



MONTGOMERY COUNTY GOVERNMENT

***Group Insurance
Summary Description***

Effective January 1, 2016

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PURPOSE OF THE PLAN

The Group Insurance Plan (the "Plan"), for eligible employees of Montgomery County, is comprised of benefit programs that allow you to design a personalized plan that best meets your needs. In addition, federal law, through Section 125 of the Internal Revenue Code, permits the County to offer certain benefits on a tax-favored (before-tax) basis.

BENEFITS AVAILABLE

As an eligible permanent full or part time employee of Montgomery County Government, you must have the following basic benefits, which you pay for through after-tax pay deductions:

- Basic term life, accidental death and dismemberment (AD&D), and business travel accident (BTA) insurance. Life insurance is optional for Circuit Court judges.
- Long term disability (LTD1) for full-time members of the Employees' Retirement System (ERS).

Please note:

- *Part-time employees are not eligible for LTD1.*
- *Employees of participating agencies who are members of the ERS may be eligible for LTD1. Contact your employer for more information.*

You may elect to purchase other life insurance benefits through after-tax pay deductions:

- Additional term life and AD&D insurance
- Dependent life insurance

In addition to the above basic benefits, you may also elect to pay for the following optional benefits through before-tax pay reductions:

- Medical
- Dental
- Vision
- Prescription drugs
- Health care flexible spending account
- Dependent care flexible spending account

If you are an employee of a Participating Agency you should contact your employer's Office of Human Resources (OHR) for information on the eligibility and enrollment applicable to you under the Montgomery County Plan.

If you are full scope temporary employee of the County in the MCGEO bargaining unit, you are generally eligible to elect optional benefits during the first Open Enrollment six months after your most current date of hire. You are not eligible for the Basic Benefits.

The benefits available under the Plan are delivered through various providers, each with its own separate rules governing coverage and administration. These rules are explained in more detail in the individual benefit booklets. Copies are available from the OHR Health Insurance Team.

A listing of the individual benefits, as well as the highlights, can be found in the Addendum section.

ELIGIBILITY

You are eligible to participate in the Plan if you are a permanent full-time or part-time employee (who works at least 10 hours per week) or a temporary full-scope employee of the County or an eligible employee of a participating agency (contact your employer for more information). If you are a full-scope temporary employee, you are not eligible for the basic benefits, after-tax benefits described on page 3 (i.e., any life insurance and LTD) and the flexible spending accounts.

If you are a seasonal or limited scope temporary employee of the County, you are not eligible to participate in the Plan.

You are enrolled in the Plan effective on your date of hire as an eligible employee. However, the effective dates of coverage for the certain benefits may be different and are determined by the terms of the individual benefits.

If your spouse or eligible domestic partner is also an employee or retiree of the County or a participating agency, and is eligible in his/her own right to enroll in a County benefit program, you are not restricted as to the benefits or coverage options you may elect (*subject to the note in the Addendum section under Dependent Life Insurance*). It is important, however, that you carefully coordinate your elections for benefits and coverage options with those of your spouse or eligible domestic partner.

Some of the benefits under the Plan are available for your eligible dependents. These benefits include medical, dental, vision and prescription drug plans. Although individual benefits may define dependent differently, in general, eligible dependents include:

- Your spouse or eligible domestic partner (please refer to the separate *Domestic Partner Benefits Affidavit* document for complete eligibility requirements and tax implications).
- Your children (including the children of your eligible domestic partner) until the day of their 26th birthday. The term "children" includes any biological children, any adopted children, and any stepchildren.
- An eligible dependent includes a child for whom you have legal guardianship. The child's coverage may continue until his/her 26th birthday if, before his/her 18th birthday, you had legal guardianship of the child and the child was covered under a County Government health plan before age 18.
- An unmarried child (including an unmarried child of your eligible domestic partner) age 26 and older who is incapable of self-support because of a mental or physical disability and who depends on you for support. The child's coverage may continue if the disability began before the day of his/her 26th birthday and the child was covered under a County Government health plan before age 26.

Coverage will continue as long as the disabled child is incapacitated and financially dependent upon you; however, coverage may be otherwise terminated in accordance with the terms of the health plan option. You must provide the County with proof that the child's incapacity and dependency occurred before age 26 although the County's health plan retains the discretion to

make the determination. If you change your health plan option, you must again provide the County with proof that the child's incapacity and dependency occurred before age 26 with the County's health plan retaining the discretion to make the determination.

It is your responsibility to notify OHR Health Insurance Team in writing of your child's incapacity and dependency before their 26th birthday. You are responsible for contacting your County health plan in order to receive a determination that your child is disabled prior to their 26th birthday. Health plan forms for determining your child's incapacity and dependency can be obtained from OHR. After your health plan makes its determination, you must submit a copy of the determination to OHR Health Insurance Team.

Proof of eligibility is required before your dependents will have coverage. *See Proof of Eligibility for Dependents in the Addendum section.*

You are responsible for notifying the OHR Health Insurance Team when your dependents are no longer eligible for coverage. If you do not do so, you will be responsible for 100% of the cost of all claims incurred.

DOMESTIC PARTNER BENEFITS

County law requires that any employment benefit the County provides for the spouse of a County employee or the spouse's eligible dependents must be provided for the domestic partner of a County employee and the partner's eligible dependents.

What are the requirements for domestic partnership?

To establish a domestic partnership, you and your partner must *either*,

1) satisfy all of the following requirements:

- be the same sex (or opposite sex for members of the FOP as of 7/1/2000 or members of the IAFF as of 7/1/2001);
- share a close personal relationship and be responsible for each other's welfare;
- have shared the same legal residence for at least 12 months;
- be at least 18 years old;
- have voluntarily consented to the relationship, without fraud or duress;
- not be married to, or in a domestic partnership with, any other person;
- not be related by blood or affinity in a way that would disqualify them from marriage under State law if the employee and partner were opposite sexes;
- be legally competent to contract; and
- share sufficient financial and legal obligations (described below in the section on *Required Evidence*) or,

2) legally register the domestic partnership, if:

- a domestic partnership registration system exists in the jurisdiction where the employee resides; and
- the OHR Health Insurance Team determines that the legal requirements for registration are substantially similar to the requirements listed under 1) on page 5.

What evidence is required for domestic partnership?

You must provide the following:

1) either,

- an Affidavit for Domestic Partnership from the OHR Health Insurance Team signed in the presence of a notary public by both the employee and the employee's partner; **or**
- an official copy of the domestic partnership registration.

and;

2) evidence that you and your partner share items described in at least 2 of the following (this requirement does not apply to a qualified, registered domestic partnership):

- a joint housing lease, mortgage, or deed;
- joint ownership of a motor vehicle;
- a joint checking or credit account;
- designation of the partner as the primary beneficiary of the employee's life insurance, retirement benefits, or residuary estate under a will; or
- designation of the partner as holding a durable power of attorney for health care decisions regarding the employee.

Under which group insurance plans may I enroll my domestic partner and my partner's eligible dependents?

You may enroll your domestic partner and your partner's eligible dependents in your medical plan, your prescription plan, your dental plan and your vision plan. The dependent life insurance policy does not allow for coverage of a domestic partner or a partner's dependents.

Please note that, reimbursements cannot be made from your Health Care Flexible Spending Account of expenses incurred by your domestic partner or your partner's eligible dependents, if they are not your legal tax dependents. This also applies to the Dependent Care Flexible Spending Account (in addition to other requirements).

How do I enroll my domestic partner and my partner's eligible dependents in my group insurance plans?

After filing your partnership with OHR you have 60 days to enroll your domestic partner and partner's eligible dependents. You must:

- complete a benefit enrollment form, if your level of coverage will change (e.g., single to family);
- complete a Dependent Addition form, adding your domestic partner and your partner's eligible dependents (*please note that proof of eligibility, such as a birth certificate, is required to add your partner's eligible dependents to your group insurance plans*); and
- complete any forms required by your group insurance plan to add a dependent.

If your forms are not received by the OHR Health Insurance Team within 60 days of filing a domestic partnership affidavit with all required supporting evidence; you will have to wait until the next enrollment period to add your domestic partner and your partner's eligible dependents, to be effective the next plan year.

What are the tax implications?

If you cover dependents who do not qualify as tax dependents under the Internal Revenue Code, the value of the County's contribution toward that coverage is considered taxable wages and is also subject to tax withholding. This is *imputed income*. In addition, active employees will have to pay a portion of the group insurance costs with after tax deductions.

The County assumes that neither your domestic partner nor your partner's eligible dependents qualify as tax dependents, unless you provide acceptable documentation.

For more information, contact the OHR Health Insurance Team.

What if my domestic partnership ends?

Should your relationship with your domestic partner end, or you no longer meet the domestic partnership requirements, the domestic partner and the partner's eligible dependents are no longer eligible for coverage under Montgomery County's group insurance plans. You must notify the OHR Health Insurance Team (on an approved Statement of Dissolution of Domestic Partnership form) within 60 days of the termination event. Benefits will terminate and the domestic partner and the partner's eligible dependents may be able to continue their health coverage under COBRA.

Same Sex Spouse

If you are legally married to your spouse, you will be treated for tax purposes in the same manner as if your spouse were the opposite sex. You will pay for any spousal or family coverage, for eligible dependents, on a pre-tax basis and will not have imputed income.

ENROLLMENT

To enroll in the Plan, you must elect the benefits.

