2023-2024

GCPS

EMPLOYEE BENEFITS GUIDE

Welcome to the 2023-2024 Benefits Open Enrollment

The GCPS annual insurance open enrollment period is about to begin.

We recognize the importance of benefits within the overall compensation package provided to all of our eligible employees.

Open enrollment runs
May 10th—May 21st

FY 24 Changes at a Glance

- Addition of PrudentRx for Exclusive Specialty under Bronze Plan (PrudentRx already in place for Gold and Silver Plans)
- Enhanced Utilization Management for certain specialty prescriptions such as Auvi-Q, Descovy, Xyrem, and Dupixent.

NOT SURE HOW TO GET STARTED?
DON'T WORRY!

Prior to open enrollment, you will receive step-by-step enrollment instructions from the Office of Human Resources. Until then, now is the perfect time to prepare by doing the following:

- ✔ Checking that your personal information is accurate in your Employee Self Service Portal (ESS)
- ✔ Reviewing the benefits in which you are currently enrolled.
- ✔ Taking a look at the changes for 2023-2024
- ✔ In this booklet, you'll find easy-to-understand instructions to help you make your benefit decisions.
- ✔ As always, we value you as a member of the GCPS family and look forward to a healthy and safe 2023-2024.

REMEMBER:

Open enrollment is the one time of year you can make any adjustments you'd like for the upcoming plan year.

CONTACT INFORMATION

If you have any questions regarding your benefits, please contact one of the carriers listed below or the Human Resources Office.

Medical
CareFirst
carefirst.com
(888) 448-0079

Prescription Drug
CVS/CareMark
caremark.com
(888) 202-1654

Dental
Delta Dental
deltadentalins.com
(800) 932-0783

Vision
NVA
e-nva.com
(800) 672-7723

Basic Life and AD&D
The Standard
standard.com
(800) 628-8600

Virtual Benefits
CareFirst Video Visit
carefirstvideovisit.com/landing.htm
(877) 699-4117

Flexible Spending Accounts (FSA)
FlexibleBenefits Administrators
fba.wealthcareportal.com/page/home
(800) 437-3539

Employee Assistance Program (EAP)
Deer Oaks
deeroakseap.com
(866) 327-2400

Your Benefits Team
Rebecca Sleeman, (301) 334-8929,
rebecca.sleeman@garrettcountyschools.org
Angela Flanigan, (301) 334-8904,
angela.flanigan@garrettcountyschools.org

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Throughout this guide you will find video and link icons that will take you to resources that provide additional information on the benefits available to you.

Who is Garrett County Board of Education?

Education is the key to the vitality and sustainability of our community. The Garrett County Public School System maintains an environment in which staff, students, parents, and the community work collectively for a brighter tomorrow. While celebrating the culture and traditions of Garrett County, the schools create an environment where students are nurtured to become productive, enthusiastic, and successful members of society.

Who is Eligible?

Garrett County Board of Education offers medical benefits through CareFirst and Prescription Drug benefits through CVS CareMark. These plans are designed to provide you and your family with access to high quality healthcare. The plans available to employees are BlueChoice Advantage Plan Gold, BlueChoice Advantage Plan Silver and BlueChoice Advantage Plan HSA Bronze. They cover a broad range of healthcare services and supplies, including prescriptions, office visits, and hospitalizations. Please refer to the summary on the following pages for specific details on the medical plans available.

Eligible dependents include the employee's spouse and children to age 26, regardless of student status.

When to Enroll

You can enroll in the plans each year during open enrollment.

New hires can enroll on date of hire. Full time employees and their dependents may enroll in one of three medical plans, a dental plan, a vision plan, a basic life plan, an optional supplemental life plan, and an optional Flexible Spending Account. The Employee Assistance Program (EAP) is provided by Garrett County Board of Education at no cost to employees.

Eligibility: The first day of the month following the date of hire or the date of hire, if hired on the first day of the month.

For enrollment and eligibility questions, please contact the Human Resources Department for assistance.

How to Make Changes

The Internal Revenue Service (IRS) states that eligible employees may only make elections to the plan once a year at open enrollment. The following qualify as changes in status: marriage, divorce, birth or adoption of a child, change in child's dependent status, death of spouse, child or other qualified dependent, change in residence due to an employment transfer for you or your spouse, commencement or termination of adoption proceedings, or change in spouse's benefits or employment status. Unless you have a qualified change in status, you cannot make changes to the benefits you elect until the next open enrollment period. If any of the above listed qualified changes occur, **you must inform the Human Resources Department within 30 days of the event to avoid a lapse in coverage**. All other changes are deferred to open enrollment.

Adding a Dependent

When adding any new dependents to your insurance coverage, the following information must be provided:

Spouse:

Copy of Marriage Certificate **AND** Copy of the top half of the front page of your most recently filed Federal Income Tax Return **OR** Joint Household Bill, Joint Bank/Credit Account, Joint Mortgage/Lease, or Insurance Policy listing you and your spouse's name, the date, and your current mailing address. Documents must be dated within the last 6 months.

Surviving Spouse:

Copy of the top half of the front page of your most recently filed Federal Income Tax Return confirming that you filed as "Head of Household", "Single", or showing that your spouse passed away in that tax year.

