected the UnitedHealthcare Choice Plus POS, UnitedHealthcare Select EPO or Kaiser Permanente HMO plan, you will be enrolled, respectively in the UnitedHealthcare Medicare Complement Plan, the UnitedHealthcare EPO > Age 65 Plan or the Kaiser Permanente Medicare Complement Plan. In order to access the benefits in the Medicare Complement plan, you must be enrolled in both parts A and B of Medicare. This also applies to your dependents who become Medicare eligible.

Sworn Park Police

Sworn Park Police officers who were hired or rehired after March 31, 1986 are eligible for Medicare even if they are not eligible for Social Security benefits. These officers will be required to enroll in Medicare Part A and Part B and enroll in the appropriate plan for Medicare eligible retirees. Sworn Park Police officers hired before April 1, 1986, may not be eligible for Social Security or Medicare benefits and may remain in their current medical plan, with proof of ineligibility. If an officer had any other employment, outside the Commission, where 40 quarters of qualifying employment make the officer eligible, the officer must enroll in Medicare Parts A and B. In all cases any eligible dependents must enroll in Medicare Parts A and B. Medicare will become the primary payer and the Commission's medical plan will pay as secondary payer.

Split Coverage: One (1) Member under 65 and One (1) Member over 65 (Medicare Eligible)

If you and your spouse are enrolled and you are Medicare eligible, you will be enrolled in the corresponding Medicare Complement plan (UnitedHealthcare Medicare Complement Plan, United Healthcare EPO > Age 65 Plan or Kaiser Permanente Medicare Complement Plan). Medicare will be your primary insurer. Your spouse under 65 (not Medicare eligible) will continue enrollment in the associated non-Medicare Complement plan (UnitedHealthcare Choice POS Plan, United Healthcare Select EPO Plan, or Kaiser Permanente HMO Plan). Because both members are enrolled in two different plans, each member will need to use their own social security number as their member ID number.

If you are under 65 (not Medicare eligible) and your spouse is over 65 (Medicare eligible), Medicare is primary for your spouse. Your spouse will be enrolled in the appropriate Medicare Complement Plan.

Medicare Complement Plan

If you are over 65 (Medicare eligible) or completely disabled (on Long-Term Disability) and are no longer working for the Commission, Medicare becomes primary for your benefits. This means that Medicare will pay benefits first and the Commission plan pays second.

- If you are enrolled in Traditional Medicare and the UnitedHealthcare Medicare Complement Plan, you can see doctors in or out-of-the network. If an expense is not allowed under Medicare, it will not be covered by the United Healthcare Complement Plan.
- If you are enrolled in both Traditional Medicare and the UnitedHealthcare Select EPO > Age 65 Plan, you must select a doctor within the UnitedHealthcare Select EPO network, unless services are for a bona fide emergency. This plan covers some benefits that Medicare does not cover including hearing tests, invitro-fertilization and Virtual Visits.
- If you are enrolled in both Traditional Medicare and the Kaiser Permanente Medicare Complement Plan, Kaiser will not pay for any services obtained outside of their network, unless due to a bona fide emergency. Providers administering non-emergency services outside of the Kaiser Permanente network will have to bill Traditional Medicare.

Over Age 65 (Medicare Eligible) and Living out of the Country

No routine benefits will be available to you unless you seek treatment in the United States in accordance with the provisions of your plan and you are enrolled in Medicare Parts A and B.

While out of the country, you will only be covered for bona fide emergencies if you are enrolled in the UnitedHealthcare EPO> Age 65 plan or the Kaiser Permanente Medicare Complement Plan. If you are enrolled in the UnitedHealthcare Medicare Complement Plan, services outside of the country are not covered.

Coverage should pay at 100% covering all Medicare Part A and Part B deductibles and all coinsurance. Medicare denied charges are not covered other than those emergency care charges incurred while you are out of the country. These out-of-country claims should be paid based on charges. If you exhaust a Medicare benefit, there is no further benefit in the Medicare Complement plan. If you are Medicare eligible and live outside of the United States, you must return to the United States to seek routine treatment, in order for a benefit to be available.

There is no prescription coverage under the UnitedHealthcare Medicare Complement Plan. In order to obtain prescription coverage, you will need to enroll in the Commission's prescription plan which is a Medicare Part D plan for Medicare eligible retirees. Prescription coverage is included with the Kaiser Permanente Medicare Complement Plan and is also a Medicare Part D plan.

Over Age 65 (Medicare Eligible) and Still Actively Working At the Commission

If you are still working as a career employee at the Commission when you reach normal Medicare age (currently age 65), your Commission benefits remain primary. You are not required to enroll in Medicare until you stop working. If you do enroll, your Medicare benefits are secondary. Be sure to give your treating providers your Commission medical plan cards first and tell them that the Commission pays first. Once you retire or terminate from the Commission, your Medicare coverage will be primary and therefore pays first.

Medicare

General Information

Your Commission medical plan continues to be primary if you are actively at work beyond age 65. You may choose to enroll in Medicare at age 65 for secondary medical insurance coverage while you are working. When you retire and reach age 65, Medicare becomes your primary coverage.

Once you retire and Medicare becomes your primary carrier, you must enroll in Medicare parts A and B in order to continue to be eligible for the medical plan under the Commission. The Commission's medical plan will provide secondary coverage. This will apply to your dependents as well when they become eligible for Medicare.

If You Become Disabled

If you are an employee, retiree, survivor or other dependent and you become disabled, even though you may be under age 65, you are eligible for Medicare after you have received Social Security disability benefits for two years. You must enroll in both Parts A and B in order to remain eligible for Commission benefits. Failure to do so timely may result in you becoming responsible for those expenses that would have been covered by Medicare as determined by the Health & Benefits office or their designee.

Medicare Part A

Medicare Part A covers in-patient hospital care and care in a skilled nursing facility, in addition to home health and hospice care. Medicare Part A is free if you worked and paid Social security taxes for at least ten years. If you have less time credited for work and the payment of Social Security taxes, you will have to pay a monthly premium for Medicare Part A.

If you are covered by Medicare Part A, you will pay an annual deductible towards any costs for hospitalization. For the first sixty days of hospitalization, Medicare pays approximately eighty percent of approved hospitalization charges. If you are hospitalized longer than 60 days, you will pay more of the costs.

Medicare Part B

Medicare Part B covers charges for doctor and clinical lab services, x-rays, outpatient preventive care, durable medical equipment, surgical fees and supplies, hospital outpatient services, laboratory tests, x-rays, mental health care, and some home health and ambulance services. You pay a monthly premium for this coverage. After you meet an annual deductible, Medicare pays 80 percent of approved charges.

You do not have to enroll in Medicare Part B while actively working and covered under a group medical plan such as those provided by the Commission.

What Medicare Covers

For the most current list of services covered by Medicare, please refer to Medicare's Handbook at www.medicare.gov

When Medicare Generally Becomes Effective

Usually Medicare becomes effective the first day of the month in which you turn 65. However, if your birthday is the first of the month, your Medicare coverage becomes effective the first of the month prior to your birthday.

End Stage Renal Disease (ESRD)

If you have permanent kidney failure and/or a kidney transplant and are enrolled in a medical plan sponsored by the Commission, Medicare will become your primary insurance after two and a half years (30 months). At the time that Medicare becomes the primary payer you must enroll in Medicare Part A and Part B. If you do not enroll you may be responsible for the costs that Medicare would have paid if you were enrolled. Contact the Health & Benefits office to obtain more details.

Medicare Part D - Prescription Drug Program

The Medicare Part D program is the out-patient prescription drug benefit component of Medicare. Medicare Part D is an optional program for Medicare beneficiaries through which they can pay a premium and enroll in an out-patient prescription drug plan that will pay a portion of their prescription drug costs. When you or your dependents become eligible for Medicare:

- If you are enrolled in the Caremark prescription plan, you will be transitioned to a Medicare Part D plan called SilverScript, administered by Caremark. There will be no loss in coverage because the Caremark plan will act as a supplemental plan to the SilverScript plan similar to how our medical plans supplement Medicare Part A and B.
- If you are enrolled in the Kaiser Permanente HMO plan, you will be transitioned to the Medicare Part D plan under the Kaiser Permanente Medicare Complement Plan.
- In either case, you must provide the Health & Benefits Office with a copy of your Medicare card confirming your enrollment in Medicare Part A and Part B.