Each year, the County has an Open Enrollment period during which you may elect benefits for the upcoming calendar year. This enrollment period usually begins in late October/early November and ends in mid-November. During Open Enrollment, you elect your benefits for the upcoming calendar year. Your election also serves as your authorization for after-tax pay deductions and before-tax pay reductions for the benefits you elect.

Should you become eligible for the Plan during the year (e.g., a newly hired employee), you will be provided material to elect your benefits for the remainder of the year. Generally, your elections will not be effective until you have submitted a completed election form along with the required supporting documentation to the OHR Health Insurance Team.

Pay deductions and/or pay reductions applicable to your benefit elections will commence on a non-pro rated basis as soon as practicable, without regard to the pay period.

If you are a full-scope temporary employee, you must pay for your benefits on an after-tax basis and you must pay the County directly for the cost of your benefits. The cost will not be deducted from your pay.

TERMINATION OF COUNTY EMPLOYMENT

When you terminate employment your last day of coverage will be the date you receive your last pay. However you will not receive coverage for any pay received due to severance or leave pay-out.

FAILURE TO SUBMIT AN ELECTION FORM

If you fail to submit a benefit election form before the end of an enrollment period, you will be deemed to have elected the following default coverage and authorized the pay deductions and/or pay reductions:

Please note that the default coverage elections are in addition to the mandatory basic benefits of term life, AD&D, BTA and LTD1 (if applicable).

- The medical, dental, vision, prescription drugs, additional term life and AD&D insurance, and dependent life insurance currently in effect.
- No allocation to dependent care or health care flexible spending accounts.

If you are a newly hired employee or are newly eligible for benefits, and fail to submit a benefit election form within 60 days of your hire date or qualified status change, you will be deemed to have elected **no** coverage for the remainder of the calendar year, with the exception of the mandatory basic benefits of term life, AD&D, BTA and LTD1 (if applicable).

Please note that in order to participate in the dependent care and health care flexible spending accounts, each year you must make an election during the enrollment period. If you participate in these accounts and fail to submit an election during the enrollment period, you will be deemed to have made an election not to participate for the upcoming calendar year.

CHANGING YOUR BENEFIT ELECTIONS

You may elect new benefits each year. Keep in mind that your choices are in effect for the entire calendar year, and can only be changed during the year if you have a *qualified status change*. Qualified status changes include:

Legal marital status. Events that change your legal marital status such as marriage, the death of a spouse, divorce and annulment.

Domestic partnership. Entering into or dissolving a domestic partnership.

Number of dependents. Events that change the number of your dependents such as birth, death, adoption and placement for adoption of a child.

Employment status. The following events that change your, your spouse's or dependent's employment status:

- A termination or commencement of employment;
- A strike or lockout;
- A commencement of or return from an unpaid leave of absence; or
- A change in a worksite.

This category also includes a change in your employment status or the employment status of a dependent, in which you or your dependent become (or cease to be) eligible for coverage under a plan.

Dependent's eligibility for coverage. Events that cause your dependent to satisfy or cease to satisfy eligibility requirements for coverage such as attainment of a certain age, change in dependent status or change in employment.

Residence. A change in your, your spouse's or dependent's residence.

Special rule for court-ordered health coverage of child. A judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order) that requires you to provide coverage for your child. You may also cancel coverage for the child if the order requires your spouse, former spouse or another individual to provide coverage for the child.

Special rule for Medicare or Medicaid entitlement. You may be able to make a prospective election change to cancel or reduce coverage under the Plan if you, your spouse or dependent who is enrolled in the Plan becomes entitled to Medicare or Medicaid coverage or if you lose premium assistance from your state under the Children's Health Insurance Program. Conversely, if you, your spouse, or dependent loses eligibility for Medicare or Medicaid coverage or become eligible for premium assistance from your state under the Children's Health Insurance Program, you may make a prospective election to commence or increase coverage under the Plan.

Dependent care – cost changes. You may change your election for your dependent care flexible spending account in the event of a cost change, but only if your dependent care provider is *not your relative*, as defined in the Internal Revenue Code.

Dependent care – coverage changes. You may change your election for your dependent care flexible spending account when your dependent care provider is replaced by another.

The occurrence of a special enrollment period under HIPAA. For example, you may change your election if you lose coverage under another plan.

Other special circumstances. Other special circumstances that may permit you to change your elections include cost and coverage changes to a health plan, such as a significant change in your health coverage or your spouse's coverage. You may also elect changes to correspond with your spouse's open enrollment period.

Please Note:

- Changes in benefit elections must correspond with the qualified status change that affects

eligibility for coverage under the Plan.

- Depending upon your qualified status change, you may revoke or decrease your elections for medical, dental, vision, prescription drugs, additional term life and AD&D insurance, dependent life insurance and the dependent care flexible spending account. However, you may only increase your pay reduction election to the health care flexible spending account.
- A qualified status change does not permit you to revoke the mandatory basic benefits.

Active Employee – If you have a qualified status change or experience one of the circumstances described above, you must submit the proper forms and supporting documentation to verify the event to the OHR Health Insurance Team within 60 days of the event occurring. Changes in group insurance elections will be effective on the day the completed forms and supporting documentation are submitted to the OHR Health Insurance Team within the 60 day timeframe. If the qualified status change is the birth, adoption or placement for adoption of a child, any group insurance elections will be retroactive to the child’s date of birth, date of placement for adoption or date of adoption if the completed forms and supporting documentation are submitted to OHR Health Insurance Team within the 60 day timeframe. If you submit the completed forms and supporting documentation for the birth, adoption or placement for adoption of a newborn (6 months of age or less) outside the 60 day time frame, the effective date of coverage will be the date the completed forms and supporting documentation are submitted. If the child is older than 6 months and you are outside the 60 day time frame, you must wait until the next enrollment period to add the child. Any adjustments to your pay deductions and/or pay reductions applicable to your election change will commence on a non-pro rated basis as soon as practicable, without regard to the pay period. If you do not make the proper notification within 60 days, you must wait until the next enrollment period to make any election changes.

Retiree – If you have a qualified status change or experience one of the circumstances described above, you must submit the proper forms and supporting documentation to verify the event to the OHR Health Insurance Team within 60 days of the event. If the qualified status change is the birth, adoption or placement for adoption of a child, any group insurance elections will be retroactive to the child’s date of birth, date of placement for adoption or date of adoption. If you submit the completed forms and supporting documentation for the birth, adoption or placement for adoption of a newborn (6 months of age or less) outside the 60 day time frame, the effective date of coverage will be the date the completed forms and supporting documentation are submitted. If the child is older than 6 months and you are outside the 60 day time frame, you must wait until the next enrollment period to add the child. Other qualified status change elections will be effective on the first day of the month following submission to the OHR Health Insurance Team provided the submission is received and processed by the 10th day of the month (or the last business day before the 10th of the month if the 10th falls on a weekend or holiday). If the OHR Health Insurance Team receives the forms after the 10th of the month, the effective date of the qualified status change will start on the first day of the second month.

Any adjustments to your premiums applicable to your qualified status change will commence on the effective date of the qualified status change (e.g., the first day of the month following notification if proper notice given before the 10th day of the month). If you do not make the proper notification within 60 days, you must wait until the next enrollment period to make any election changes.

It is recommended that you notify OHR Health Insurance Team promptly as a qualified status change could change your level of enrollment and your monthly premium.

You are responsible for your share of the costs associated with your benefit elections. Should there be insufficient funds to execute your authorized pro-rata pay reductions and/or payroll deductions, OHR will authorize collection of the missed allocations from future pay checks during the plan year. If you had your compensation reduced as a result of a qualified status change or do not have enough compensation to pay for the elected benefits, you will be contacted by OHR and given the opportunity to reduce your authorized reductions and/or deductions. If no response is received and the missed allocations cannot be collected for any reason during the plan year, coverage under the affected plan or plans will be canceled.

If you have 2 jobs with Montgomery County Government, premiums for group insurance coverage will only be deducted from your primary job assignment.

If you are a 10 month employee, your premiums will be deducted from paychecks on a 10-month (21-pay period) basis. If you do not wish to have your deductions taken on a 10-month basis, you may only elect during open enrollment to have your deductions taken on a 12-month (26-pay period) basis. If you elect to have deductions on a 12 month basis, you will be billed for the 2 months of premiums missed while you are not working in your primary job assignment. If payment is not made during these 2 months, premiums will be deducted from your pay upon your return to work.

If you are a full scope temporary employee and fail to timely pay your premiums, your coverage will be terminated.

LEAVE OF ABSENCE

If you are on an approved paid leave of absence, your coverage will continue on the same basis as before the leave commenced.

If you are on an approved unpaid leave of absence that is covered under the Family and Medical Leave Act of 1993 (“FMLA”), the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”) or parental leave:

- You may continue to be covered under the same benefit elections in effect prior to the leave or you may revoke your elections (under FMLA, you may not be eligible, in some circumstances, to participate in the dependent care flexible spending account).
- While on leave, you will be responsible for your share of the costs associated with your benefit elections; any amounts not paid will be recovered from future pay checks when you return to work. If you do not return to work, you are still responsible for your share of the costs. If your leave is covered under FMLA, you may pre-pay your share of the costs associated with your benefit elections prior to the commencement of the leave. If your leave spans two plan years, you may not pre pay on a before-tax basis for any coverage in the second plan year.
- Unless you revoked your election, when you return to work, the pay deductions and any pay reductions applicable to your benefit elections will commence automatically. If you revoked coverage, you have 60 days from the date you return to work to reelect coverage. If you do not reelect coverage, you will be deemed to have the coverage described under “Failure to Submit an Election Form.”