Child Under Age 26:

Copy of the child's birth certificate naming you and your spouse as the child's parent, or appropriate court order/adoption decree naming you or your spouse as the child's legal guardian. **OR** If applicable, a copy of the divorce decree granting full or joint custody (names of all parties must be included). **OR** If applicable, a copy of a court-issued Qualified Medical Child Support Order (QMCSO) or other court order stating you or your spouse are required to provide healthcare (names of all parties must be included).

Disabled Dependent:

Any of the same documents required for Child Under Age 26.

MEDICAL INSURANCE

HOW TO GET STARTED

1

SELECT YOUR MEDICAL PLAN

- ☐ BlueChoice Gold
- ☐ BlueChoice Silver
- ☐ BlueChoice HSA Bronze

TIP: Get the most out of your insurance by using in-network providers.

FREQUENTLY ASKED QUESTIONS

? How many hours do I need to work to be eligible for insurance benefits?

You must be a full-time employee working a minimum of 30 hours per week on a regular basis.

? Will I receive a new Medical ID card?

Those newly electing coverage will receive two ID cards in the mail, one for Medical, one for Rx. Those already enrolled will receive a new medical card. If you are a new hire, log onto carefirst.com to set up a Member account once you receive your member ID card. Current Rx cards will remain active.

? Does the deductible run on a calendar year or policy year basis?

A policy-year basis/fiscal year: July 1 - June 30.

? How long can I cover my dependent children?

Dependent children are eligible until the end of the month in which they turn age 26.

? I just got hired. When will my benefits become effective?

Your medical insurance benefit will begin on the 1st day of the month following date of hire or date of hire if hired on the first of the month.

YOUR HEALTH PLAN OPTIONS

As a full-time employee of GCPS, you have the choice between three medical plan options: BlueChoice Advantage Plan Gold, BlueChoice Advantage Plan Silver and BlueChoice Advantage Plan HSA Bronze.

For each, your deductible will run from July 1 – June 30.

While all plans give you the option of using out-of-network providers, you can save money by using in-network providers because CareFirst has negotiated significant discounts with them. If you choose to go out-of-network, you'll be responsible for the difference between the actual charge and CareFirst's UCR (Usual, Customary and Reasonable) charge, plus your out-of-network deductible, coinsurance, and balance billing.

These plans cover a broad range of healthcare services and supplies, including prescriptions, office visits and hospitalizations. Please refer to the following pages for specific details on the medical plans available to you and your family.

You can access the Summary of Benefits and Coverage (SBCs) here.

CARE OPTIONS AND WHEN TO USE THEM

While we recommend that you seek routine medical care from your primary care physician whenever possible, there are alternatives available to you. Services may vary, so it's a good idea to visit the care provider's website. Be sure to check that the facility is in the BlueChoice Advantage network by calling the toll -free number on the back of your medical ID card, or by visiting carefirst.com and choosing the "Find A Doctor" tile.

NURSELINE

- Decide when to visit your doctor or go to an Urgent Care or ER
- Understand your medications
- Find network doctors and prepare for an appointment

NURSELINE

CareFirst members have 24/7 access to medical advice telephonically and online through FirstHelp and Ask Our Nurses services. FirstHelp is a telephone medical advice service staffed by registered nurses who can answer questions related to one's health and help guide the member to the most appropriate care. Ask Our Nurses is an online extension of FirstHelp. The telephone number for FirstHelp is toll-free (1-800-535-9700) and listed on the back of your identification card. Ask Our Nurses is accessible through CareFirst's secure member portal or mobile app, *My Account*.

PRIMARY CARE

- Primary preventive care
- Non-urgent treatment
- Routine Physical

PRIMARY CARE

For routine, primary/ preventive care or non-urgent treatment, we recommend going to your doctor's office. Your doctor knows you and your health history and has access to your medical records. You may also connect with your primary care provider by telephone or virtually, if this option is offered through your Dr's office (this type of visit would still be charged as an office visit).

CENTRIC PRIMARY CARE

- Well care
- Preventive and urgent care
- Behavioral Health
- Lifestyle Support
- Care Coordination

CENTRIC PRIMARY CARE

CloseKnit is a patient-centric, virtual-first primary care practice. Open 24/7/365 through a simple, convenient app. Our virtual –first delivery model offers a breadth of care services. CloseKnit delivers an affordable **(applicable copay/coinsurance)**, total health experience from a dedicated care team. Register for an account at CloseKnitHealth.com.

TELEHEALTH

- Cold/flu
- Diarrhea
- Fever
- Rash
- Sinus Problems
- Pink Eye
- Sore Throat

TELEHEALTH

CareFirst Video Visit allows members to securely connect with a doctor whenever and wherever you want—without an appointment (for urgent care services). Video Visit provides members with medical guidance when your primary care provider (PCP) isn't available, like after hours, on weekends or while traveling. The program also includes scheduled visits for behavioral health (therapy and psychiatry), diet / nutrition and lactation support. **Pending your medical plan coverage, you may be charged (please see page 9 for details).**

If you believe you are experiencing a medical emergency, go to the nearest emergency room or call 911, even if your symptoms are not described here.