If you are eligible for Medicare Part D and you have questions regarding the Commission's prescription plan, you may contact the Health & Benefits Office at 301-454-1683, 1684 or 1685. If you have questions about Medicare Part D, please contact the Centers for Medicare and Medicaid (CMS) at cms.gov or on 1-410-786-3000. You can also visit www.medicare.gov.

Retirement Savings Plans

Although retirement may seem like a long way off, it is never too soon to start building financial security for the future. Whether you are retiring next year or next decade the Commission's 457, Roth IRA and Traditional IRA plans can help. These Plans lets you save a significant portion of your pay and offers tax advantages on your savings and investments. With a number of investment options, you can choose how to invest your savings depending on your financial objectives and investment philosophy.

Defined Benefit vs. Defined Contribution Plans

Retirement Plans are either defined benefit or defined contribution plans. A defined benefit plan would be the Employee Retirement System (ERS) plans A, B, C and D.

Defined contribution plans offered by the Commission include the 457, Traditional IRA and Roth IRA.

Deferred Compensation 457 Plan

The 457 plan allows employees to contribute tax deferred earnings to an individual account that can be invested in a variety of funds selected by the participant.

Who Is Eligible

All Career full and part time, Appointed Department heads, Commissioners and Term Contract employees are eligible to enroll in the Commission's 457 plan any time.

Plan Administrators

The Commission has two plan administrators:

- MISSIONSQUARE; and
- MetLife Resources (formerly Citistreet/Copeland). This plan is frozen to new participants.

Each plan administrator offers different investment options. You may participate in one plan at a time. If you are enrolled in MetLife Resources and decide to change plan administrators, you may be subject to penalties if you move your balance. If you stop contributions to MetLife Resources, you may not resume contributions to that plan administrator.

About Your Contributions

You may contribute the lesser of:

- 100 percent of includible compensation (after FICA and 401(a) contributions paid by the employer) or
- The dollar limit in effect that year.

Your contributions may be a fixed dollar amount or you may elect a percentage of your gross earnings (1%, 2%, 3% etc.). All contributions are on a pre-tax basis through payroll deduction only. This means your deduction reduces your taxable income before your state and federal taxes are calculated, providing you with more net income.

Rollover Account

You may roll over retirement assets between the following plans: 401k, 403b, 457 retirement plans and Traditional IRAs at any time. In general, assets from an employer sponsored plan (401k, 403b, 457) may be transferred or rolled over from that plan to another plan or Traditional IRA, at any time, if you are already separated from service and only if the distribution is an "eligible rollover distribution" (ERD).

RETIREMENT PLANNING

The money that you roll over will be subject to the same IRS plan requirements as the initial plan from which it originated. For example, if you roll over a 401(k) balance to a 457 plan, the money will be subject to all IRS regulations such as the 10% penalty if it is withdrawn before the minimum age requirements.

Changing Your Contributions

You may start making contributions to the plan at any time. You may change or stop contributions at any time.

How to Request a Change

To make contribution changes to either plan, contact your Benefit Coordinator or the Health & Benefits Office for the appropriate form or print it from the Commission's intranet or internet site. Your request will be processed for the next available pay date or specific future date that you specify.

Your Investment Options

You have a choice among several investment options for your 457 contributions. The option(s) you choose may depend on how long you plan to leave the funds in your accounts and your investment philosophy. For example, the performance of certain funds can vary widely from one year to the next. While investing in such funds means higher risk, it also offers the potential for higher reward over time. The "variable" products (stock & bond funds) do not guarantee principal or interest. The participant assumes risk of investment performance.

MISSIONSQUARE Guided Pathways

Guided Pathways is an MISSIONSQUARE program designed to enhance the investment education services that have always been a core benefit for Commission participants in the MISSIONSQUARE deferred compensation plan. Participants may choose from three levels of investment advice and account management that meets their needs including: 1) guidance, 2) advice and 3) managed accounts. Managed Accounts is a discretionary investment advisory service provided as part of MISSIONSQUARE's Guided Pathways program. These programs may be accessed over the phone, on the internet, and for qualifying persons, through an in-person meeting.

The following are more detailed descriptions of the three levels of service:

- Guidance – Based on the employee's retirement goals, Guidance provides an asset allocation recommendation from which the employee can build his or her own mix of stocks, bonds and cash or stable value funds from the options available within the plan. This is a free service.
- Advice – For a nominal fee (currently \$20 annually), Advice provides employees with a "point-in-time" fund specific investment portfolio recommendation from the funds available within your plan. Employees remain responsible for monitoring their account and initiating any investment changes.
- Managed Accounts – For an asset-based fee, this service offers a substantially higher level of assistance than Guidance or Advice. Professional managers design the right portfolio to help employees reach their retirement goals and provide ongoing management to keep employees on track.

RETIREMENT PLANNING

The chart below shows the tiered fee structure of the Managed Accounts service.

Account Balance	Annual Fee
First \$100,000	0.50%
Next \$200,000	0.40%
Next \$200,000	0.30%
Over \$500,000	0.20%

If determined suitable for the program, employees who want to have their accounts managed for them, will be required to sign an investment advisory agreement with MISSIONSQUARE giving account management permission to a registered investment advisor. The participant may terminate the advisory agreement at any time.

If you are interested in obtaining more information and/or signing up for the Managed Accounts program, please contact the Health & Benefits Office. You may redirect your future contributions simply by calling MISSIONSQUARE's toll free number (800-669-7400). You may also use the same number to make exchanges among the plan's investment options. MISSIONSQUARE exchanges requested before 4:00 p.m. (EST) will be posted on that business day based upon the closing price of the affected mutual fund(s). Exchanges requested after 4:00 p.m. (EST) will be processed on the next business day.

Initial Enrollment Default Election

If you are a new participant and you do not initially select a fund or funds to which your contribution should be invested in the MISSIONSQUARE plan, your fund will default to a standard plan default investment option selected by MISSIONSQUARE. That default option is an age-appropriate Milestone Fund. The Milestone Retirement Income Fund is designed to provide the appropriate risk levels for investors with a target retirement date that is approximately equal to the employee's anticipated retirement date.

Vesting

The term "vesting" refers to your non-forfeitable right to own the contributions in your account. You are always 100% vested in your contributions.

Annual Limits

Year	Regular Contribution Limit	Age 50 Catch-Up Contribution Limit	Total Regular and Age 50 Catch-Up Contribution Limit	3-Year Pre-Retirement Catch-Up Contribution Limit
2025	\$23,500	\$7,500	\$31,000	\$47,000

Age 50 Catch-Up Provision

From the year in which you reach age 50 until you terminate employment, you may make 'age-50' catch-up contributions up to a specified dollar limit. The Age 50 contribution is in addition to the regular contribution.

Pre-Retirement Catch-Up Provision

The pre-retirement catch-up provision allows you to make up for contributions not deferred in previous years. You may catch up for any years since January 1, 1979 if you were eligible to contribute to a deferred compensation plan but did not contribute the maximum amount.

This catch-up provision is limited to the three-year period immediately preceding the normal retirement age you elect for catch-up purposes. The amount you are permitted to contribute through your Commission plan during this three-year period is determined by subtracting the actual amount you previously contributed to your plan from the maximum contribution amount allowed by law. This means, for example, that if you were eligible to use this catch-up provision in 2023, you would be able to contribute \$22,500 in "normal" contributions plus \$22,500 in additional catch-up funds for a total of \$45,000.

At the end of the third year, if you decide not to retire, your contributions will again be subject to the normal or age 50+ catch-up plan year contribution limitations. If you begin the catch-up provision at any point in the first plan year, that year becomes one of the plan years of catch-up.

Catch-up Provisions in Any Year

You can only take advantage of one catch-up provision in any year; either the age 50 catch-up or the 3-Year pre-retirement catch-up. You may not use the age 50 catch-up provision during the year(s) in which you use the pre-retirement three-year catch-up provision and vice versa.

Loans

Loans are not available from this plan.

Unforeseen Emergency Withdrawals

Unforeseen Emergency Withdrawal applications are available from both plan administrators. The Internal Revenue Code provisions strictly define unforeseeable emergencies within a Section 457 deferred compensation plan as a severe financial hardship created by:

- Sudden and unexpected illness or accident to you or your dependents;
- Loss of your property due to casualty;
- Other similar, equally severe and unforeseeable circumstances which are beyond your control.

Assets in your deferred compensation account must represent a last resort. The emergency must be one that cannot be relieved through insurance reimbursements, cash in savings accounts and credit unions, a loan from a financial institution, cash value of life insurance, the liquidation of other assets, and stopping your contributions.