If you are on an approved unpaid leave of absence that is not covered under FMLA, USERRA or parental leave:

- You may continue to be covered under the same benefit elections in effect prior to the leave; the time period for such continuation is established under the County's leave without pay policy (which may be modified by collective bargaining agreements) and may vary according to the reason for your unpaid leave of absence; also, the time period for continuation may be shorter than your approved leave and you may become eligible for COBRA.
- While on leave, you will be responsible for and billed for your share of the costs associated with your benefit elections; when you return to work, the pay deductions and any pay reductions applicable to your benefit elections will commence automatically. If you do not return to work, you are still responsible for your share of the costs.
- If you fail to pay your share of the costs associated with your benefit elections while on leave, your coverage will be canceled.
- If your approved leave extends beyond the time period for coverage continuation under the County's leave without pay policy (which may be modified by collective bargaining agreements), you may continue coverage under COBRA (see below).

These are only the general provisions which permit you to continue coverage during an approved leave of absence. There are other rules that can affect your eligibility to continue coverage and participate in the Plan. It is important that you contact the OHR Health Insurance Team before any leave of absence, so you can receive information specific to your situation.

CONTINUATION OF COVERAGE (COBRA)

COBRA continuation coverage is a temporary extension of coverage under the Plan. **The following information generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive 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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

You may have other options available to you when you lose group health coverage. 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 coverage would otherwise end because of a life event known as a “qualifying event.” After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse (including an eligible domestic partner), and your dependent children (including the eligible children of your domestic partner) 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 are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- 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 enrolled in Medicare (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 any of the following qualifying events happens:

- 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 enrolled in Medicare (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.”

When is COBRA 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. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee becoming enrolled in Medicare (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You must give notice of some qualifying events.

For the 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, in writing or by e-mail, within 60 days after the qualifying event occurs. You must provide this written notice to:

The Office of Human Resources, Health Insurance Team
101 Monroe Street, 7th floor
Rockville, Maryland 20850

If timely notice is not provided, no continuation coverage will be offered.

How is COBRA 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. When the qualifying event is the death of the employee, the employee's enrollment in Medicare (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee enrolled in Medicare less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee may be able to last up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children may be able to last up to 36 months after the date of Medicare enrollment, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended:

1. ***Disability extension of 18-month period of continuation coverage.*** If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator, in writing, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and you must notify the Plan Administration before the end of the 18 month continuation period. If the person ceases to be disabled this extension does not apply. You must provide this written notice, including the Social Security determination to:

The Office of Human Resources, Health Insurance Team
101 Monroe Street, 7th floor
Rockville, Maryland 20850

If timely notice is not provided, no continuation coverage will be offered.

- 2. *Second qualifying event extension of 18-month period of continuation coverage.*** If your family experiences another qualifying event while receiving 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 you provide written notice of the second qualifying event to the Plan Administrator within 60 days of the second qualifying event. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. You must provide this written notice to:

The Office of Human Resources, Health Insurance Team
101 Monroe Street, 7th floor
Rockville, Maryland 20850

If timely notice is not provided, no continuation coverage will be offered.

Termination of Continuation Coverage

Continuation coverage will be terminated before the end of the maximum period if:

- The required premium is not paid in full on time;
- A qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan;
- A qualified beneficiary becomes enrolled in Medicare (under Part A, Part B, or both) after electing continuation coverage;
- The employer ceases to provide any group health plan for its employees; or
- Coverage was extended due to disability and the person is no longer disabled.

Other coverage options besides COBRA Continuation Coverage

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, 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.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of 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.

IN THE EVENT OF YOUR DEATH (AS AN ACTIVE EMPLOYEE)

If you die as an active employee who meets the eligibility requirements for group insurance benefits for retired employees (using your date of death as your separation from service date), your eligible surviving spouse or eligible domestic partner and/or other dependents (who were eligible at the time of death, including an unborn child) may elect coverage under the benefit plans available to retirees. Your surviving spouse or eligible domestic partner may only cover other dependents who were eligible for coverage at the time of your death, including an unborn child. A non-spouse or non-eligible domestic partner dependent remains eligible for coverage only if the individual continues to meet the definition of dependent and may only elect individual coverage, if not covered by the surviving spouse or eligible domestic partner. See the section titled *Group Insurance Benefits For Retired Employees* for eligibility details.

If you die as an active employee who does *not* meet the eligibility requirements for group insurance benefits for retired employees (using your date of death as your separation from service date), your surviving spouse or eligible domestic partner and/or other dependents (who were eligible at the time of death, including an unborn child) remains eligible for coverage under the Plan under the benefit plans available to retirees for the period of time equal to the number of years of your eligibility under the group insurance plan. Your surviving spouse or eligible domestic partner may only cover other dependents who were eligible for coverage at the time of your death, including an unborn child. A non-spouse or non-eligible domestic partner dependent remains eligible for coverage only if the individual continues to meet the definition of dependent and may only elect individual coverage, if not covered by the surviving spouse or eligible domestic partner. The County cost share during that period will be the same as was in effect at the time of your death. When that period ends, coverage under the benefit plans will end subject to continuation of coverage under COBRA.

TAX ADVANTAGE

Most of the benefits available in the Plan are purchased before-tax. This results in a tax-effective way to share the cost of your benefit elections because your contributions are not subject to federal income tax, Social Security taxes (FICA), and most state and local taxes. Participation in the health care and dependent care flexible spending accounts also provides a tax-efficient means to pay for certain eligible non-reimbursed health care and dependent care expenses.

YOUR SOCIAL SECURITY BENEFIT

Because before-tax benefit costs and the flexible spending account contributions reduce the amount you pay in Social Security taxes (FICA), they may cause your Social Security benefits to be reduced.

CONTINUATION OF THE PLAN

The County expects to continue the Plan, but it is the County's position that there is no implied contract between employees and the County to do so, and reserves the right at any time and for any reason to amend or terminate the Plan, subject to the County's collective bargaining agreements.

The Plan may also be amended by the County at any time, either prospectively or retroactively, to conform to the Internal Revenue Code.

CLAIMS AND APPEALS

Each Plan has its own deadline for submitting claims. See the individual descriptions for more information.

In general, any denial of a claim for benefits must be in writing to you and must state the reason for the denial. You will be provided a reasonable opportunity to file a written request for a review of the decision denying the claim. Each individual benefit under the Plan has its own procedures for making claims and for appealing denied claims. The procedures contain important information regarding time limits for requesting a review. If you do not request a review in a timely manner, your claim will remain denied. These procedures are described in detail in the individual benefit booklets available from the OHR Health Insurance Team.

PLAN TERMINATION

Should the Plan ever terminate, the County will pay benefits payable on the date of termination.

PLAN DOCUMENT

This Summary Description only highlights the benefits contained in the Plan; the official Plan document and benefit booklets will always control, even when conflicts arise between the language of the Summary Description and the Plan document itself. A copy of the Plan document may be obtained upon written request to the OHR Health Insurance Team. A reasonable charge may be made for copying this material.

GROUP INSURANCE BENEFITS FOR RETIRED EMPLOYEES

The following is a summary of the group insurance benefits available at retirement. The information presented reflects *current benefits and policies* only. They are applicable to:

- employees who retire on or after January 1, 2001,
- those who were already retired as of January 1, 2001, provided they were enrolled in group insurance benefits as of December 31, 2000, and
- those who were already retired as of January 1, 2001 and were **not** enrolled in group insurance benefits as of December 31, 2000, but re-enrolled into group insurance during the special window opportunity provided under the Council Resolution *Retiree Re-election Opportunity for Group Insurance Cost Sharing* approved March 5, 2002.

The County expects to continue the group insurance benefits, but it is the County's position that there is no implied contract between retired employees and the County to do so. The County reserves the right at any time and for any lawful reason to amend or terminate its group insurance benefits and policies for retired employees.

These group insurance benefits may also be amended by the County at any time, either prospectively or retroactively, to comply with the Internal Revenue Code.

ELIGIBILITY FOR EMPLOYEES HIRED BEFORE JULY 1, 2011

If you are a member of the optional or integrated plan under the Montgomery County Employees' Retirement System (ERS) and hired before July 1, 2011, and retire under a normal, early, disability or discontinued service retirement, you are eligible for group insurance benefits. However, you are **not** eligible for group insurance benefits if you leave County service prior to retirement eligibility with a deferred vested benefit payable upon your normal retirement date.

<i>If you belong to Group</i>	<i>Early Retirement at least...</i>	<i>Normal Retirement at least...</i>
A, AZ, AK or H, HZ, HK, or AB AT, AS, or UZ, UK A/H (SLT or police TCC supv. or on-supv.)	15 years of service and age 50 20 years of service and age 45	5 years of service and age 60 30 years of service and age 55 30 years of service and age 50
E, EZ, EK	15 years of service and age 45 20 years of service and age 41	15 years of service and age 55 25 years of service and age 46
F, FZ, FK	15 years of service and age 45 20 years of service and age 41	15 years of service and age 55 25 years of service and any age
DRSP Entry		25 years of service and age 46
G, GZ, GK	N/A	15 years of service and age 55 20 years of service and any age
DROP Entry		Eligible for normal retirement

If you are a member of the Montgomery County Elected Officials' Plan (EOP, Group ZK), the Retirement Savings Plan (RSP, Group RN, RM, RC, RP), or the Guaranteed Retirement Income Plan (GRIP, Group CN, CM, CC, CP, CZ) and hired before July 1, 2011, you are eligible for group insurance upon separation from service if your age and credited service under a County Retirement Plan at the time of separation from service meet the following:

<i>If you belong to Group</i>	<i>And you have credited service of at least</i>	<i>And your age is at least</i>
RN, RM RC; or CN, CM, CC, CZ; or ZK	5 years 15 years 20 years	60 50 45
RP, CP - Police, Corrections, Sheriffs	15 years 20 years	45 41
RP, CP - Fire	20 years	Any age

If you are awarded a non service connected disability under any County plan and are not eligible for group insurance under the eligibility above, you will be eligible for group insurance benefits if you have at least 5 years of County service credited under a retirement plan. You remain eligible for group insurance benefits for the duration of the disability.