CALL 9-1-1

Primary Care vs. Urgent Care vs. ER

CARE OPTIONS AND WHEN TO USE THEM

While we recommend that you seek routine medical care from your primary care physician whenever possible, there are alternatives available to you. Services may vary, so it's a good idea to visit the care provider's website. Be sure to check that the facility is in the BlueChoice Advantage network by calling the toll -free number on the back of your medical ID card, or by visiting carefirst.com and choosing the "Find A Doctor" tile.

BEHAVIORAL HEALTH

- Talk with someone who understands
- Connect with licensed therapist
- Join a support forum
- Learn new coping skills

CONVENIENCE CARE

- Common infections (Ear infections, pink eye, strep throat & Bronchitis)
- Flu shots
- Pregnancy tests
- Vaccines
- Rashes
- Screenings

URGENT CARE

- Sprains
- Small cuts
- Strains
- Sore throats
- Minor infections
- Mild Asthma Attacks
- Back Pain or strains

EMERGENCY ROOM

- Heavy bleeding
- Large open wounds
- Chest pain
- Spinal injuries
- Difficulty breathing
- Major burns
- Severe head injuries

If you believe you are experiencing a medical emergency, go to the nearest emergency room or call 911, even if your symptoms are not described here.

CALL 9-1-1

BEHAVIORAL HEALTH DIGITAL RESOURCE

The help you need is waiting.

To set up your free account, visit carefirst.com/myaccount and enter your CareFirst My Account username and password. Once logged in to My Account, scroll down to the Featured Resources and select the Behavioral Health Digital Resource tile. After you've registered, simply log in and start your journey to better mental health.

CONVENIENCE CARE

These providers are a good alternative when you are not able to get to your doctor's office and your condition is not urgent or an emergency.

They are often located in malls or retail stores (such as CVS Caremark, Walgreens, Wal-Mart and Target), and generally serve patients 18 months of age or older without an appointment. Services may be provided at a lower out-of-pocket cost than an urgent care center.

URGENT CARE

Sometimes you need medical care fast, but a trip to the emergency room may not be necessary.

During office hours, you may be able to go to your doctor's office. Outside regular office hours—or if you can't be seen by your doctor immediately—you may consider going to an Urgent Care Center where you can generally be treated for many minor medical problems faster than at an emergency room.

EMERGENCY ROOM

An emergency medical condition is any condition (including severe pain) which you believe that, without immediate medical care, may result in serious injury or is life threatening.

Emergency services are always considered in-network. If you receive treatment for an emergency in a non-network facility, you may be transferred to an in-network facility once your condition has been stabilized.

Primary Care vs. Urgent Care vs. ER

TELEHEALTH

CAREFIRST VIDEO VISIT

If you enroll in the **BlueChoice Advantage Gold** or **BlueChoice Advantage Silver** plans, you can connect with a licensed physician via phone or **video anytime, anywhere and with $0 copay through CareFirst Video Visit.** CareFirst Video Visit's U.S. board certified doctors are available 24/7/365 to resolve many of your medical issues through phone or video consults.

- Bladder infection/ urinary tract infection
- Cold/flu
- Diarrhea
- Fever
- Migraine/ headaches
- Pink eye
- Rash
- Sinus problems
- Sore throat

If you are enrolled in the **BlueChoice Advantage HSA Bronze,** your **cost will be $55** when using this service.

Registering with CareFirst Video Visit is quick and easy online. Visit the CareFirst Video Visit website at CareFirst Video Visit.com, click "Set up account" and provide the required information. You may also call CareFirst Video Visit for assistance over the phone at (877) 699-4117.

Once your account is set up, you can call and request a consult any time you need care.

7 REASONS TO REGISTER WITH CAREFIRST VIDEO VISIT

1. Provides confidential, convenient, and affordable healthcare 24/7/365.
2. You can speak with a licensed doctor about non-emergency health issues anywhere, whether you're at home, at work, or on vacation.
3. The average wait time to speak with a doctor is 10 minutes.
4. Doctors can diagnose and treat cold and flu symptoms, upper respiratory infections, ear infections, skin problems, allergy symptoms and more.
5. Doctors can also send a prescription straight to your pharmacy of choice when medically necessary.
6. Your dependents are eligible to receive care from CareFirst Video Visit, including adult children up to age 26.
7. You can connect with CareFirst Video Visit by phone, web, or mobile app.