For an emergency to comply with the IRS Code and regulation, it must satisfy **all** of the following:

- Financial hardship must be severe and beyond your control;
- Funds in your deferred compensation account must represent a last resort;
- Emergency circumstances must be sudden, unexpected, and not able to be budgeted.

In the event of sudden illness, financial hardship must result from events affecting you or a dependent that can be claimed on your income tax return.

Who Approves Your Hardship Withdrawal

All hardship withdrawals must be submitted to the Health & Benefits Office for review and approval. MISSIONSQUARE- RC and MetLife Resources will make a recommendation but all decisions are made in the Department of Human Resources, within which resides the Health & Benefit Office.

RETIREMENT PLANNING

Circumstances that May Qualify as Unforeseen Emergencies

Regulations under the Code offer the following covered specific circumstances:

- Unreimbursed medical expenses resulting from your/your dependent's sudden illness or accident;
- Involuntary loss of wages resulting from an illness or accident;
- Damage to your home due to an accident or natural disaster (beyond insurance reimbursement);
- Damage to your car or other personal property due to an accident or natural disaster (beyond insurance reimbursement);
- Legal bills involving criminal charges against you/your dependent;
- Imminent foreclosure of or eviction from your primary residence; or
- Funeral expenses for a family member.

Circumstances that Do Not Qualify as Unforeseen Emergencies

If you wait beyond what is considered a reasonable amount of time from the emergency event your untimely request will not be considered an emergency. Generally, an emergency request must be made within 6 months of the start of the event and no later than the end of the emergency circumstances. Specific events **not** considered emergencies by the IRS are purchase of real estate and payment of college tuition.

Other situations that do not qualify as unforeseen emergencies include:

- Purchase of a home, automobile, or other personal property, etc.;
- Unreimbursed medical expenses associated with elective surgery or routine/preventive medical care;
- Unpaid rent, utility bills, mortgage payments;
- Repayments of loans;
- Personal bankruptcy (except when resulting directly and solely from illness or casualty loss;)
- Payments of income tax, back taxes, or fines associated with back taxes
- Martial separation, divorce or child support;
- Routine dental bills;
- Payment of college tuition; or
- Travel expenses to attend a funeral (i.e. in another country)

Eligibility Test

To test whether or not your particular situation might qualify as an emergency, pose these key questions:

- If the situation is not one specifically allowed by the regulations, is it as severe a hardship as, for example, sudden illness or accident?
- Is the situation unforeseeable and beyond your control?
- Could you have budgeted for the situation?

Statement of Your Account

You will receive a statement of your account each quarter that shows:

- Your balance in each account and how your accounts are invested and
- Your activity for the quarter including your contributions, investment gains, losses and transfers, withdrawals, and forfeitures.

RETIREMENT PLANNING

Termination of Employment

You may withdraw your money at any time following your termination or retirement date. The plan administrator may cash-out the account of a terminated employee whose balance is less than \$5,000. Rollovers may be disregarded in determining whether the \$5,000 limit is exceeded. If this decision is made, you will be notified and will have time to designate another tax-deferred investment vehicle.

Bankruptcy Protection

Your 457 funds are excluded from bankruptcy proceedings according to the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005.

Qualified Domestic Relations Order

In most cases, payments from the plan may be made only to you or your beneficiary/survivors. However, under a "qualified domestic relations order," a court-order payment related to a divorce or legal separation, the plan may be required by law to pay part of your benefit to someone else, such as a former spouse or a child(ren). If you are affected by this type of order, you should contact the Health & Benefits Office.

Penalties for Early Withdrawal

There is no penalty for withdrawing money from your 457 Plan before you reach retirement age, but you are subject to federal and state taxes.

Annual Leave Deferred From Your Final Paycheck

The Internal Revenue Service allows deferrals of accrued annual leave/vacation from compensation after separation from service (i.e. retirement), so long as the amount is deferred to the 457 plan within 2-1/2 months following severance from employment and other requirements of the IRS Code Section 457(b) are met. In addition to the timing requirements with respect to deferrals, the agreement to defer such amounts must also be entered into prior to the first day of the month in which the amounts otherwise would be paid or made available. Your election must be made no later than the month prior to your retirement date.

Regular contributions to the 457-plan combined with the current value of accrued annual leave hours to be deferred may not exceed the annual contribution limits for the current plan year. For example, if you retire August 1st and you have already contributed \$10,000 to the plan, you may only defer the cash value of your accrued annual leave up to the difference between what you have already contributed and the annual contribution limit .

If you retire January 1 of the following year (your election to retire is made in the prior December), you will have one regular 457 contribution in your paycheck for January. Your election of accrued annual leave is limited to the lesser of the annual contribution limit you have elected to use, minus your regular contribution for the first paycheck, or your election of the cash value of the deferral of accrued annual leave. If you are planning to retire and intend to place your accrued annual leave in the 457 plan, remember to complete and submit your annual leave election form to the Health & Benefits Office no later than one month prior to your retirement date.

MetLife Resources (formerly Citistreet and Copeland) and MISSIONSQUARE-Retirement Corporation

The MetLife Resources 457 plan is closed to all but current participants. This plan offers variable annuities rather than mutual funds. Although funds appear to be mutual funds, they are in fact variable annuities. Additional expenses and charges are associated with variable annuities that will reduce your fund performance over the long term. There are also surrender charges that vary depending on whether you are invested in the Traveler or Lincoln Life funds. Charges may apply for each biweekly contribution you make for up to 10 years following each bi-weekly payroll contribution.

RETIREMENT PLANNING

If you are currently enrolled in the frozen MetLife Resources deferred compensation plan and would like to become a participant in the MISSIONSQUARE plan, you must stop your contributions to MetLife Resources and begin contributions to the MISSIONSQUARE plan. **Once you stop contributing to the MetLife Resources plan you may not restart at a later date. You must enroll in the MISSIONSQUARE plan if you wish to begin contributing to the 457 plan again.** You may not contribute to both plans at the same time. Please contact the Health & Benefits Office to make this change. If you would like help rolling over your MetLife deferred compensation plan balances to MISSIONSQUARE, please contact Shantel Washington, our MISSIONSQUARE representative at (866) 822- 3442 or (410) 323-3404. You may also email Ms. Washington at swashington@MissionSquarerc.org.

Traditional IRA and Roth IRA

You may make additional retirement plan defined contributions through MISSIONSQUARE's Traditional or Roth IRA plan. Contributions to these plans are on an after-tax basis.

Who Is Eligible

All Career full and part time, Appointed Department heads, Commissioners and Term Contract employees are eligible to enroll in the Commission's 457 plan any time.

Vesting

The term "vesting" refers to your non-forfeitable right to own the contributions in your account. You are always 100% vested in your contributions.

Changing Your Contributions

You may start making contributions to the plan at any time. You may change or stop contributions at any time.

How to Request a Change

To make contribution changes to either plan, contact your Benefit Coordinator or the Health & Benefits Office for the appropriate form or print it from the Commission's intranet or internet site.

Processing Changes

If your request to change, stop, or begin deferrals is received by close of business the Thursday before the end of a pay period, your request will generally be processed for that pay period. Requests received after that Thursday will generally be processed in the next pay period.

	Roth IRA	Traditional IRA
Annual Contribution Limit	\$7,000 (\$8,000 if age 50 or above)	\$7,000 (\$8,000 if age 50 or above)
Pre-Tax or After-Tax Contributions	After-tax Contributions	Pre-tax Contributions
Earnings Grow Tax-Free	Yes	Yes

Earnings Taxed at Withdrawal	No, if account in force for five years and you meet one of the criteria below: <ul style="list-style-type: none"> • Over age 59 ½ • Death or Disability • Qualified first-time home purchase 	Yes
	Roth IRA	Traditional IRA
Are contributions tax deductible?	No.	You may be able to deduct some or all of your traditional IRA contributions. The deductible amount could be reduced or eliminated if you or your spouse is already covered by a retirement plan at work.
Contributions Taxed Upon Withdrawal	No	Yes, if deductible
Contributions Allowed After Age 70 ½	Yes	No
Required Minimum Distribution April 1st Following Age 70 1/2	No	Yes
	Roth IRA	Traditional IRA
Is there a penalty for Withdrawals taken before 59 1/2	There are no penalties on withdrawals of Roth IRA contributions. But there's a 10% federal penalty tax on withdrawals of earnings. There are a few exceptions.	With a traditional IRA, there's a 10% federal penalty tax on withdrawals of both contributions and earnings. There are a few exceptions.