If you are awarded a service connected disability under a County plan and are not eligible for group insurance under the eligibility above, you will be eligible for group insurance benefits for the duration of the disability and you will be treated as having 5 years of County service for cost-sharing purposes.

If you do not meet the criteria, you are not eligible for group insurance when you leave County service, except as provided under COBRA (see Continuation of Coverage (COBRA)).

If you are an employee of a Participating Agency you should contact your employer’s Office of Human Resources (OHR) for information on whether your employer participates in the County’s retiree group insurance benefits. If your employer participates in the County’s retiree group insurance benefits, the eligibility criteria applies to you.

COST SHARING FOR EMPLOYEES HIRED BEFORE JULY 1, 2011

Hire Date: December 31, 1986 through June 30, 2011, unrepresented, IAFF and MCGEO; Before June 30, 2011 FOP members only

If your most recent date of hire as a permanent full-time or part-time employee was after December 31, 1986 and before July 1, 2011, you are eligible for the following cost sharing arrangement for medical, dental, discount vision, standard option* prescription, term life insurance and dependent life insurance (Option 1, only). If you are an FOP member hired before July 1, 2011, this method also applies to you.

“Years” refers to years of eligibility under the group insurance plan; it does not include any transferred or purchased service, or any sick leave converted to credited service for ERS purposes.

	<u>County Share</u>	<u>Retiree Share</u> *
15 or more years.....	70%	30%
14 years.....	68%	32%
13 years.....	66%	34%
12 years.....	64%	36%
11 years.....	62%	38%
10 years.....	60%	40%
9 years.....	58%	42%
8 years.....	56%	44%
7 years.....	54%	46%
6 year.....	52%	48%
5 years.....	50%	50%

* The County/Retiree cost sharing arrangement will not change for retirees enrolled in the Standard Option prescription plan. Retirees that choose to participate in the high option prescription plan will pay a higher percentage of the cost.

Hire Date Before January 1, 1987-unrepresented, IAFF and MCGEO members

If your most recent date of hire as a permanent full-time or part-time employee was prior to January 1, 1987, you may elect the cost sharing arrangement for medical, dental, discount vision, standard option* prescription, term life insurance and dependent life insurance for employees hired after December 31, 1987 detailed above or you may elect the cost sharing option below. You must be an

unrepresented employee, a member of IAFF or MCGEO to have this option. Once you retire, you may not change your cost sharing arrangement.

“Years” refers to years of eligibility under the group insurance plan; it does not include any transferred or purchased service, or any sick leave converted to credited service for ERS purposes.

	<u>County Share</u>	<u>Retiree Share</u>
For the period of time equal to the number of years of your eligibility under the group insurance plan, beginning from your retirement date ^{/1}	80%	20%*
After that period.....	0%	100%

^{/1} Please note that this cost sharing period is not affected by any times during which, as a retiree, you elected no coverage for the benefits available to you.

* The County/Retiree cost sharing arrangement will not change for retirees enrolled in the standard option prescription plan. Retirees who choose to participate in the high option prescription plan will pay a higher percentage of the cost.

If under the 2010 Retirement Incentive Program, regardless of date of hire, you elected the enhanced cost sharing arrangement, you will pay 10% of the cost (and the County will pay 90%) for the first 5 years of retirement. If you cover family members as dependents, your cost share for this coverage will be the normal retiree cost share for the dependent coverage. After 5 years from date of retirement, your cost share will revert to what you elected at retirement.

See Retiree Life Insurance for special cost share information for life insurance.

ELIGIBILITY FOR EMPLOYEES HIRED OR REHIRED ON OR AFTER JULY 1, 2011.

If you are a member of any County retirement plan and hired or rehired as a permanent employee on or after July 1, 2011, you must have **at least 10 years of County service** (credited under a County retirement plan) to be eligible for group insurance continuation when you leave County service. All other eligibility criteria remain the same as for employees hired before July 1, 2011 in the charts above (e.g., must have 15 years of credited service and be at least 50 years old). **Note:** If you are an employee of a Participating Agency, you should contact your employer’s Office of Human Resources for information on the eligibility for participation in retiree benefits.

If you are awarded a service connected disability (under any County plan) and do not have 10 years of County service under a County retirement plan, you will be eligible for the group insurance benefits for the duration of the disability.

If you do not meet the criteria, you are not eligible for group insurance when you leave County service, except as provided under COBRA (see Continuation of Coverage (COBRA)).

If you are an employee of a Participating Agency, you should contact your employer’s Office of Human Resources (OHR) for information on whether your employer participates in the County’s

retiree group insurance benefits. If your employer participates, in the County's retiree group insurance benefits, the eligibility criteria applies to you.

COST SHARING FOR EMPLOYEES HIRED ON AND AFTER JULY 1, 2011

If your most recent date of hire as a permanent employee was after June 30, 2011, the cost sharing is as follows:

Retiree Health Cost Share for those hired on and after 7/1/2011		
<u>Yrs of Svc</u>	<u>EE %</u>	<u>ER %</u>
10	50.00	50.00
11	48.67	51.33
12	47.34	52.66
13	46.00	54.00
14	44.67	55.33
15	43.34	56.66
16	42.00	58.00
17	40.67	59.33
18	39.34	60.66
19	38.00	62.00
20	36.67	63.33
21	35.34	64.66
22	34.00	66.00
23	32.67	67.33
24	31.34	68.66
25+	30.00	70.00

“Years” refers to years of eligibility under the group insurance plan; it does not include any transferred or purchased service, or any sick leave converted to credited service for ERS purposes.

The County’s share at retirement will not be greater than the amount immediately preceding retirement.

See Retiree Life Insurance for special cost share information for life insurance.

IN THE EVENT YOU RETURN TO WORK FOR THE COUNTY AFTER RETIREMENT

If you return to work for the County or a participating agency in a position eligible for County group insurance, your participation in retiree group insurance will continue, with the exception of life insurance during your period of re-employment. When you again leave County (or participating agency) employment, your participation in the retiree group insurance program continues with the the life insurance amount in effect at the time you originally retired, subject to any reductions which would have occurred during your time of re-employment.

You will participate in the active group life insurance. You may elect benefits which are not offered to retirees, such as the flexible spending accounts.

If you are rehired as a full-scope temporary employee, you may retain your retiree life insurance since full-scope temporary employees are not eligible for life insurance.

IN THE EVENT OF YOUR DEATH (AFTER RETIREMENT)

As a retiree who meets the eligibility requirements for group insurance benefits for retired employees, your eligible surviving spouse or eligible domestic partner may elect coverage under the benefit plans available to retirees, as if he/she was the retiree, under the same terms and conditions as you, except that your surviving spouse or eligible domestic partner may only cover other dependents who were eligible for coverage at the time of your death, including an unborn child. The County cost share during that period will be the same as was in effect at the time of your death.

BENEFITS AVAILABLE

Retirees are eligible for the following benefits:

- Medical
- Caremark High Option \$5 / \$10 Plan or Caremark Standard Option Plan
- Dental PPO (Traditional Dental Plan)
- Opti-Vision Discount Plan
- Retiree Term Life Insurance

Unless otherwise stipulated in collective bargaining agreements, retirees are not eligible for the following benefits, currently available to active employees:

- Basic Accidental Death and Dismemberment Insurance
- Business Travel Accident Insurance
- Vision Plan (active employees)
- Dental HMO (active employees)
- Health Care Flexible Spending Account
- Dependent Care Flexible Spending Account
- Optional Life Insurance (unless in effect at retirement)

You may be able to continue your Vision Plan coverage and your Health Care Flexible Spending Account coverage through COBRA, if you had coverage at the time of retirement.

ELECTING YOUR BENEFITS AT RETIREMENT

At the time of your retirement, you may elect medical, dental, vision, and prescription coverage. For each of these benefits you elect, you may also elect coverage for your eligible dependents. You may also elect to continue your dependent and optional life insurance into retirement. Each election can be made independent of other elections.

If your spouse or eligible domestic partner is also an employee or retiree of the County or a participating agency, and is eligible in their own right to enroll in a County benefit program, you are not restricted as to the benefits or coverage options you may elect (*subject to the note in the Addendum section under Dependent Life Insurance*). It is important, however, that you carefully coordinate your elections for benefits and coverage options with those of your spouse or eligible domestic partner.

If you elect *no* coverage for medical, discount vision or prescription, you will have to wait until the following Open Enrollment to elect these benefits, unless you experience a qualified status change, as described in the section titled “Changing Your Benefit Elections” (such as marriage, divorce, birth or adoption or placement for adoption of a child). Also, if you elect *no* coverage, it is important that you have other coverage, either through a group or private plan.