(877) 699-4117 carefirstvideovisit.com

Medical/Prescription Drug Insurance Plan Options

CareFirst and CVS	BlueChoice Advantage Silver (Formerly POS Plan)	BlueChoice Advantage Gold (Formerly PPO Plan)	BlueChoice Advantage HSA Bronze (Formerly HDHP/HSA Plan)
	In-Network	**In-Network**	**In-Network**
Deductible (fiscal year) Individual / Family	$550 / $1,100	$55/$110	$2,200 / $4,400
Out-of-Pocket Maximum Individual / Family	$4,400 / $8,800	$3,300 / $6,600	$5,500 / $11,000
Office Visit Primary Care Physician Specialist	100% after $40 copay 100% after $50 copay	100% after $25 copay 100% after $25 copay	90% after deductible 90% after deductible
Preventive Care	100% covered	100% covered	100% covered
Lab and X-ray	100% covered	100% covered	90% after deductible
Specialty Imaging, MRI, CT, MRA/MRS, Nuclear Med & PET—Outpatient Hospital, a managed care services provided by a hospital	85% after deductible	90% after deductible	90% after deductible
Specialty Imaging, MRI, CT, MRA/MRS, Nuclear Med, & PET—Free Standing Facility, a facility that does not share basic services with a hospital-based provider	100% covered	100% covered	90% after deductible
Urgent Care	100% after $50 copay	100% after $25 copay	90% after deductible
Emergency Care Hospital Ambulance transportation	$175 copay, waived if admitted 100% after deductible	$50 copay, waived if admitted 90% after deductible	90% after deductible
Outpatient Surgery	100% after $150 Facility copay + 100% after $50 Physician copay	100% after $75 Facility copay + 100% after $25 Physician copay	90% after deductible
Inpatient Hospital Services	85% after deductible	90% after deductible	90% after deductible
Prescription Drug Retail *(34-day supply)* Mail Order *(90-day supply)*	$20 / $50 / $75/15% up to $200* $40 / $100 / $150	$20/ $40 / $75* $40 / $80 / $150	90% after deductible Specialty - up to $150 per script max* after deductible
	Out-of-Network	**Out-of-Network**	**Out-of-Network**
Deductible Individual / Family	$1,000 / $2,000	$330 / $990	$4,400 / $8,800
Out-of-Pocket Maximum Individual / Family	$5,500 / $11,000	$3,300 / $6,600	$7,700 / $15,400

Premiums can be withheld from your paycheck on a pre-tax basis for Medical, Dental, and Vision insurance. Based upon your individual tax bracket, this could save you a considerable amount of money.

***Exclusive Specialty through Prudent Rx is 100% covered. Without Prudent Rx, member coinsurance is 30%. Access PrudentRx FAQ's here.**

All plans are detailed in CareFirst's 2023 Certificate of Coverage (COC), available on carefirst.com. This is a brief summary only. For exact terms and conditions, please refer to your certificate.

You can access the Summary of Benefits and Coverage (SBCs) here.

HEALTH SAVINGS ACCOUNT (HSA)

Two ways you can put money into your HSA:(1) Regular payroll deductions on a pre-tax basis and (2) lump-sum contributions of any amount, anytime, up to the maximum limit.

GCPS contributes $550 towards an individual HSA and $1,100 towards a family HSA

UNDERSTANDING A HEALTH SAVINGS ACCOUNT (HSA)

WHAT IS AN HSA?

A savings account where you can either direct pre-tax payroll deductions or deposit money to be used to pay for current or future qualified medical expenses for you and/or your dependents. Once money goes into the account, it's yours to keep—the HSA is owned by you, just like a personal checking or savings account.

THE HSA CAN ALSO BE AN INVESTMENT OPPORTUNITY.

Depending upon your HSA account balance, your account can grow tax-free in an investment of your choice (like an interest-bearing savings account, a money market account, a wide variety of mutual funds—or all three). Of course, your funds are always available if you need them for qualified health care expenses.

YOUR FUNDS CAN CARRY OVER AND EVEN GROW OVER TIME.

The money always belongs to you, even if you leave the company, and unused funds carry over from year to year. You never have to worry about losing your money. That means if you don't use a lot of health care services now, your HSA funds will be there if you need them in the future—even after retirement.

HSA FUNDS CAN BE USED FOR YOUR FAMILY.

You can use your HSA for your spouse and tax dependents for their eligible expenses—even if they're not covered by your medical plan.

[What is a Health Savings Account?]

WHAT ARE THE RULES?

- You must be covered under a Qualified High Deductible Health plan (QHDHP) in order to establish an HSA.
- You cannot establish an HSA if you or your spouse also have a medical FSA, unless it is a Limited Purpose FSA.
- You cannot be enrolled in Medicare or Tricare due to age or disability.
- You cannot set up an HSA if you have insurance coverage under another plan, for example your spouse's employer, unless that secondary coverage is also a qualified high deductible health plan.
- You cannot be claimed as a dependent under someone else's tax return.

WHAT ELSE SHOULD I KNOW?

- You can invest up to the IRS's annual contribution limit. Contributions are based on a calendar year. The contribution limits for 2023 are $3,850 for Single and $7,750 for Family coverage. If you're age 55 or older, you are allowed to make extra contributions each year.
- The contributions grow tax-free and come out tax-free as long as you utilize the funds for approved services based on the IRS Publication 502, (medical, dental, vision expenses and over-the-counter medications with a physician's prescription).
- Your unused contributions roll over from year to year and can be taken with you if you leave your current job.
- If you use the money for non-qualified expenses, then the money becomes taxable and subject to a 20% excise tax penalty (like in an IRA account).
- There is no penalty for distributions following death, disability (as defined in IRC 72), or attainment of Medicare eligibility age, but taxes would apply for non-qualified distributions.
- If your healthcare expenses are more than your HSA balance, you need to pay the remaining cost another way, such as a credit card or personal check. But save your receipts in case you are ever audited! You can request reimbursement later, after you have accumulated more money in your account.