Employee Retirement System (ERS)

The Maryland-National Capital Park and Planning Commission (Commission) Employees' Retirement System (ERS), a defined benefit plan, dates back to July 1, 1972. Today it consists of four defined benefit plans: Plan A (closed), Plan B (closed), Plan C (closed), Plan D and Plan E. All retirement benefits provided by the ERS are guaranteed payable for the lifetime of the member. Each payment option provides those who qualify, a lifetime income stream upon retirement with options to provide income to their survivor/beneficiary in the event of their demise. The plan is funded by both employee and employer contributions.

You may obtain additional information concerning the ERS plan at www.ers.mncppc.org including:

- Plan Document
- Summary Plan Document for each Defined Benefit Plan (A, B, C, D, and E)
- Retirement Checklist
- Retirement Benefit Selection Options
- Retirement Application
- Information on Retirement Workshops

If you would like to determine your eligibility, obtain an estimated pension benefit, or have questions concerning your ERS plan, please contact the ERS Member Relations Team by:

- Email – contactERS@mncppc.org
- Phone – 301-454-1415
- Fax: 301-454-1413, or
- Visit: M-NCPPC Executive Office Building
6611 Kenilworth Avenue, Suite 100
Riverdale, MD 20727

Qualified Domestic Relations Order (QDRO)

One of the fundamental principles of a pension is that plan benefits cannot be assigned to other individuals. This applied to the M-NCPPC ERS and 457(b) plans. However, in 1984 the federal government created an exception to that rule for qualified domestic relations orders (QDRO).

Plans Affected

As a general rule, QDRO rules apply to qualified pension, profit sharing, and stock bonus plans. More specifically, the QDRO rules do not apply to plans to which Section 401(a)(13) of the Internal Revenue Code does not apply. Health benefit plans like group insurance programs are not affected by the QDRO rules.

What Is A Domestic Relations Order (DRO)?

A domestic relations order is a judgment, decree, order, or approval of a property settlement that:

- Relates to the provision of child support, alimony payments, or marital property rights to a spouse (present or former), child, or other dependent of a plan participant
- Is made pursuant to a state domestic relations law, including a community property law.

A DRO is a qualified DRO (QDRO) if it creates or recognizes the existence of an alternate payee's right, or assigns to an alternate payee, the right to receive all or a portion of the benefits payable to a participant under a plan, specifies required information, and does not alter the amount or form of plan benefits. An alternate payee is a spouse, former spouse, child or other dependent, or a participant who is recognized by a domestic relations order as having a right to receive all, or a portion of, the benefits under a plan with respect to the participant. A property settlement agreement that has not been approved by a court is not a DRO.

Checklist of Domestic Relations Orders (DROs)

The order must:

- Be a DRO
- Contain the name and last known mailing address of the participant
- Contain the name and last known mailing address of each alternate payee covered by the order
- Specify the amount or percentage of the participant's benefits to be paid by the plan to each alternate payee, or the manner in which such amount or percentage is to be determined
- Specify the number of payments or the period to which such order applies
- Contain the name of the plan(s) to which it applies
- Provide benefits at a time or in a form which is available under the plan document
- Only require the plan to provide benefits which do not exceed the participant's plan benefits
- Refrain from affecting any benefits of a prior known QDRO

If you are ordered by a QDRO to share your retirement benefit with an alternate payee, you must immediately submit a copy of the QDRO to the Health & Benefits office and the Employee Retirement System (ERS) for a determination that the QDRO will be recognized by your retirement plan.

SUPPLEMENTAL INFORMATION



IMPORTANT INFORMATION

NAME OR ADDRESS CHANGE

If you are an active employee and wish to change your name or address, you must contact the Human Resources Records office (301-454-1703).

If you are a retiree and wish to change your name or address, you must contact the Employee Retiree System Office (301-454-1415).

All dependent name changes must be submitted to the Health & Benefits Office, supported by appropriate legal documentation (marriage certificate, birth certificate, Social Security card, court order etc.). You will need to complete an *Application for Benefit Enrollment* form indicating the dependent's name change. No changes will be made without the proper documentation.

BENEFICIARY DESIGNATION

You should complete a separate beneficiary form for life insurance, your final paycheck, deferred compensation plan and the Employee Retirement System. You would contact the same departments below whenever you want to update your beneficiary designations. The following table summarizes the forms and what benefits they cover:

Beneficiary Form	Description of Benefits	Return Form To:
Basic Life Insurance/AD&D and Supplemental Life Insurance	Your Basic/AD&D and Supplemental Life Insurance Benefit *You are the beneficiary for spouse life and dependent life insurance **You can name different Designated Beneficiaries for Basic, AD&D, and Supplemental Life Insurance.	Health & Benefits Office
Final Paycheck	Includes Annual Leave, Last Pay, Comp Time	Human Resources Records Office
Deferred Compensation	Your 457 plan contributions to MISSIONSQUARE of MetLife Resources and your Traditional/Roth IRA contributions	Respective Plan administrator: MetLife Resources or MISSIONSQUARE
Employee Retirement System (ERS)	Both your contributions and any vested Commission contributions	Employee Retirement System

When you are hired and when you enroll in the plans, you are asked to name a beneficiary. This person will receive the benefit if you die while covered under the plan. You may name anyone as beneficiary and you may name more than one person. You are also encouraged to name a contingent beneficiary who becomes your beneficiary if your named beneficiary dies before you do. If you want to change your beneficiary, you can do so at any time by contacting your Benefits Coordinator or the Health & Benefits Office for a Beneficiary Designation form. For your designation to be accepted, the person you designate as your beneficiary cannot witness your designation. Your beneficiary designation will not be effective until it is received and accepted by the Health & Benefits Office, the Records Section, or the ERS plan administrator.

IMPORTANT INFORMATION

- If no beneficiary is living at the time of your life insurance payment or if you did not name a beneficiary, the benefits will be paid to the first surviving person(s) on this list:
 1. The remaining beneficiaries you named. The deceased beneficiary's share will be paid in equal shares to the other beneficiaries.
 2. Your widow or widower.
 3. Your children, in equal shares.
 4. Your parents, in equal shares.
 5. Your brothers and sisters, in equal shares.
 6. Your estate.

- **Benefits Paid to a Minor**

Death benefits will not be paid to a minor, but to the minor's legal guardian. Legal guardianship is court appointed. At the time of your death, if you listed your spouse and child(ren), your spouse will be required to be court-appointed guardian to access the child(ren)'s share of the benefit.

- **Listing Charities or Other Organizations**

You may also list a charity; however, you must provide the formal charity name as well as the tax-exempt number to ensure that the correct charity receives the money.

- **Your Estate**

You are not required to formally establish an estate prior to your death. You may leave assets to your estate without formally establishing an estate. If you die without a will, your remaining property, including a life insurance designation, is disposed of under state laws of succession (i.e., to the spouse, then to the children etc.). If you leave your assets to your estate, all assets will not be available until the will has been probated.

- **Naming Minor Children as Beneficiaries**

It is sometimes suggested that a trustee be designated to receive the group insurance proceeds on behalf of minor beneficiaries, but such an arrangement should be discouraged unless there is a written trust agreement in effect. If there is no written trust agreement, the employee may: (1) name his estate as beneficiaries and provide in his will for the disposition of the insurance, or (2) name the minor child without qualification. In this latter case, the insurance companies await appointment of a guardian by the court having jurisdiction and make payment to such legally appointed guardian.

- **Power of Attorney Regarding Beneficiaries**

Granting power of attorney does not give that person the right to change a beneficiary designation unless the power of attorney document explicitly states that the attorney-in-fact has authority or permission to make beneficiary changes and/or designations.

HOW TO BE A BETTER CONSUMER OF HEALTH SERVICES

If You Use an Out of Network Healthcare Provider

Sometimes the doctor or facility that you prefer does not participate in your plan's provider network. (Remember that services received out-of-network under the Kaiser Permanente plans and under the UnitedHealthcare EPO plan are covered only if they are for a bona emergency.)

You can be proactive in reducing the amount that you pay for out-of-network services. Talk to your provider before you receive any services. If you must use hospital services, have your provider talk to the facility for you. Ask your provider to accept the Plan's normal discounted fee arrangement. If he/she will not agree to that, ask them to accept the UCR fee (and not balance bill you).

If you have a 20% or 30% co-pay, you can sometimes negotiate with providers so that they may split the co-pay or even charge you only a fixed co-pay such as \$10 or \$15. Remember that all negotiating should be done before you receive services or for services you will be receiving after your initial visit.