If you are currently enrolled in dental and later elect *no* dental coverage, you must satisfy a two-year waiting period to be eligible to re-enroll in dental. If you elect no dental coverage at the time of your retirement, the two-year waiting period may be longer since you may only elect benefits during Open Enrollment. Therefore, it is important that you are covered under another dental plan, if you elect *no* dental coverage. These enrollment restrictions are subject to the qualified status change provisions as described earlier in this booklet in the section titled “Changing Your Benefit Elections” (such as marriage, divorce, birth, adoption or placement for adoption of a child).

As a retiree, during the annual Open Enrollment, you may change your medical, dental, discount vision and prescription coverage elections. For each of these benefits you elect, you may also elect coverage for your eligible dependents during this time. These elections will be effective the first of the following calendar year.

You may also make such changes mid-year if you experience a qualified status change as described earlier in this booklet in the section *Changing Your Benefit Elections*.

RETIREE TERM LIFE INSURANCE

If you are less than age 65 when you retire, your term life insurance will be an amount equal to 5% of the amount in force on the day prior to retirement (last active amount) for each full year you were insured prior to your retirement date, up to 100%. On the fifth anniversary of your retirement, and on each following anniversary of that date, the amount reduces by 10% of your initial post-retirement amount, but the amount will not reduce to less than 25% of your initial post-retirement amount. In any event, your amount on and after age 65 will not exceed 25% of your initial post-retirement amount.

If you are age 65 or older when you retire, the pre-age 65 *formula* applies for determining your initial post-retirement amount, but that amount is immediately reduced to 25%.

If you retire due to a disability, your retirement date for purposes of determining *when* your term life insurance amount reduces will be your normal retirement date or, if earlier, the date your total disability ends. For purposes of determining years insured, your retirement date will be your disability retirement date. Your term life insurance is 100% County paid until you reach your normal retirement date under your retirement plan. From that time until age 65, your cost sharing arrangement in effect for your other benefits will apply to the cost of your term life insurance, provided you are eligible for term life insurance at the time of your disability. Your life insurance ends if you are deemed no longer disabled before age 65 and did not meet the eligibility criteria for retiree group insurance.

When you turn age 65: Your Basic Term Life Insurance becomes 100% County paid, regardless of your cost sharing arrangement. This happens automatically. (Reference your latest annual Group Insurance Confirmation Statement for your current coverage amount.)

If you elected the enhanced retiree term life insurance under the 2010 Retirement Incentive Program, you will not have any reduction in post-retirement basic life insurance for the first 10 years of retirement. After 10 years from date of retirement, basic life insurance benefits will return to the level that would have otherwise been in effect on that date had you not elected this option.

DEPENDENT LIFE INSURANCE

Note: This coverage is optional and must be in effect at the time of retirement. (Reference your latest annual Group Insurance Confirmation Statement for current coverage amount). Dependent life insurance covers your spouse and eligible dependent children. Eligible dependent children are your unmarried children who are less than 26 years old. At retirement, you may elect to continue the coverage in effect at the time of your retirement. You may also elect to change your coverage or elect no dependent life insurance. After retirement, you may not elect a new coverage option, but you may cancel your dependent life insurance.

You are automatically the beneficiary for this insurance. *Please note: If both you and your spouse are eligible for Montgomery County sponsored dependent life insurance, and both of you elect dependent life insurance, benefits for an eligible dependent child will be payable either under your coverage or your spouse's, but not both.*

OPTIONAL LIFE INSURANCE

Optional life insurance is coverage in addition to your basic term life insurance. You may elect to continue your optional life insurance into retirement provided your coverage was in effect at the time of retirement; reference your latest annual Group Insurance Confirmation Statement for current coverage amount. The coverage is frozen at the amount in effect at the time of retirement. After retirement, you may not change your coverage amount, but you may cancel your optional life insurance. This coverage ends at age 70. The cost is 100% retiree paid.

MEDICARE

Medical Coverage

Generally, you become eligible for Medicare at age 65 or if awarded Social Security disability prior to age 65. Medicare becomes your primary medical insurance and the County's medical plan becomes your secondary medical insurance effective the date you become eligible for Medicare. You must enroll in Medicare Part A and Part B at that time, if you fail to do so, your out of pocket expenses may become higher.

Most County medical plans *coordinate* with Medicare.* This means that the benefits payable under your County medical plan will generally work together with Medicare to ensure that you receive as complete a coverage as possible (but not a duplication of coverage). Generally, your retiree medical premium reduces and your prescription premium increase when you become Medicare-eligible.

**Kaiser participants:* You cannot continue coverage under the same Kaiser plan that you had prior to age 65. When Medicare becomes the primary coverage for you or any of your covered dependents, the Medicare eligible individual is required to enroll in Kaiser's Medicare Plus Plan. Kaiser will contact you directly regarding enrollment. If you do not enroll in Kaiser's Medicare Plus plan when required, your enrollment in Kaiser will be discontinued. At that time, you may contact the County if you wish to elect another medical plan option.

What happens if you do not enroll in Medicare Part B?

If you do not enroll in Medicare Part B, your out-of-pocket expenses may be significantly higher. Why? Because your County medical plan (except Kaiser) pays as if you had enrolled in Medicare Part B – even if you did not.

Example: Let's say that, before age 65, your County medical plan covered a certain benefit ("Benefit X") at \$200. When you turn age 65, Benefit X is classified as a Medicare Part B benefit that is covered by Medicare Part B for \$120. The County medical plan, being your *secondary* insurance that coordinates with Medicare, covers Benefit X at \$80. Regardless of whether or not you have enrolled in Medicare Part B, the County medical plan covers Benefit X at \$80 (not \$200). That means that if you are not enrolled in Medicare Part B, you would be responsible for paying the amount not covered by your County insurance (\$120).

If you receive a service that is not covered by Medicare, but *is* covered under your County medical plan, the benefit will be paid as specified under the County's plan (subject to an annual deductible and then payment of 80% of R&C) because it is acting as primary coverage for that service. However, services not covered by Medicare *are not* covered under the CareFirst Indemnity plan.

What about your County medical plan premiums?

When either you or your spouse/eligible domestic partner becomes eligible for Medicare at age 65, your premium will also change. When someone first becomes Medicare-eligible, the premium paid will decrease from the Non-Medicare rate to a lower split rate. When you and all your dependents become eligible for Medicare, the rate paid will decrease to the Medicare rate.

Prescription -Medicare Part D

If you (and/or your dependents) are eligible for Medicare (including due to disability) and elect to participate in the Prescription Plan, the Caremark High Option or the Caremark Standard Plan, you (and/or your dependents) will automatically be enrolled in Medicare Part D. If you elect to participate in Kaiser, this is not applicable to you. You are not eligible for Medicare Part D and the County's Prescription Plan, if you (a) have an international address; (b) do not have Medicare Part A and/or Part B; or (c) are incarcerated.

The Prescription Plan coordinates around Medicare to provide prescription drug coverage. Silverscript administers the program for the County. Medicare requires that you have a 21 day period to opt out of the Medicare Part D program. However, if you opt out, **you (and your dependents, if applicable) will not have any prescription drug coverage through the County's Prescription Plans.**

Under Medicare, if you pay an income based adjusted premium, you will also pay an additional amount for Part D.

Under the coordination with Medicare, all aspects of the Prescription Plan are as described under the Prescription Plan later in this book. For example, you will pay the applicable copayment and the Prescription Plan's formulary will apply.

What happens if you opt out of Medicare Part D?

If you (and/or your eligible dependents) opt out of Medicare Part D, you (and/or your eligible dependents) are not eligible to participate in the County's Prescription Drug Plan and will terminate participation in the Prescription Drug Plan.

For more information:

- Visit www.medicare.gov.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

ADDENDUM

CURRENT BENEFITS AND COVERAGE OPTIONS OFFERED UNDER THE PLAN

Type of Benefit	Benefit Plans and Providers	Coverage Options
<p><u>Basic life insurance</u> Premium split:*</p> <ul style="list-style-type: none"> County – 75% Employee (after-tax) – 25% 	<ul style="list-style-type: none"> Term life insurance Accidental death and dismemberment (AD&D) Business travel accident (BTA) <p><i>Minnesota Life</i></p>	Basic Benefit
<p><u>Long term disability (LTD1)</u> Premium split:</p> <ul style="list-style-type: none"> County – 75% Employee (after-tax) – 25% 	<ul style="list-style-type: none"> LTD1 for ERS members – <i>The Standard</i> 	<p>Basic Benefit for Full-time Employees in the ERS</p> <p>Part time employees in the ERS are not eligible.</p>
<p><u>Medical</u> Premium split:</p> <ul style="list-style-type: none"> County – 75% Employee (before-tax) – 25% for High and Standard Option POS (CareFirst) County-80% Employee (before-tax) 20% for HMO (Kaiser and United Healthcare) 	<ul style="list-style-type: none"> High Option POS Plan (Medical only) - <i>CareFirst BlueCross BlueShield</i> Standard Option POS Plan (Medical only) - <i>CareFirst BlueCross BlueShield</i> HMO (Medical plus Kaiser Rx) - <i>Kaiser Permanente</i> HMO (Medical only) – <i>United Healthcare</i> 	<ul style="list-style-type: none"> Self Self + 1 Family No Coverage
<p><u>Dental</u> Premium split:</p> <ul style="list-style-type: none"> County – 75% Employee (before-tax) – 25% 	<ul style="list-style-type: none"> Traditional plan (Dental PPO) – <i>United Concordia</i> Dental HMO (DHMO) - <i>United Concordia</i> 	<ul style="list-style-type: none"> Self Self + 1 Family No Coverage - 2 year restriction for re-entry
<p><u>Vision</u> Premium split:</p> <ul style="list-style-type: none"> County – 75% Employee (before-tax) – 25% 	<ul style="list-style-type: none"> Vision plan – <i>National Vision Administrators (NVA)</i> actives only Opti-Vision Discount Plan – <i>National Vision Administrators (NVA)</i> retirees only 	<ul style="list-style-type: none"> Self Self + 1 Family No Coverage - 2 year restriction for re-entry
<p><u>Prescription (Rx)</u> Premium split:</p> <ul style="list-style-type: none"> County* – 75% Employee* (before-tax) – 25% 	<p><i>Caremark</i></p> <ul style="list-style-type: none"> High Option \$4/\$8 (MCGEO & IAFF) \$5/\$10 (FOP, Retirees & nonbargained) Standard Option \$10/\$20/\$35 	<ul style="list-style-type: none"> Self Self + 1 Family No Coverage

* The County/Employee cost sharing arrangement will not change for employees enrolled in the Standard Option prescription plan. Employees that choose to participate in the High Option prescription plan will pay a higher percentage of the cost.