YOU CAN USE HSA FUNDS FOR IRS-APPROVED ITEMS SUCH AS:

- Doctor's office visits
- Dental services
- Eye exams, eyeglasses, laser surgery, contact lenses and solution
- Hearing aids
- Orthodontia, dental cleanings, and fillings
- Prescription drugs and some over-the-counter medications (with a physician's prescription)
- Physical therapy, speech therapy, and chiropractic expenses

More information about approved items, plus additional details about the HSA, is available at irs.gov.

Every time you use your HSA, save your receipt in case the IRS asks you to prove your claim was for a qualified expense. If you use HSA funds for a non-qualified expense, you will pay tax and a penalty on those funds.

The HSA is your personal account and contains your personal funds. It can be considered an asset by a creditor and garnished as applicable.

As an HSA account holder, you will be required to file a Form 8889 with the IRS each year. This form identifies any contributions, distributions, or earned interest associated with your account.

This may be the best plan option for you if any of the following is true:

- You do not incur a lot of medical and prescription medication expenses.
- You would like money in a savings account to pay for Qualified Expenses permitted under Federal Law.
- You would like the opportunity to contribute pre-tax income to a Health Savings Account.

FREQUENTLY ASKED QUESTIONS

What will I pay at the pharmacy with the HSA qualified plan options?

You will pay the actual discounted cost of the drug until you satisfy your calendar year deductible in full.

What will I pay at the physician's office with the HSA qualified plan?

You'll provide your ID card at the time of the visit and the physician's office will submit the claim to CareFirst. You will not owe anything at the time of the visit. Later you'll receive an Explanation of Benefits (EOB) from CareFirst that shows the charges discounted based on their contract with the physician. When you receive a bill from the physician's office, you pay the portion of the discounted cost you are responsible for as shown on the EOB.

Where can I get a copy of an EOB?

You can access all of your EOB information, as well as obtain other important information, by logging on to carefirst.com.

FLEXIBLE SPENDING ACCOUNTS (FSA)

2 SELECT FSA ACCOUNTS

☐ **Health Care Flexible Spending Account**

Flexible Benefit Administrators website

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

This account enables you to pay medical, dental, vision, and prescription drug expenses that may or may not be covered under your insurance program (or your spouse's) with pre-tax dollars. You can also pay for dependent health care, even if you choose single (vs. family) coverage. The total amount of your annual election is available to you up front, reducing the chance of having a large out-of-pocket expense early in the plan year. Be aware—any unused portion of the account over $610.00 at the end of the plan year, is forfeited.

Eligible Expenses Examples	
• Coinsurance and copayments	• Laboratory fees
• Contraceptives	• Licensed practical nurses
• Crutches	• Orthodontia
• Dental expenses	• Orthopedic shoes
• Dentures	• Oxygen
• Diagnostic expenses	• Prescription drugs
• Eyeglasses, including exam fee	• Psychiatric care
• Handicapped care and support	• Psychologist expenses
• Nutrition counseling	• Routine physical
• Hearing devices and batteries	• Seeing-eye dog expenses
• Hospital bills	• Prescribed vitamin supplements (medically necessary)
• Deductible Amounts	

Click here for the full list of Healthcare FSA Eligible Expenses

What is a Flexible Spending Account?

How the Health Care Flexible Spending Account Works

When you have out-of-pocket expenses (such as copayments and deductibles), you can either use your FSA debit card to pay for these expenses at qualified providers or submit an FSA claim form with your receipt to Flex Benefit Administrators. Reimbursement is issued to you through direct deposit into your bank account, or if you prefer, a check can be issued to you.

Login to your Flexible Benefits portal anytime to submit a claim, check your account balance and manage your account.

2023 Maximum Contributions

Health Care Flexible Spending Account	$3,050 max

DENTAL INSURANCE

3 REVIEW YOUR DENTAL PLAN

DELTA DENTAL IS THE DENTAL CARRIER FOR 2023-2024

The dental plan is a PPO that offers coverage in and out-of-network. It is to your advantage to utilize a network dentist in order to achieve the greatest cost savings. If you choose to go out-of-network, you will be responsible for any cost exceeding Delta Dental's negotiated fees, plus any deductible and coinsurance associated with your procedure.

Dependent children are eligible until the end of the month in which they turn age 26.

Dental Insurance Plan Options

PPO Delta Dental	In-Network	Out-of-Network
Deductible Individual / Family	$50 / $150	$50 / $150
Annual Maximum	$1,200	$1,200
Diagnostics/ Preventive Services	Carrier pays 100% (no deductible)	Carrier pays 80% (no deductible)
Basic Services	80%	80%
Major Services	50%	50%
Orthodontia Services Child(ren)	50% up to $1,000 lifetime maximum	50% up to $1,000 lifetime maximum

DELTA DENTAL®

FIND A DENTIST

To find a Delta Dental provider in your area, visit the website at deltadentalins.com.

In-Network Providers: Provider is reimbursed based on contracted fees and cannot balance bill you.

Out-of-Network Providers: Provider is reimbursed based on Reasonable and Customary standards and balance billing is possible.

What is Dental Insurance?

VISION INSURANCE

4 REVIEW YOUR VISION PLAN

DID YOU KNOW?
There are discounts available for Lasik surgery.

FIND A PROVIDER

To find a National Vision Administrators (NVA) provider in your area, visit the website at e-nva.com.