Have You Received A Bill For Services That You Feel Should Not Have Been Charged?

Sometimes there is a glitch in the billing process. If you receive a bill for services that you think should have been covered by your plan, please check the following:

1. Did your provider send the bill to the Plan? Sometimes providers forget to bill the Plan and when they don't receive payment from the Plan in six-eight weeks, they will bill you.
2. Did the Plan receive the bill? The provider may have sent the bill but for some reason the Plan does not have the bill.

In both cases, you should call the customer service number of the Plan to verify whether they received the claim. If the Plan does not have a record of the claim, call your provider and ask them to resubmit it.

Customer Service Inquiries Made on Your Behalf

If you want someone else to call the Plan on your behalf, you will need to contact the Plan ahead of time to authorize them to talk with any person that you select. If you later decide that you do not want that person to be able to talk about your account, you may call back and rescind your original request.

Your Responsibility to the Commission and the Plans

You also have responsibility for the proper filing of claims.

- Provide complete and accurate information on claim forms. If someone else such as your spouse or another family member files claims on your behalf, you should review the form before you sign it. This applies to instances where a separated spouse may be filing claims under your coverage.
- Review the Explanation of Benefits (EOB) form when it is sent to you to make certain benefits have been correctly paid based on your knowledge of the expenses and the services rendered.
- Never allow another person to seek treatment under your identity. If your plan identification card is lost, you should report the loss to the Commission or the Plan immediately.
- Notify the Plan's Customer Service Representative if you have reason to believe there may be a billing error.

BENEFITS ADMINISTRATION



Healthcare Plan Grievances and Appeals

If you have a complaint or are dissatisfied with a denial of coverage for claims under your healthcare plan, you may be able to **appeal** or file a **grievance**. For questions about your rights or assistance, contact the healthcare plan directly.

You may also contact your state insurance department, or the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the State's Health Education and Advocacy Unit of the Consumer Protection Division Maryland Office of the Attorney General, Health Education and Advocacy Unit at 1-877-261-8807 or www.oag.state.md.us/Consumer.HEAU.htm.

Insurance and Benefits Fraud

Each year part of the increase in health insurance costs is attributable to the increasing number of dollars that are lost due to health insurance fraud. In response to increasing costs and growing fraud, the Federal Fraud Claims Act was passed. Under the umbrella of HIPAA, the federal government has determined that anyone who knowingly and willfully executes or attempts to execute a scheme or artifice to:

1. To defraud any health care benefit program; or
2. To obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program, in connection with the delivery of or payment for health care services, shall be fined under this title (18USC, Ch. 63, Sec. 1347) or imprisoned not more than ten years, or both.

Provider Fraud

To maintain the integrity of your health plan, check and double check claims statements for accuracy and notify your health carrier whenever a provider:

- Bills for services or treatments that you or your dependents have not received;
- Has inflated the cost of services;
- Asks you or your dependents to sign a blank claim form;
- Asks you or your dependents to undergo tests that you or your dependents feel are not needed;
- Bills for a more expensive service than what was actually done.

Employee, Retiree, Survivor and Member Fraud

To maintain the integrity of your health plans and to contain costs, you are required to notify the Health & Benefits Office whenever you know that an employee:

- Lied or made misleading statements on applications or certification forms or withheld material information;
- Submitted false claims;
- Has enrolled an ineligible dependent;
- Does not have a qualifying injury, illness or disability;
- Obtained the same prescription drugs from several doctors or plans;
- Is working elsewhere and is receiving income replacement benefits through one of the Commission sponsored plans such as Workers Compensation, LTD, or Sick Leave Bank.

Fraud Schemes

Be aware that there are fraud schemes looking for victims. Watch for the following:

- Free testing or screening offers that involve showing your health insurance ID card or Medicare card;
- Doctors who bill for in-patient hospital services on dates you weren't in the hospital;
- Inflated hospital charges for drugs or other services (always ask for a detailed bill;)
- Doctors or other providers who want you to sign a claim form before providing a service.

Controlling Fraud

You can keep fraud to a minimum with these measures:

- Always carefully check your Explanation of Benefits (EOB) that you received from your insurance company or from Medicare. Look for charges for services that you didn't receive, treatments that were more complex than the ones you received, and multiple charges for a service that you received only once.
- Ask your provider if the treatments and services they prescribe are medically necessary and what your options are.

When Fraud Is Discovered

If you have intentionally obtained a benefit or service for you or your dependent, to which you or your dependent were not entitled, you may be considered responsible for the cost of that benefit or service. If the Commission considers you responsible, you may be required to reimburse the Commission or the benefit plan for those costs. Failure to do so may result in loss of benefits and disciplinary action up to and including termination.

Participants in the Commission's health benefit plans are subject to the Commission's Fraud, Waste and Abuse policy, 3-31 as amended.

Subrogation and Reimbursement Rights

It is the Commission's intent that any plan or program offered by the Commission has priority to any third-party recovery the beneficiary obtains regardless of whether the beneficiary has been made whole by the recovery.

Individuals Covered by Provision

The plans shall be entitled to subrogation and/or reimbursement of all rights of recovery of a participant, his or her parent(s) and dependent(s) or a representative, guardian or trustee of the participant, parent(s) or dependent(s) (hereinafter, collectively "claimant").

Right to Subrogate

The plan is subrogated to any and all rights of recovery and causes of action that the claimant may have against any third party, whether by suit, settlement or otherwise, that may be liable for a claimant's injury or illness for which the plan has paid or is obligated to pay benefits on the claimant's behalf.

Rights to Reimbursement with Source of Funds Specifically Identified

The plan shall also be entitled, to the extent of payments made or to be made on account of the claim, to the proceeds of any settlement, judgment or payment from any source liable for making a payment relating to the claimant's injury, illness or condition. A source includes, but is not limited to, a responsible party and/or responsible party's insurer (or self-funded protection), no-fault protection, personal injury protection, medical payments coverage, financial responsibility, uninsured or underinsured insurance coverage, an employer under the provisions of a workers' compensation law and an individual policy of insurance maintained by a claimant.

Rejection of Make-Whole Doctrine

Such subrogation and reimbursement rights shall apply on a priority, first-dollar basis to any recovery, whether by suit, settlement or otherwise, whether there is a partial or full recovery and regardless of whether the amounts are characterized or described as medical expenses or as amounts other than for medical expenses.

Equitable Lien by Agreement

Once the plan makes or is obligated to make payments on behalf of a claimant, the plan is granted, and the claimant consents to, an equitable lien by agreement or a constructive trust on the proceeds of any payment, settlement or judgment received by the eligible employee or dependent from any source to the extent of payments made or to be made by the plan on the claimant's behalf.

Miscellaneous Information

Coordination of Benefits (COB)

COB affects those employees and eligible dependents who are covered by more than one group plan. The plans will work together to pay for eligible expenses while avoiding duplication of payments for the same services. This prevents anyone from receiving more than 100% of the eligible charge. Most group plans have adopted the birthday rule; however, if parents are not married this may be different. See your plan's summary description for details.

Who Pays for Coverage

The Commission pays a portion of the cost of coverage, which includes medical, dental, psychiatric care/substance abuse and prescription drug coverage for all full-time, part-time career and term-contract employees enrolled in any of the Commission's plans. Your share of coverage premiums is paid through payroll deductions.

If you do not receive a paycheck at the time deductions are made (i.e., leave), you will be billed directly through the Self-Pay Program administered by Benefit Strategies. You will pay your premiums directly to Benefit Strategies.

When Coverage Ends

Your coverage for Life Insurance, AD&D, and LTD will end at midnight on the day that any of these events occur:

- You leave the Commission, or
- You become ineligible for benefits due to a reduction in your working hours, (i.e., part-time, or temporary), or eligible employment status change or
- You die.

If you become disabled your LTD coverage ends the date you are approved for LTD benefits and your Life and AD&D coverage end after being disabled for one year unless you apply for a waiver. Your coverage for medical, prescription, dental, vision and legal plan benefits will end on the last day of the month in which you terminate.

The Commission may continue your coverage for certain time periods under these circumstances:

- a. If you take a medical leave, the Commission will continue to make contributions of your health care premiums for the time you are on Long Term Disability or Leave Without Pay. To cover you and your dependents during this period, you must continue to pay any required premium through the Self-Pay Program.

- b. If you are on Leave Without Pay, the Commission will continue to make contributions of your health care premiums for up to 12 months for an approved, qualifying reason. To cover you and your dependents during this period, you must continue to pay any required premium.