* The cost sharing applies to active employees; retiree cost sharing is explained on pages 19-21.

Type of Benefit	Benefit Plans and Providers	Coverage Options
<p><u>Optional life insurance</u> Premium split:</p> <ul style="list-style-type: none"> Employee (after-tax) – 100% 	<ul style="list-style-type: none"> Term life insurance, Accidental death and dismemberment (AD&D) <i>Minnesota Life</i> 	<ul style="list-style-type: none"> 1 x's basic annual earnings 2 x's basic annual earnings 3 x's basic annual earnings 4 x's basic annual earnings 5 x's basic annual earnings 6 x's basic annual earnings 7 x's basic annual earnings 8 x's basic annual earnings No coverage (To a maximum of \$1,000,000; covered until 70th birthday)
<p><u>Dependent life insurance</u> Premium split:</p> <p>First level -</p> <ul style="list-style-type: none"> County – 75% Employee (after-tax) – 25% <p>Second and Third levels -</p> <ul style="list-style-type: none"> Employee (after-tax) – 100% 	<ul style="list-style-type: none"> Term life insurance – <i>Minnesota Life</i> 	<ul style="list-style-type: none"> \$2,000 spouse; \$1,000 child to age 26; \$1,000 newborn within 31 days of birth \$4,000 spouse; \$2,000 child to age 26; \$1,000 newborn within 31 days of birth \$10,000 spouse; \$5,000 child to age 26; \$1,000 within 31 days of birth No Coverage
<p><u>Flexible Spending Account</u> Premium split:</p> <ul style="list-style-type: none"> Employee (before-tax) – 100% 	<ul style="list-style-type: none"> Health Care Flexible Spending Account Plan 	\$0 to \$2,550 in whole dollar amounts
<p><u>Flexible Spending Account</u> Premium split:</p> <ul style="list-style-type: none"> Employee (before-tax) – 100% 	<ul style="list-style-type: none"> Dependent Care Flexible Spending Account Plan 	\$0 to \$5,000 in whole dollar amounts

BENEFIT HIGHLIGHTS

Below are some highlights of the benefits listed on the previous pages. Please refer to the current individual benefit booklets for coverage details, including any exclusions and limitations. In the case of a conflict, the individual benefit booklets will control.

BASIC LIFE INSURANCE

If you are a full-time employee, you are required to have the following basic insurance coverage:

Term life insurance of 1 times your basic annual earnings, up to \$200,000. For active employees, at age 65, coverage is reduced to 65% of the pre-65 face value.

- * Accidental death and dismemberment (AD&D) insurance of 8 times your basic annual earnings, up to \$600,000, for a loss of life that is a direct result of an accidental injury sustained in the performance of County employment (lesser amounts may be payable for certain dismemberments resulting from accidental bodily injury).
- * AD&D insurance of 4 times your basic annual earnings, up to \$300,000, for a loss of life that is *not* a direct result of an accidental injury sustained in the performance of County employment (lesser amounts may be payable for certain dismemberments resulting from accidental bodily injury).
- * Business travel accident (BTA) insurance of \$100,000 for a loss of life resulting from an accident while traveling in a common carrier (e.g., a commercial airline, train or bus) during a business trip; \$50,000 for a loss of life resulting from an accident during a business trip *other than* while traveling in a common carrier (lesser amounts may be payable for certain dismemberments resulting from accidental bodily injury occurring during a business trip). *Please note that the business trip must be outside of Montgomery County, Maryland.*
- * An employee whose life expectancy is less than twelve (12) months may be eligible to receive an accelerated death benefit of 100% of the policy in force.

Members of the International Association of Fire Fighters (IAFF), Local 1664 and Fraternal Order of Police (FOP), Lodge 35 have a minimum basic benefit of \$500,000 for a loss of life that is a direct result of an accidental injury sustained in the performance of County employment.

If you are a part-time employee, your required basic insurance coverage is your annual earnings. See the Certificate of Insurance for life insurance to determine your AD&D coverage amounts.

If you are a Circuit Court judge, you are not required to have life insurance and may elect coverage within 60 days from your appointment to the bench.

LONG TERM DISABILITY (LTD1)

LTD1 for full-time employees who are members of the optional or integrated plan under the Employees' Retirement System (ERS):

If you are a full-time employee and a member of the **optional or integrated plan under the ERS**, you are required to have LTD1 coverage (part-time employees who are members of the **optional or integrated plan under the ERS** are not eligible for coverage). Your coverage becomes effective after 6 months of continuous active service with the County. You are not eligible to participate upon your 70th birthday.

The monthly income benefit under LTD1 is 60% of your basic monthly earnings, up to a maximum of \$2,500. Your monthly income benefit will be reduced by certain other sources of income, including amounts you and your dependents may be eligible to receive under Social Security due to your disability.

While covered under LTD1, you are entitled to benefits if you become totally disabled from performing the duties of your occupation due to sickness or accidental bodily injury and remain totally disabled continuously throughout the benefit waiting period of 5 months. After the expiration of the benefit waiting period, you will receive monthly income benefit payments during the continuation of your disability, but for no longer than 12 months.

If your monthly income benefit has been payable for 12 months and your disability completely prevents you from engaging in any occupation for which you are qualified by training, education or experience, you will continue to receive your monthly income benefit.

However, monthly income benefit payments will cease on the earlier of the following dates:

- * The date you receive retirement benefits under any pension plan to which your employer contributes or makes payroll deductions, other than benefits which become payable solely because of disability.
- * The date shown below, based on when your disability commences:

Age 61 or under – your 65th birthday or the day 36 payments have been made, whichever is later.

Age 62, 63 or 64 – the date 36 payments have been made.

Age 65, 66 or 67 – the date 24 payments have been made.

Age 68 or 69 – the date 12 payments have been made.

MEDICAL PLANS

You may elect one of the medical options offered under the Plan or choose no coverage at all. Below are brief descriptions of each option and a comparison chart of key features.

*Please note that, with the exception of Kaiser Permanente, the medical options **do not** provide prescription drug coverage. However, you have the option to elect prescription drug coverage under a separate plan offered through Caremark.*

The CareFirst BlueCross BlueShield Point-of-Service Plans (POS) are managed care programs that require you to select a primary care physician (PCP). You must select a PCP and receive services from that PCP or a network specialist in order to receive in-network benefits. Under the POS, you may also choose to coordinate your own medical care and receive out-of-network benefits. You must submit any claims for services from out of network providers within fifteen (15) months of the date of service.

The POS also offers a component plan that provides in- and out-of-network benefits if you reside outside the POS network service area. Active employees who reside outside the POS network service area may elect this “out of service area” component plan or remain in the “in service area” component.

Enrollment in the “out of service area” component plan for retirees who reside outside the POS network service area is automatic. If you are a retiree and move out of the POS network area (as determined by CareFirst BlueCross BlueShield) while participating in the CareFirst BlueCross BlueShield (BCBS) Point-of-Service (POS) plan you will **automatically** become enrolled in the BCBS POS Out of Area plan. If you are a retiree moving into the POS network area and participate in the CareFirst BlueCross BlueShield (BCBS) Point-of-Service (POS) Out of Area plan, you will **automatically** be enrolled in the BCBS POS In Area plan. If you wish to make other changes, you must contact the OHR Health Insurance Team regarding your available health plan choices.

If Medicare is the primary coverage for you or any of your covered dependents, please refer to the separate CareFirst BlueCross BlueShield Medicare Supplemental Plan summary.

There are two POS plans offered – a High Option Plan and a Standard Option Plan. Prescription drug coverage is not included with either plan, but may be elected under a separate plan offered through Caremark.

Kaiser Permanente is a health maintenance organization (HMO) which provides all care at special Kaiser centers. You must use providers at the Kaiser centers to receive benefits under this plan. If you receive care elsewhere, you must pay the full cost. Please note that the Kaiser Permanente HMO medical plan does include prescription drug coverage and therefore, it is not necessary to elect such coverage under a separate plan. Members pay \$5 at on-site pharmacies and for mail order; \$15 at participating community pharmacies.