NVA IS THE VISION CARRIER FOR 2023-2024

The vision plan offers coverage both in-network and out-of-network. It is to your advantage to utilize a network provider in order to achieve the greatest cost savings. If you go out-of-network, your benefit is based on a reimbursement schedule.

Also, if you are considering Lasik surgery or other non-covered benefits, there are discounts available with some providers.

Vision plan will be a separate election, with a 50% active employee cost share.

What is Vision Insurance?

Vision Insurance Plan Options

NVA	In-Network	Out-of-Network
Examination Copay	100% covered	Reimbursement Up to $45
Frequency of Service Exam Lenses Frames Contact lenses in lieu of frames	Every 24 months Every 24 months Every 24 months Every 24 months	
Lenses Single Bifocal Trifocal Lenticular	 100% covered 100% covered 100% covered 100% covered	Reimbursement Up to $55 Up to $85 Up to $105 Up to $190
Frames	Covered up to $100 retail allowance	Reimbursement Up to $50
Contact Lenses in lieu of lenses/frame*	Covered up to $130 retail allowance	Reimbursement $130
Medically Necessary Contacts	100% covered	Reimbursement Up to $285

*Allowances include the contact lens and fitting fee.

LIFE INSURANCE AND AD&D

5 **REVIEW YOUR LIFE POLICIES**

☐ **Basic Life and AD&D**

Group Policy #647116

BASIC LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Basic Life insurance from Standard Insurance Company helps provide financial protection by promising to pay a benefit in the event of an eligible member's, or his or her dependent's, covered death. Basic Accidental Death and Dismemberment (AD&D) insurance may provide an additional amount in the event of a covered death or dismemberment as a result of an accident. The cost of this insurance is paid by Garrett County Public Schools.

BASIC DEPENDENT LIFE INSURANCE

Basic Dependent Life insurance is provided to eligible employees as a benefit for their spouse and/or dependent children. Children must be unmarried and under age 26 to qualify for this coverage. The coverage amount for your spouse and each eligible dependent child is $1,000.00. Children are automatically dropped from this coverage upon their 26th birthday.

ADDITIONAL LIFE INSURANCE (SUPPLEMENTAL LIFE)

Life insurance coverage can help your family meet daily expenses, maintain their standard of living, pay off debt, secure your children's education, and more in the event of your passing. Supplemental Life insurance may be purchased by eligible employees as an additional coverage beyond their Basic Life insurance policy provided by the Board. The premium for this coverage is paid 100% by the employee through easy payroll deductions.

COVERAGE AMOUNT GUIDELINES:

Supplemental Life insurance is sold up to a total of $200,000.00 per employee.

ONLINE ANNUAL ENROLLMENT

GCPS holds an annual online enrollment period each fall through The Standard. All eligible employees are required to login to their individual portal through The Standard's website and make changes to coverage amounts, beneficiaries, and/or dependents for the Dependent Life Benefit. Failure to login during this annual online enrollment period results in employees being unable to make any changes to their life insurance choices for the calendar year beginning each January 1st.

What is Life and AD&D Insurance?

RETIREMENT

6 MARYLAND STATE RETIREMENT AND PENSION SYSTEM (SRPS)

Maryland State Retirement & Pension System (SRPS)

sra.maryland.gov

120 East Baltimore Street

Baltimore, MD 21202

Ways to Contact SRPS

Toll Free	1-800-492-5909
Local	1-410-625-5555
TDD/TTY	1-410-625-5535

Garrett County Public Schools (GCPS) is a participating employer in the Maryland State Retirement and Pension System (SRPS). SRPS administers death, disability and retirement benefits on behalf of more than 405,000 members. Full- and part-time employees of GCPS who are scheduled to work at least 500 hours per fiscal year are required to enroll as members in the Maryland State Retirement and Pension System.

Retirement Benefits Specialists are available at the offices of the Maryland State Retirement and Pension System to assist you in understanding your retirement benefits via phone, one-on-one counseling, correspondence, and seminars. Specialists are able to help you understand your benefits and option selections for all retirement and pension systems, types of retirement, and survivor benefits. If you have specific financial questions regarding your personal retirement account, please contact a Retirement Benefits Specialist directly at The State Retirement and Pension System at 1-800-492-5909 and choose option #2.

For more information please contact Angela Flanigan(301-334-8904) or Rebecca Sleeman (301-334-8929) to discuss this benefit.

OTHER BENEFITS

GCPS WELLBEING

The leadership of GCPS values you and the paramount contributions you make to the students and the community we serve. We want to support you in being your very best and encourage you to take steps to enhance your wellbeing via the GCPS Wellbeing Program.

To assist you in this journey, GCPS offers employees (active or retired under age 65) and their spouses on the CareFirst medical plan an opportunity to earn a wellbeing incentive. The Wellbeing Incentive is offered every plan year. Member employees and spouses who meet participation criteria will receive a $50/month (employee) $25/month (spouse) wellbeing incentive toward their July 1, 2023 – June 30, 2024 health insurance premiums.

The criteria for member employees and spouses is as follows:

Medical Incentive

- Complete a Biometric Screening – annual wellness visit or onsite screening and
- Complete a Real Age – online or paper form, or

Non-Medical Incentive

- To Be Determined

Additional information regarding the Wellbeing Incentive will be provided during open enrollment.