Family coverage ends when yours does, unless one or more of the following events occur:

- Non-payment of you or your family premium,
- A divorce or legal separation,
- A child no longer qualifies as a dependent,
- Your death. In this case, the Commission will continue to make 100% contributions to medical care and prescription premiums for up to 6 months after your death (also called Survivor Benefits or Family Security) or until your dependents become covered under another group Plan or Medicare, whichever occurs first (See Continuing Coverage Section), or
- A Qualified Medical Child Support Order (QMCSO) is no longer in effect.

Changing or Ending The Plans and Benefits

The Commission expects the plans and benefits described in this booklet to continue, but still reserves the right to amend, modify, suspend, or terminate the plans and benefits at any time and for any reason except as limited by applicable union contracts and the Merit Rules. If any insurance company changes or ends any plans or benefits you will be notified.

The plans and benefits described in this booklet in no way imply a contract of employment between you and the Commission. The Commission's right to discipline or discharge any employee is in no manner changed by any provision of these plans and benefits.

Authority of Commission to Interpret Benefit Programs

The Commission has the full discretionary authority to interpret the benefit programs in this Handbook in accordance with the terms of each benefit program and to determine eligibility under each benefit program. The Commission has delegated its authority for the administration of the benefit programs and its authority to make final claims determinations to the claims administrators. Benefits under the benefit programs are paid only if the claims administrators decide in their discretion that the claimant is entitled to them.

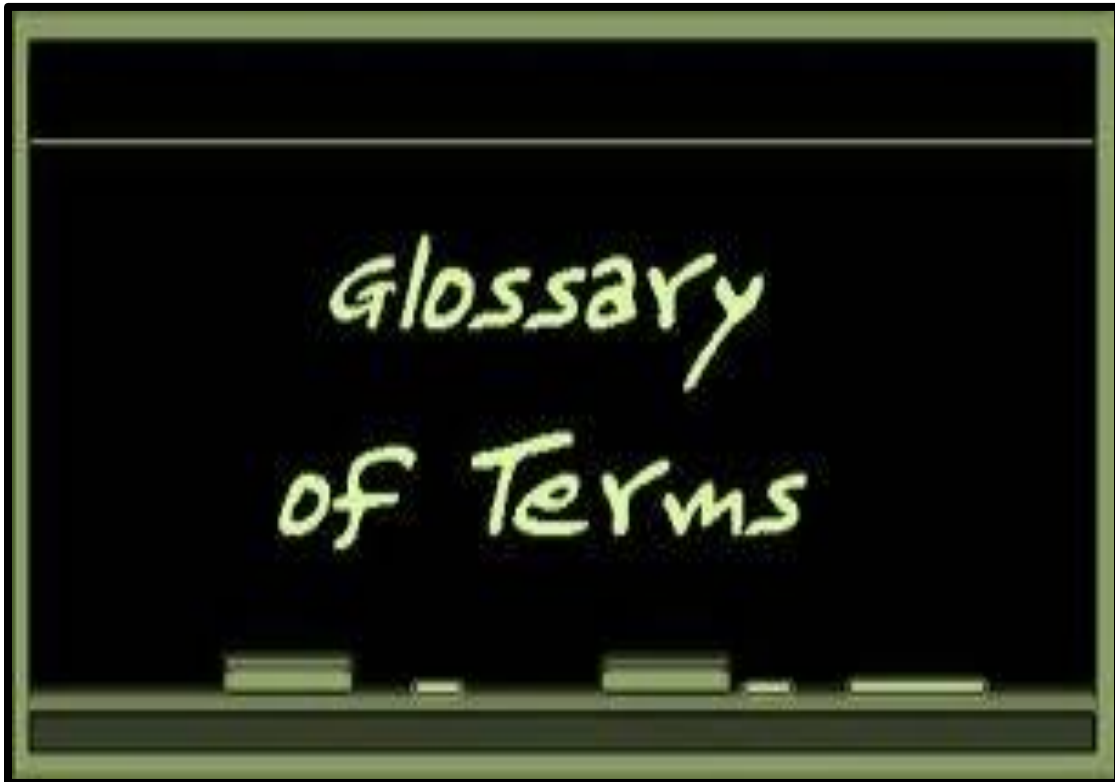
Statute of Limitations for Plan Claims

No legal action may be commenced or maintained to recover benefits under the benefit programs in this Handbook more than 12 months after the final review/appeal decision by the claim administrator has been rendered (or deemed rendered).

Benefit Approval and Administration

On an annual basis and as otherwise appropriate, the Commission reviews and approves benefit changes. All benefit programs in this Handbook are administered by the Department of Human Resources and Management, Human Resources Division, Health & Benefits.

GLOSSARY OF TERMS AND ACRONYMS



Glossary of Terms

Accident/Accidental Injury - A sudden, unforeseen, unintended activity or event exact as to time and place resulting in physical injury affecting a body function and requiring treatment within 48 hours of the occurrence to protect the body function.

Actively At Work – An employee is considered actively at work, if the employee can physically come to work and perform the essential duties of the job. An employee on sick leave, sick leave bank, workers' compensation or LTD is not considered actively at work. Other leave categories may apply as well.

Allowed Benefit – Also called Allowed Amount. See Usual, Reasonable or Customary fee and Approved Amount.

Annuity – A contract between an insurance company and an individual in which the company agrees to provide a stream of income, which may be fixed or variable in amount for a specified period of time.

Approved Amount – The fee the Plan sets as reasonable for a covered medical service. This is the amount a doctor or supplier is paid by you and the Plan for a service or supply. It may be less than the actual amount charged by a doctor or supplier. The approved amount is sometimes called the "Approved Charge" or Allowed Benefit.

Balance Billing – This is when Private Fee-for-Service Plan providers (doctors or hospitals) can charge and bill you more than the plan's payment amount for services.

Beneficiary – Some you designate who will inherit your assets when you die. You can designate more than one person.

Benefit Period – Usually the 12 calendar months beginning January 1st and ending December 31st.

Brand Name Drug - A drug for which a manufacturer has patent protection. The drug is usually available from only one source.

Case Management – A collaborative process which assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet an individual's health needs, using communications and available resources to promote quality, cost-effective outcomes. Case managers make sure that you get needed services and track your use of facilities and resources.

Catch-Up Provision – A provision that allows employees covered by a 457 plan to make larger contributions to the plan than typically permitted.

Children's Health Insurance Program (CHIP) - A program established in 1997 and reauthorized in 2009, which is administered by states and funded through a combination of federal and state payments. CHIP allows states to provide health insurance (known as child health assistance) to uninsured "targeted" low-income children. States also may provide coverage to targeted low-income pregnant women. State CHIP programs can establish state CHIP plans as separately administered programs, Medicaid expansions, or a combination of the two. Unlike Medicaid, the CHIP program caps federal funds available to states and must periodically be reauthorized.

Chronic – A long lasting disease or illness such as a chronic illness.

COBRA - Federal mandate that allows individuals to continue to purchase employee health benefits following a qualifying event, applicable to (a) employees who leave the Commission or change employment status; and (b) all covered dependents who become ineligible for coverage due to a qualifying event, such as divorce or exceeding the age limit.

GLOSSARY OF TERMS AND ACRONYMS

Condition – A collection of signs and symptoms associated with a specific pathophysiologic process.

Co-insurance - The percentage a member pays for healthcare covered services after the deductible (if applicable) is satisfied.

Co-insurance Limit – See Out-of-Pocket Limit for an explanation.

Co-payment – A medical insurance cost sharing arrangement that requires a plan participant to pay a fixed dollar amount when a medical service is provided.

Coordination of Benefits (COB) – The process of reconciling health care expenses for those employees and their dependents covered by more than one group plan. The plans will work together to pay for eligible claim expenses while avoiding duplicate payments for the same services. This prevents anyone from receiving more than 100% of the eligible charges. Most group plans have adopted the birthday rule; however, if parents are not married, this may be different.

The birthday rule states that if both parents cover dependent children, the plan of the parent whose birthday is first during the year is primary. For example, if one parent's birthday is in March, and the other's is in April, the plan of the March parent is primary.

Credited Service – The total period of years and months of completed service as credited under the terms and conditions of the ERS.

Deductible – A fixed dollar amount during the benefit period that an insurance plan participant pays before the plan will pay for covered expenses.

Dependent – A primary participant's spouse and eligible children. Each plan may have different dependent qualifiers.

Drug – Any natural or manufactured substance with physiological or psychological effects.