If Medicare is the primary coverage for you or any of your covered dependents, you are required to enroll in Kaiser’s Medicare Plus plan. Kaiser will contact you directly regarding your enrollment. If you are a Kaiser participant and do not enroll in Kaiser’s Medicare Plus plan when required, your enrollment in Kaiser will be discontinued. At that time, you may contact the County if you wish to elect another medical plan option.

If you are a retiree and move out of the Kaiser Permanente network area (as determined by Kaiser Permanente) while participating in the Kaiser Permanente HMO plan, you will **automatically** be enrolled in the United Healthcare and Caremark Standard Option Prescription plans. If you wish to make other changes, you must contact the OHR Health Insurance Team regarding your available health plan choices.

United Healthcare is an individual practice health maintenance organization (HMO). Private physicians who belong to the United Healthcare network render care in their own offices. You must submit any claims for services within fifteen (15) months following the date of service. You must use United Healthcare providers in order to receive benefits under this plan. If you receive care elsewhere, you must pay the full cost. Prescription drug coverage is not included, but may be elected under a separate plan offered through Caremark.

It is important that you carefully read the coverage details contained in the individual medical booklets to determine which plan is best for you. Also, it is important that you are covered under another medical plan if you elect no medical coverage at all. Please remember that your elections are in force for the entire calendar year. The coverage described in the medical comparison chart is how the County's plans pay when they are your primary coverage. Generally, if you are also covered under Medicare and are retired from the workforce, Medicare is your primary coverage and your County plan is secondary. This may change the copays and charges listed in the medical comparison chart. If you are retired from the workforce and if your County medical plan *coordinates* with Medicare, the benefits payable under your County medical plan will generally be reduced by the benefits payable under Medicare, regardless of whether you are actually enrolled in Medicare.

MEDICAL PLANS COMPARISON CHART

Benefit Type	Kaiser Permanente	United Healthcare	POS High and Standard Option Plans In Service Area	POS High and Standard Option Plans Out of Area
Allergy Testing	\$5 copay.	\$5 copay Primary Care Physician; \$10 copay Specialist.	High Option - In network: covered in full; Out-of-network: 80% covered after deductible. Standard Option – Same as High Option.	High Option - In network: covered in full; Out-of-network: 80% covered after deductible. Standard Option – Same as High Option.
Deductible	Copay where applicable.	No Annual Deductible.	High Option - In network: none; Out-of-network: \$300 individual; \$600 family. Standard Option - Same as High Option	High Option - In network: none; Out-of-network: \$250 individual; \$500 family. Standard Option - Same as High Option
Diagnostic/Lab/X-Ray	Covered in full.	Covered in full. No Copayment.	High Option - In network: covered in full; Out-of-network: 80% covered after deductible. Standard Option – Same as High Option.	High Option - In network: covered in full; Out-of-network: 80% covered after deductible. Standard Option – Same as High Option.
Dr. Office Visits	\$5 copay.	\$5 copay Primary Care Physician; \$10 copay Specialist.	High Option - In network: \$10 copay; Out-of-network: 80% covered after deductible. Standard Option - In network: \$15 copay; Out-of-network: same as High Option.	High Option - In network: \$10 copay; Out-of-network: 80% covered after deductible. Standard Option - In network: \$15 copay; Out-of-network: same as High Option.
Emergency Room	\$50 copay – waived if admitted to hospital.	\$25 copay (plan definition of emergency must be met) – waived if admitted to hospital; \$15 copay for Urgent Care Centers.	High Option - In network: \$25 copay waived if admitted to hospital; Out-of-network: 80% covered after deductible. Standard Option – In network: \$35 copay waived if admitted to hospital; Out-of-network: same as High Option.	High Option - In network: \$50 copay, waived if admitted; Out-of-network: 80% covered after deductible. Standard Option – Same as High Option.
Hearing Aids	For minor children. One hearing aid for each hearing impaired ear once every 36 months.	For minor children. One hearing aid for each hearing impaired ear once every 36 months.	High Option - In network For minor children. One hearing aid for each hearing impaired ear once every 36 months. Standard Option – Same as High Option.	High Option - In network For minor children. One hearing aid for each hearing impaired ear once every 36 months. Standard Option – Same as High Option.

MEDICAL PLANS COMPARISON CHART

Benefit Type	Kaiser Permanente	United Healthcare	POS High and Standard Option Plans In Service Area	POS High and Standard Option Plans Out of Area
Hearing Screening	\$5 copay for hearing exam (hearing aids are excluded).	\$5 copay Primary Care Physician; \$10 copay Specialist.	High Option - In network: childhood hearing screening covered in full; Out-of-network: childhood hearing screening, 80% not subject to deductible. Standard Option – Same as High Option.	High Option - In network: childhood hearing screening covered in full; Out-of-network: childhood hearing screening, 80% not subject to deductible. Standard Option – Same as High Option.
Home Health Care Services	Covered in full if medically necessary.	Covered in full. No copayment; 60 visit maximum for skilled care services per calendar year.	High Option - In network: covered in full (90 visits max/calendar year); Out-of-network: 80% covered after deductible (90 visits max/calendar year). Standard Option – Same as High Option.	High Option - In network: covered in full (40 visits per calendar year); Out-of-network: 80% covered after deductible (40 visits per calendar year). Standard Option – Same as High Option.
Hospice	Covered in full.	Covered in full. (See coverage booklet for eligibility information.)	High Option - In network: covered in full; Out-of-network: 80% covered after deductible. Standard Option – Same as High Option.	High Option - In network: covered in full; Out-of-network: 80% covered after deductible. Standard Option – Same as High Option.
Hospital	Covered in full.	Covered in full.	High Option - In network: covered in full; Out-of-network: 80% covered after deductible. Standard Option – In network: covered in full after \$150 copay per admission; Out-of-network: same as High Option.	High Option - In network: covered in full; Out-of-network: 80% covered after deductible. Standard Option – In network: covered in full after \$150 copay per admission; Out-of-network: same as High Option.
Immunizations	Included in well child care visits up to age 5 at no charge.	\$5 copay Primary Care Physician	High Option - In network: covered in full; Out-of-network: 80% covered after deductible. Standard Option – Same as High Option.	High Option - In network: covered in full when billed with office visit; Out-of-network: 80% covered after deductible. Standard Option – Same as High Option.
In vitro Fertilization	Limited to 3 attempts per live birth. Lifetime maximum of \$100,000.	Limited to 3 attempts per live birth. Lifetime maximum of \$100,000.	Limited to 3 attempts per live birth. Lifetime maximum of \$100,000.	Limited to 3 attempts per live birth. Lifetime maximum of \$100,000.

MEDICAL PLANS COMPARISON CHART

Benefit Type	Kaiser Permanente	United Healthcare	POS High and Standard Option Plans In Service Area	POS High and Standard Option Plans Out of Area
Mammography - Preventive Screening Schedule	Schedule consistent with the current recommendations of the American College of Physicians.	Covered in full. Age 35-39: one baseline mammogram; Age 40-49; One mammogram every two calendar years; Age 50+ One mammogram per calendar year.	High Option – Covered in full. Age 35-39: one baseline mammogram; Age 40-49; One mammogram every two calendar years; Age 50+ One mammogram per calendar year. Standard Option - Same as High Option	High Option – Covered in full. Age 35-39: one baseline mammogram; Age 40-49; One mammogram every two calendar years; Age 50+ One mammogram per calendar year. Standard Option - Same as High Option
Maternity	Covered in full once pregnancy is diagnosed.	No copayment applies after the first visit.	High Option - In network: first visit 100% after \$10 copay; other visits 100%; Out-of-network: 80% covered after deductible. Standard Option – In network: first visit 100% after \$30 copay; other visits 100%; Out-of-network: same as High Option.	High Option - In network: covered in full; Out-of-network: 80% covered after deductible. Standard Option – In network: first visit 100% after \$30 copay; other visits 100%; Out-of-network - Same as High Option.
Maximum Lifetime Benefit	Unlimited Maximum.	Unlimited Maximum.	High Option - Unlimited Maximum. Standard Option - Same as High Option	High Option - Unlimited Maximum. Standard Option - Same as High Option
Out-of-Pocket Annual Maximum	N/A	\$1,100 per individual up to a cap of \$3,600 for a family	High Option - In network: Individual: \$1,000 plus the annual deductible; Family: \$2,000 plus the annual deductible; Out-of-network: Individual: \$2,000 plus the annual deductible; Family: \$4,000 plus the annual deductible. Standard Option - Same as High Option	High Option - In network: Individual: \$1,000 plus the annual deductible; Family: \$2,000 plus the annual deductible; Out-of-network: Individual: \$2,000 plus the annual deductible; Family: \$4,000 plus the annual deductible. Standard Option - Same as High Option
Physical	Covered with no copay.	\$5 copay Primary Care Physician;	High Option - In network: \$10 copay; Out-of-network: 80% covered after deductible (limit 1/calendar year). Standard Option - In network: \$15 copay Primary Care Physician; \$30 copay Specialist; Out-of-network: same	High Option - In network: \$10 copay; Out-of-network: 80% covered after deductible (limit 1/calendar year). Standard Option - In network: \$15 copay Primary Care Physician; \$30 copay Specialist; Out-of-network: same as High

			as High Option.	Option.
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MEDICAL PLANS COMPARISON CHART