GCPS is committed to helping you achieve your best health. Rewards for participating in the GCPS Wellbeing Program are available to all employees and spouses on the healthcare plan. If you think you might be unable to meet a standard for the Wellbeing Incentive, you could qualify for an opportunity to earn the same incentive by different means. Contact Rebecca Sleeman at 301-334-8929 or rebecca.sleeman@garrettcountyschools.org and she will work with you (and if you wish, with your doctor) to find an alternative with the same reward that is right for you in light of your health status.

Meet CareFirst Wellbeing℠

CareFirst Wellbeing is your personalized, digital connection to living and maintaining your healthiest life. Here, we've brought together all the tools you'll need to manage every aspect of your well-being, from physical fitness and family relationships to stress management and financial health.

Access instructions and further information here.

Tobacco/Nicotine Status and Surcharge:

Garrett County Public Schools employees and their spouses on the healthcare plan will be asked to self-report their tobacco/nicotine status via an attestation form that will be included in open enrollment materials.

Employees and their spouses on the healthcare plan who attest to being a tobacco/nicotine user (or who otherwise do not complete the form), will each be assessed a $600 ($50/month) Tobacco/Nicotine Surcharge beginning July 1, 2023 through June 30, 2024. To avoid the Tobacco/Nicotine Surcharge, as a reasonable alternative, employees and spouses may complete CareFirst's Tobacco Cessation Coaching or the Garrett County Health Department Tobacco Cessation Program by contacting ShareCare/CareFirst at 1 (877) 260-3253 or the Garrett County Health Department at (301) 334-7730. **Please note**: that these cessation programs are **multi-session programs that can take several weeks/months to complete**. Please enroll as soon as possible to ensure you complete either of these programs by March 31, 2024. Questions:

Please contact Rebecca Sleeman at Rebecca.Sleeman@garrettcountyschools.org or 301-334-8929

EMPLOYEE ASSISTANCE PROGRAM (EAP)

The Deer Oaks EAP is a free, confidential service provided to covered employees and their dependents. Deer Oaks provides assistance to employees and household members for a variety of mental health and other family issues such as financial, identity recovery assistance, daily living services and child and elder care. There is also a legal plan option that covers many routine legal issues.

This program offers a wide variety of counseling and assessments, referrals, prevention and education resources and consultation services which are all designed to assist you and your family.

deeroakseap.com

Username: garrettcountyschools

Password: garrettcountyschools

(866) 327-2400

eap@deeroaks.com

IMPORTANT NOTICES

MEDICARE PART D CREDITABLE COVERAGE

Important Notice from Garrett County Board of Education About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Garrett County Board of Education and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

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

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current Garrett County Board of Education coverage **may** be affected. You can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop the Garrett County Board of Education medical plan, **be aware that you and your dependents may not be able to get this coverage back**.

IMPORTANT NOTICES

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

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

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

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

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Garrett County Board of Education changes. You also may request a copy of this notice at any time.

Contact: Rebecca Sleeman, 301-334-8929

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	July 1, 2023
Name of Entity/Sender:	Garrett County Public Schools
Contact--Position/Office:	Rebecca Sleeman, HR Generalist
Address:	40 South Second Street, Oakland, MD 21550
Phone Number:	(301) 334-8929

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: see page 10 of this guide. If you would like more information on WHCRA benefits, call your Plan Administrator at 301-334-8929.

NOTICE REGARDING WELLNESS PROGRAM

GCPS has a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "RealAge" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for cholesterol and glucose levels as well as a blood pressure and BMI screening. You are not required to complete the RealAge or to participate in the blood test or other medical examinations.

However, pending wellness regulations, employees who choose to participate in the wellness program may receive an incentive of a reduced employee contribution to their medical plan. Although you are not required to complete the RealAge or participate in the biometric screening, only employees who do so will receive the incentive.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Rebecca Sleeman at Rebecca.Sleeman@garrettcountyschools.org

The information from your RealAge and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness and/or health plan program. You also are encouraged to share your results or concerns with your own doctor.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2023. Contact your State for more information on eligibility.

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-766-9012
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2023, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

MARKETPLACE COVERAGE OPTIONS

PART A: General Information

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

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS IN THE MARKETPLACE?

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

DOES EMPLOYER HEALTH COVERAGE AFFECT ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.12% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

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

HOW CAN I GET MORE INFORMATION?

For more information about your coverage offered by your employer, please check your summary plan description or contact CareFirst HR department.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

1 An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs.

MARKETPLACE COVERAGE OPTIONS CONTINUED

PART B: Information About Health Coverage Offered By Your Employer

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

Employer Name: Garrett County Public Schools	**Employer Identification Number (EIN):** Inquire at your HR Department
Employer Address: 40 South Second Street, Oakland, MD 21550	**Employer Phone Number:** (301) 334-8929
Who can we contact about employee health coverage at this job? Rebecca Sleeman	**Phone Number (if different from above):** Email Address: **Rebecca.Sleeman@garrettcountyschools.org**

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  All employees. Eligible employees are:
  - ☑ Full time employees, working a minimum 30 hours per week on a regular basis. Employees will be effective the first day of the month following date of hire or date of hire if hired on the first day of the month.
  - ☐ Some employees. Eligible employees are:
- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are: Spouse and children to age 26, regardless of student status.
  - ☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Above is the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

Further COBRA Services P.O.
Box 143005 Irving, TX 75014

Employer Name: Garrett County Public Schools

Account Number: 6192278

INITIAL COBRA NOTICE

Introduction
You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to [*enter name of employer sponsoring the Plan*], and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days [*or enter longer period permitted under the terms of the Plan*] after the qualifying event occurs. You must provide this notice to: Rebecca.Sleeman@garrettcountyschools.org

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started 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 COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Rebecca Sleeman at 301-334-8929

This notice is intended as a brief outline; please see HR for more information.