Durable Medical Equipment - Equipment or device which:

- Can withstand repeated use;
- Is primarily and customarily used to serve a medical purpose;
- Generally, is not useful to a person in the absence of an illness or injury; and
- Is appropriate for use in the home.

EAP – Employee Assistance Program, a referral service and managed care program for mental health and substance abuse problems.

Election - A decision you make to participate or contribute to a plan. If you do choose to participate, you will complete an *election* or enrollment form.

Eligible Dependents – Your lawful spouse and natural, step, or adopted children. May also include child(ren) for whom you or your covered spouse is legal guardian. Although you may claim others as dependents for income tax purposes (such as your parents), only those individuals identified above are considered to be eligible dependents for health insurance purposes.

GLOSSARY OF TERMS AND ACRONYMS

Eligibility Window – The 45-day period of time in which new employees and newly eligible employees (for example conversion to a career position) may enroll or make changes in benefit plans by completing an enrollment form and submitting it to the Health & Benefits Office.

Effective Date - The date that coverage goes into effect for employees and their dependents. All Commission Open Enrollment changes are effective January 1.

Emergency - An unexpected or urgent medical condition or acute trauma requiring prompt medical treatment to prevent loss of life, limb, or body function. See also Urgent Medical Condition.

End Stage Renal Disease (ESRD) – Permanent kidney failure that requires a regular course of dialysis or a kidney transplant.

Evidence of Insurability or Good Health – A medical questionnaire that an employee or eligible dependent must complete if insurance coverage is requested outside of the normal eligibility window. In some circumstances, a physical examination may be required at your own expense.

Executor – Someone selected to manage the estate of another who has died. You can select your own executor before you die and name that person in your will. Without a will, the state will pick an executor.

Experimental Or Investigative - Any treatment, procedure, facility, equipment, drug, device or supply which the general medical community or the Plan does not accept as standard medical treatment of the condition being treated. Also, any of such items requiring federal or other governmental agency approval, which has not been granted at the time services are provided.

Flexible Spending Account - A pre-tax savings account where you select an amount to set aside from each paycheck to pay eligible medical or family care expenses you incur during the year.

Formulary – A list of preferred, commonly prescribed prescription drugs, based on their safety, cost and effectiveness and cost.

Fraud – the intentional submission of false or misleading information or the omission of information for the purpose of financial gain.

Generic Drug – A biologically, or chemically equivalent, lower cost version of a brand-name drug, whose patent has expired.

Guaranteed Issue – A policy or rule requiring an insurer to issue an insurance policy to any person, regardless of health-related status or pre-existing conditions.

Health Insurance – For the Commission, health benefit plans include medical, dental, prescription and vision benefits.

Health Maintenance Organization (HMOs) – Medical plans characterized by the use of primary care physicians, referrals, and a managed care component. Preventive care is encouraged and there are no claim forms to complete. In the Individual Practice Association (IPA) model, PCPs monitor all treatment. There is no benefit for out-of-network treatment. Urgent care and emergency treatment are covered after notifying your PCP within 48 hours (72 hours on the weekend). After the required co-payment, coverage is provided at 100%.

GLOSSARY OF TERMS AND ACRONYMS

High-3 Average – Your highest average base pay over any three consecutive years of credited service. Generally, the final three years of service include the highest pay, but pay from an earlier three-year period can be used if it was higher. This is used by the ERS retirement plans.

In-Network - A pre-authorized group of medical professionals or facilities within a specific benefit plan.

Independent Medical Exam (IME) – An examination given by a non-Commission doctor who is qualified to determine the medical status of an individual.

Leave of Absence – 1) Employee earned leave, which may be taken for authorized absences or approved unpaid leave. 2) A Commission authorized leave granted to the employee without charge to an employee's leave balances

Legal Guardian - A guardian is someone appointed by the Court to assume legal responsibility for another person or another person's property or both. Guardianship is appropriate when a disabled person, known as the ward, is unable to make responsible decisions concerning his or her medical care or financial situation, usually because of a physical or mental illness.

Living Will – Written ahead of time, this is your statement of how you want to receive health care in case you are unable to make decisions or talk to your doctor. Such health care could include routing treatments and life-saving methods. If can also instruct the doctor how aggressively to fight to keep you alive, if hope is considered lost. You can also choose someone to make medical decisions in case you can't. Living Wills are also called Advance Directives.

Long Term Disability – An income replacement plan that allows participants to receive a portion of their income while they recover from an illness or injury. Under certain circumstances payment may be made until a person reaches age 65.

Maintenance medications or drugs – A medication anticipated to be required for four (4) months or more to treat a chronic condition.

Marriage – A union between two persons in a committed relationship as recognized under Maryland state law.

Marriage Partner – Either party to a Marriage (defined above).

Medical Care – Services rendered by a licensed medical provider for an approved condition under the license for the diagnosis, cure, mitigation, treatment, or prevention of diseases, or for the purpose of affecting any structure or function of the body.

Medically Necessary or Medical Necessity – Services or supplies rendered by a provider that the Administrator determines are

- Appropriate for the symptoms and diagnosis or treatment of the subscriber's condition, illness, disease, or injury. "Appropriate" means that the type, frequency, duration, level and length of service and the setting are necessary to provide safe and adequate care and treatment; and
- Provided for the diagnosis or the direct care and treatment of the covered person's condition, illness, disease, or injury; and
- In accordance with generally accepted (see term in glossary) standards of good medical practice;
- For the diagnosis or the direct care and treatment of the covered person's condition, illness, disease, or injury;
- Not regarded as experimental, unproven for a diagnosis, or for provider educational purposes;

Medically Necessary or Medical Necessity (continued) -

- Specifically allowed under the license of the provider;
- Not primarily for the convenience of the covered person, physician, or other provider; and
- The most appropriate supply or level of service that can be safely provided to the covered person. When applied to hospitalization, this further means that the covered person required acute care due to the nature of the services provided or the covered person's condition, and the covered person cannot receive safe or adequate care as an outpatient or in another less costly setting.
- Not required solely for employment, insurance foreign travel, school, camp admissions or participation in sports activities.
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent, therapeutic or diagnostic results, in the diagnosis or treatment of a patient's illness, injury or disease.

Coverage would not be provided for the cost of services that are free.

Medicare – The programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

Member/Participant - An employee, retired employee, or dependent who is eligible for coverage and also elects to be covered in a plan.

Network Provider – Providers such as doctors, hospitals, specialists, and other providers who have agreed to provide medical services at a lower cost for plan participants. When you receive treatment or services from a network provider, you are responsible for the co-pay or co-insurance and deductible only.

Non-Covered Service – A service (medical, dental, vision, etc.) rendered that is excluded from the plan's contractual benefits.

Normal Retirement Date – The date a member may retire with full retirement benefits. Eligibility requirements will vary by plan.

Open Enrollment- Annual period during which an employee may elect to enroll, change, or terminate coverage in a benefit plan.

Out-of-Network Provider – Providers who do not have an agreement with the Plan for payment of covered services. This means that you will be responsible for the difference between the provider charged amount and the Plan allowance, as well as your deductible and coinsurance.

Out-of-Pocket Expenses - Charges you pay that are not covered by your insurance plan.

Out-of-Pocket Maximum (OOP or OOM) – The maximum amount a member pays toward covered medical expenses, generally not including deductibles, copayments, pre-certification penalties, not covered expenses, charges above the allowed amounts, and the member's portion of the monthly premiums. Once the member has reached the out-of-pocket maximum amount, the plan will generally pay 100% of all additionally covered medical expenses for the year. Out-of-Pocket maximums generally apply to the out-of-network costs that are incurred.

Over-The-Counter (OTC) – Items that can be typically purchased at a local pharmacy, supermarket or medical supply store and do not require a physician's prescription for purchase; Pharmaceutical products or drugs that are available without a prescription or any medication that is equivalent to an OTC medication.

Participant – See subscriber.

GLOSSARY OF TERMS AND ACRONYMS

Participating Provider – This generally refers to a doctor that has a minimum contractual agreement with a healthcare carrier. Any provider that has signed this “participating” agreement agrees to bill the healthcare carrier directly and not bill the participant for any charges above the reasonable and customary charge (allowed amount).

Period of Coverage – The period during which a participant may use or access the benefits of a plan according to the plan’s requirement.

PHI: Protected Health Information: Protected health information under HIPAA means individually identifiable health information. Identifiable refers not only to data that is explicitly linked to a particular individual. It also includes health information with data items, which reasonably could be expected to allow individual identification.