RESOURCE LIBRARY

CLICK THE LINKS TO LEARN MORE!

MEDICAL PLANS

- Primary Care vs. Urgent Care vs. ER
- Plan Overview
- HDHP vs. Plan Overview
- HDHP with HSA Overview

INSURANCE 101

- Benefits Key terms Explained
- How to read an EOB
- What is a qualifying event?

TAX ADVANTAGE SAVINGS ACCOUNTS

- What is a Health Savings Account?
- What is a Flexible Spending Account?

ANCILLARY BENEFITS

- What is Dental Insurance?
- What is Vision Insurance?
- What is Life and AD&D Insurance?

GLOSSARY OF MEDICAL TERMS

Coinsurance—The plan's share of the cost of covered services which is calculated as a percentage of the allowed amount. This percentage is applied after the deductible has been met. You pay any remaining percentage of the cost until the out-of-pocket maximum is met. Coinsurance percentages will be different between in-network and non-network services.

Copays—A fixed amount you pay for a covered health care service. Copays can apply to office visits, urgent care or emergency room services. Copays will not satisfy any part of the deductible. Copays should not apply to any preventive services.

Deductible—The amount of money you pay before services are covered. Services subject to the deductible will not be covered until it has been fully met. It does not apply to any preventive services, as required under the Affordable Care Act.

Emergency Room—Services you receive from a hospital for any serious condition requiring immediate care.

Freestanding Facility—A facility that does not share basic services with a hospital-based provider.

Lifetime Benefit Maximum—All plans are required to have an unlimited lifetime maximum.

Medically Necessary—Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms, which meet accepted standards of medicine.

Network Provider—A provider who has a contract with your health insurer or plan to provide services at set fees. These contracted fees are usually lower than the provider's normal fees for services.

Out-of-pocket Maximum—The most you will pay during a set period of time before your health insurance begins to pay 100% of the allowed amount. The deductible, coinsurance and copays are included in the out-of-pocket maximum.

Outpatient Hospital —Managed care services provided by a hospital but not inpatient.

Preauthorization—A process by your health insurer or plan to determine if any service, treatment plan, prescription drug or durable medical equipment is medically necessary. This is sometimes called prior authorization, prior approval or precertification.

Prescription Drugs—Each plan offers its own unique prescription drug program. Specific copays apply to each tier and a medical plan can have one to five separate tiers. The retail pharmacy benefit offers a 30-day supply. Mail order prescriptions provide up to a 90-day supply. Sometimes the deductible must be satisfied before copays are applied.

Preventive Services—All services coded as Preventive must be covered 100% without a deductible, coinsurance or copayments.

SBC—Summary of Benefits and Coverage

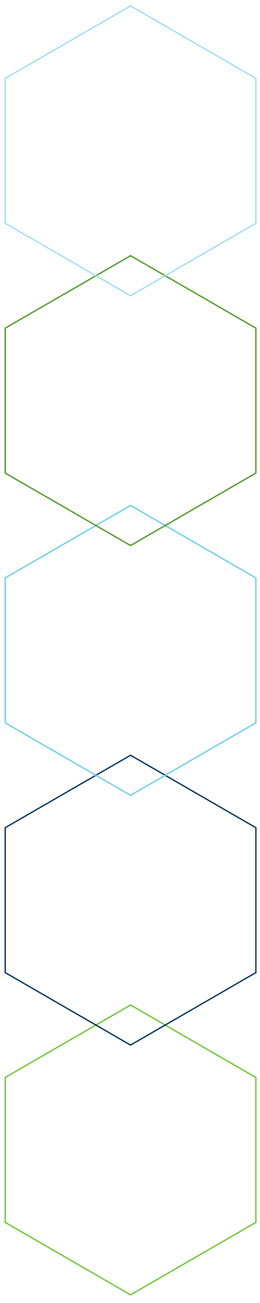
Specialty Drugs—High-cost, high-complexity and/or high touch scripts that are often biologic (drugs derived from living cells). Most, but not all, are injectable or infused.

Specialty Imaging—Includes MRI, MRA/MRS, Nuclear Medicine, CT and PET scans.

UCR (Usual, Customary and Reasonable)—The amount paid for medical services in a geographic area based on what providers in the area usually charge for the same or similar service.

Urgent Care—Care for an illness, injury or condition serious enough that a reasonable person would seek immediate care, but not so severe to require emergency room care.

NOTES:



The purpose of this booklet is to describe the highlights of your benefit program. Your specific rights to benefits under the Plans are governed solely, and in every respect, by the official plan documents and insurance contracts, and not by this booklet. If there is any discrepancy between the description of the plans as described in this material and official plan documents, the language of the documents shall govern.