Physician - A person who is a Doctor of Medicine (M.D.) or a doctor of osteopathy (D.O.) licensed and legally entitled to practice medicine in all branches, perform surgery and dispense drugs.

Plan Administrator – Generally the Benefit Plan is considered the plan administrator. In the case of Sick Leave Bank, the Commission is the plan administrator.

Plan Sponsor – the Commission is the plan sponsor for the benefit plans.

Point-of-Service (POS) – A medical benefits plan in which members select a Primary Care Physician to coordinate all care, including referrals to participating specialists. The member’s out-of-pocket costs are modest and there are no deductibles. However, members can also by-pass their PCP to access other providers directly, but in this situation the reimbursement is lower and the out-of-pocket cost is higher.

Pre-Certification (Pre-Authorization) – A review program where services or products must be approved prior to receiving them using guidelines approved by the plan. Pre-certification of benefits is designed to guarantee that you receive medically appropriate care in the most appropriate treatment setting. All overnight hospital stays must be pre-certified. Scheduled admissions must be called in by the doctor’s office prior to the admission. Without this certification, a plan may not cover your services or may reduce benefits by charging a penalty.

Pre-Existing Condition – A condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received during a certain time before the date an insurance policy or plan took effect. It may also include a condition for which a prudent person would have sought treatment.

Preferred Provider Organization (PPO) - A medical benefits plan that permits members to see any provider. A participant is not required to see a primary care physician before obtaining the services of a specialist. This plan is characterized by having the least amount of managed care.

Prescription Drugs – (a) Any medication which by federal or state law may not be dispensed without a doctor’s written approval, (b) insulin, and (c) non-reusable devices used to administer drugs.

Prescription Order or Refill – The directive to dispense prescription drug products issued by a duly licensed health care provider whose scope of practice permits such a directive.

Primary Care Physician (PCP) - A doctor of internal medicine, pediatrics, family, or general practice, and in some cases, an OB/GYN. Most HMOs require members to choose a PCP from the list of participating physicians. This doctor provides all initial care for the member and will make appropriate referrals to plan specialists when necessary. Members can change PCPs by calling the plan.

GLOSSARY OF TERMS AND ACRONYMS

Primary Payer – An insurance policy, plan or program that pays first on a claim for medical care.

Prior Authorization – See pre-certification.

Prosthetic Device – An externally worn device that replaces a body part or performs or assists the patient in performing a bodily function. Not included are eyeglasses or contact lenses or dental prosthetics, or equipment that can be used for non-medical purposes (i.e.: air conditioner).

Providers – any healthcare provider or group of providers, such as a doctor, physician group, or hospital is called a provider.

Qualified Medical Child Support Order (QMCSO) -A Qualified Medical Child Support Order (QMCSO) is a court decree stipulating that a child of a covered member is entitled to enroll in the participant's group health plan. Coverage begins on the date the child is ordered to be enrolled in the plan.

Qualifying Event - Incidents that may occur in your life that would allow you to make a change to your employee benefits outside of the normal Open Enrollment period. For example, the birth of your child would permit you to enroll in the dependent care account, or a divorce would permit you to reduce the amount you contribute to your health care account.

Reasonable and Customary – See Usual, Customary and Reasonable Allowance.

Secondary Payer – An insurance policy, plan or program that pays second on a claim for medical care.

Spouse – A marriage partner; a husband or wife. See Marriage.

Step Protocols – The use of lower cost therapies or drugs before stepping up to a more expensive therapy or brand of drug.

Subscriber – Also called Participant. This is an employee/retiree/survivor or COBRA participant who elects to enroll in health benefits. Some plans use the subscriber's Social Security Number as the identification number for the entire family. Other plans may assign individual ID numbers or medical record numbers for each dependent.

Substance Abuse – Refers to any pattern of pathological use of alcohol or of a drug, that causes impairment in social or occupational functioning, or that produces physiological dependency as evidenced by physical tolerance or by physical symptoms when the alcohol or drug is withdrawn.

Tax Deferred – An investment that allows you to postpone the tax you pay until you withdrawal the money. Any earnings compound tax deferred. In addition, you may also be in a lower tax bracket when you take money out of the tax-deferred investments, so you may pay less taxes overall.

Untimely – Refers to a request for a change in benefits that is not timely. An untimely request is a late request that does not fall within IRS or Commission time requirements.

Urgent Care – Occurs when a patient has an illness that is not life threatening but requires immediate attention to prevent serious deterioration of health.

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Urgent Medical Condition – A medical condition including a physical or mental condition, where the absence of medical attention within 24-48 hours (or more depending on the plan requirements) could reasonably be expected to result in:

- Placing a member's life or health in serious jeopardy
- The inability of the member to regain maximum function
- Serious impairment to bodily function
- The member remaining seriously mentally ill with symptoms that cause the member to be a danger to self or others or
- Severe pain to the member that cannot be managed with a physician's care or treatment.

Usual, Customary, and Reasonable Allowance – The amount of the charges that an insurance company will consider for payment in accordance with:

- Usual Charge – the amount most frequently charged by an individual provider to the majority of patients for a given service;
- Customary Charge – a charge determined by the regular charges made by most providers with similar training and experience within a given geographical area; and
- Reasonable Charge – a charge (which may differ from the Usual or the Customary Charge) determined by the Administrator by considering unusual clinical circumstances, the degree of professional involvement, or the actual cost of equipment and facilities involved in providing the service.

Vested – The non-forfeitable right to own the contributions in your account. Employee contributions are always 100% vested. Employer contributions are subject to a vesting schedule.

Young Adult – Individuals ages 19 – 25 who, under the PPACA can remain covered under their parents' employer sponsored or individually purchased medical health benefit plans.

Waiver of Premium – A provision included in some insurance policies which exempts the policyholder from paying the premiums while an insured is disabled.

GLOSSARY OF TERMS AND ACRONYMS

Acronyms

AD&D	Accidental Death and Dismemberment
CBA	Collective Bargaining Agreement
CHIP	Children's Health Insurance Program
COB	Coordinator of Benefits
COBRA	Consolidated Omnibus Budget Reconciliation Act
COLA	Cost of Living Adjustment
DAW	Dispense As Written
DME	Durable Medical Equipment
DOL	Department of Labor
DRG	Diagnostic Related Group
EOB	Explanation of Benefits
EAP	Employee Assistance Program
EHR	Electronic Health Records
EMR	Electronic Medical Records
EPO	Exclusive Provider Organization
ERS	Employee Retirement System
FDA	Food & Drug Administration
FMLA	Family Medical Leave Act
FOP	Fraternal Order of Police (Union)
FPDP	Final Pay Deferral Plan
HHS	Health and Human Services
HIPAA	Health Insurance Portability & Accountability Act
HMO	Health Maintenance Organization
IME	Independent Medical Exam
IRS	Internal Revenue Service
LTD	Long-Term Disability
MCGEO	Municipal and County Government Employees Organization/ United Food & Commercial Workers (Union)
OB/GYN	Obstetrician/Gynecologist
OTC	Over-The-Counter
QDRO	Qualified Domestic Relations Order

QMSCO	Qualified Medical Child Support Order
PCP	Primary Care Physician
PHI	Protected Health Information
PHR	Personal Health Record
POS	Point of Service
PPACA	Patient Protection & Affordable Care Act
PPD	Permanent Partial Disability Benefits
PPO	Preferred Provider Organization
PTD	Permanent Total Disability
SAMHSA	Substance Abuse and Mental Health Services Administration
SLB	Sick Leave Bank
SSN	Social Security Number
TPD	Temporary Partial Disability Benefits
TTD	Temporary Total Disability Benefits
UCR	Usual, Reasonable and Customary
USERRA	Uniformed Services Employment and Re-employment Act

The Commission expects the plans and benefits described in this booklet to continue, but still reserves the right to amend, modify, suspend, or terminate the plans and benefits at any time and for any reason except as limited by applicable union contracts and the Merit Rules. If any insurance company changes or ends any plans or benefits you will be notified.

The plans and benefits described in this booklet in no way imply a contract of employment between you and the Commission. The Commission's right to discipline or discharge any employee is in no manner changed by any provision of these plans and benefits.

The Commission has the full discretionary authority to interpret the benefit programs in this Handbook in accordance with the terms of each benefit program and to determine eligibility under each benefit program. The Commission has delegated its authority for the administration of the benefit programs and its authority to make final claims determinations to the claims administrators. Benefits under the benefit programs are paid only if the claims administrators decide in their discretion that the claimant is entitled to them.