Benefit Type	Kaiser Permanente	United Healthcare	POS High and Standard Option Plans In Service Area	POS High and Standard Option Plans Out of Area
Prescriptions	Kaiser Rx Plan (included with Kaiser HMO medical plan): \$5 at on-site pharmacies and for mail order; \$15 at participating community pharmacies.	No Rx Plan included; diabetic supplies covered under a pharmacy rider.	High and Standard Option – No Rx Plan included; diabetic supplies covered under a pharmacy rider.	High and Standard Option – No Rx Plan included; diabetic supplies covered under a pharmacy rider.
Rehabilitation Services	Inpatient: Covered in full (Unlimited). Outpatient: \$5 copay; outpatient services for physical therapy are limited to up to 30 visits; occupational and speech therapy per injury, incident or condition are covered for a period not to exceed 90 days.	\$10 copay/visit. 60 combined visits per year (short-term non-chronic conditions only).	High Option - In network: 100%; Out-of-network: 80% covered after deductible. Standard Option – Same as High Option.	High Option - In network: covered in full; Out-of-network: 80% covered after deductible. Standard Option – Same as High Option.
Skilled Nursing Facility	Covered in full; 100 days maximum.	Covered in full 60 days per calendar year maximum.	High Option - In network: covered in full (100 days max/calendar year); Out-of-network: 80% covered after deductible (100 days max/calendar year). Standard Option - Same as High Option	High Option - In network: covered in full (60 days max/calendar year); Standard Option – Same as High Option.
Specialists	\$5 copay.	\$10 copay.	High Option - In network: \$10 copay; Out-of-network: 80% covered after deductible. Standard Option - In network: \$30 copay; Out-of-network: same as High Option.	High Option - In network: \$10 copay; Out-of-network: 80% covered after deductible. Standard Option - In network: \$30 copay; Out-of-network: same as High Option.

MEDICAL PLANS COMPARISON CHART

Benefit Type	Kaiser Permanente	United Healthcare	POS High and Standard Option Plans In Service Area	POS High and Standard Option Plans Out of Area
Substance Abuse/Mental Health	Inpatient: Covered in full; Outpatient: \$5 copay	Inpatient: Covered in full; Outpatient: \$5 copay	High Option - In network: Inpatient- covered in full; Outpatient- \$10 copay; Out-of-network: Inpatient- 80% covered after deductible; Outpatient- 80% covered after deductible. Standard Option – In network: Inpatient- \$150 per admission copay; Outpatient- \$15 copay; Out-of-network: Inpatient- 80% covered after deductible; Outpatient- 80% covered after deductible.	High Option - In network: Inpatient- covered in full; Outpatient- \$10 copay; Out-of-network: Inpatient- 80% covered after deductible; Outpatient- 80% covered after deductible. Standard Option – In network: Inpatient- \$150 per admission copay; Outpatient- \$15 copay; Out-of-network: Inpatient- 80% covered after deductible; Outpatient- 80% covered after deductible.
Surgery	Covered in full.	Inpatient: covered in full; Outpatient: \$25 copay.	High Option - In network: covered in full; Out-of-network: 80% covered after deductible. Standard Option – Same as High Option.	High Option - In network: covered in full; Out-of-network: 80% covered after deductible. Standard Option – Same as High Option.
Vision (Routine)	\$5 copay for exams; 25% discount on lenses/frames at Kaiser centers; 15% discount off the cost of contact lenses.	\$25 copay/exam; 15%-20% discount through participating optical centers.	High Option - In network: refraction not covered; (pediatric visual screening - covered in full under well child care). Out-of-network: refraction not covered (pediatric visual screening - 80% not subject to deductible under well child care). Standard Option - Same as High Option	High Option - In network: refraction not covered (pediatric visual screening – covered in full under well child care); Out-of-network: refraction not covered (pediatric visual screening – 80% not subject to deductible under well childcare). Standard Option - Same as High Option
Well Child Care	Well baby/well child covered in full up to age 5.	\$5 copay Primary Care Physician	High Option - In network: \$10 copay; Out-of-network: 80% not subject to deductible (up to age 18). Standard Option - In network: \$15 copay; Out-of-network: same as High Option.	High Option - In network: \$10 copay; Out-of-network: 80% not subject to deductible (up to age 18). Standard Option - In network: \$15 copay; Out-of-network: same as High Option.

Note: This comparison is to be used as a guide only and not as the benefits offered. Consult the individual plan booklets for complete information.

DENTAL

You may elect one of the dental options offered under the Plan or choose no coverage at all. This election is independent of your medical election. Below is a brief description of each plan.

The **Traditional Dental Plan (Dental PPO)** provides payment for the following covered services, subject to the plan maximums and limitations:

- * Class I Services - Diagnostic and Preventive; payable at 100% of reasonable and customary charges (no more than two in any calendar year).
- * Class II Services - Basic Restorative, Endodontics, Periodontics, Maintenance of Prosthodontics and Oral Surgery; payable at 80% of reasonable and customary charges.
- * Class III Services - Major Restorative, Installation of Prosthodontics; Payable at 60% of reasonable and customary charges.
- * Class IV Services - Orthodontics; payable at 60% of reasonable and customary charges.

The maximum benefit, excluding Class IV Services, is \$2,000 per person each year. The lifetime maximum for Class IV Services (orthodontics) is \$1,000 per person.

Each year, you will need to meet a deductible of \$50 per person, or \$150 for family. The deductible does not apply to Class I Services.

As an additional plan feature, if you use a dentist who is a member of the Preferred Provider Organization (PPO), charges for covered services will usually be discounted. This means your cost will usually be less than that associated with a dentist who is not a member of the PPO. Please remember that under the Traditional Dental Plan (Dental PPO), you may use any dentist you wish; use of the PPO feature is voluntary. You must submit any claims for services within fifteen (15) months following the date of service.

The **Dental HMO (DHMO)** is an alternative option to the Traditional Dental Plan and operates much like a medical HMO. The key features of the plan include:

- * No charge or modest patient charges for diagnostic/preventive and restorative procedures, as well as oral surgery.
- * Fixed patient charges for services associated with crowns and bridges, endodontics, periodontics, prosthetics, denture relining and orthodontics (24 month maximum lifetime benefit for orthodontic services).
- * The patient charge schedule applies only when procedures are performed by a network dentist; **procedures performed by a non-network dentist are not covered.**
- * Only the procedures listed on the patient charge schedule for the Dental HMO (DHMO) will be covered; **those procedures not listed will not be covered.**

- * Visits to a network specialist, such as an Endodontist, Periodontist, Orthodontist, Oral Surgeon, or Pediatric Dentist (up to the 7th birthday) require a signed specialty referral form from the patient's primary dentist.

- * The Dental HMO (DHMO) is a *separate plan* from the Traditional Dental Plan (Dental PPO); there is no “out-of network” benefit associated with the Dental HMO (DHMO).

Please note that if you are currently enrolled in a dental plan and “opt out” for the upcoming calendar year during Open Enrollment, you must satisfy a two-year waiting period to be eligible to re-enroll in a dental plan. Also, if you do not elect a dental plan during your initial offering (for example, if you are a new hire or have a change in employment status), you must satisfy a two-year waiting period to be eligible to enroll in a dental plan. In this case, the two-year waiting period may be longer since you may only elect benefits for an upcoming calendar year during Open Enrollment. Therefore, it is important that you are covered under another dental plan, such as your spouse’s, if you elect to “opt out” of coverage. These enrollment restrictions are subject to the qualified status change provisions of the Plan.

VISION

The vision benefit provides you with reimbursement of your costs for routine eye exams, eyeglass frames and lenses, and contact lenses up to a maximum amount. As an additional plan feature, you have the option of using the participating provider network. The network benefit is usually higher than the schedule of benefits for non-network providers. However, you will only qualify for the network benefit when you follow the specific steps as outlined in the benefit booklet. You must submit any claims for services within one year following the date of service.

Please note that if you are currently enrolled in the vision benefit and “opt out” for the upcoming calendar year during Open Enrollment, you must satisfy a two-year waiting period to be eligible to re-enroll in the vision benefit. Also, if you do not elect the vision benefit during your initial offering (for example, if you are a new hire or have a change in employment status), you must satisfy a two-year waiting period to be eligible to enroll in the vision benefit. In this case, the two-year waiting period may be longer since you may only elect benefits for an upcoming calendar year during Open Enrollment. These enrollment restrictions are subject to the qualified status change provisions of the Plan.

The schedule of benefits is presented on the next page.

Service and Frequency	Schedule of Benefits Non-Network Providers	Schedule of Benefits Participating Provider Network
Vision Examination (once every calendar year) <ul style="list-style-type: none"> • Optometrist • Ophthalmologist 	Up to: <ul style="list-style-type: none"> • \$64 maximum • \$84 maximum 	<ul style="list-style-type: none"> • covered in full • covered in full
Frames (once every other calendar year)	Up to: <ul style="list-style-type: none"> • \$50 maximum (based on retail cost) 	<ul style="list-style-type: none"> • \$50 wholesale allowance (frames exceeding the \$50 wholesale allowance will be billed at the wholesale difference plus 20%)
Lenses per pair (once every calendar year) <ul style="list-style-type: none"> • Single refraction • Bifocal • Trifocal • Lenticular • Options • Contact lenses (when prescribed after cataract surgery or when needed to restore the visual acuity of a person's better eye to 20/70 or better) • Contacts (in lieu of glasses) 	Up to: <ul style="list-style-type: none"> • \$ 50 maximum • \$ 90 maximum • \$110 maximum • \$310 maximum <ul style="list-style-type: none"> • N/A • \$600 maximum • \$100 maximum 	Clear Glass/Plastic; Regular Size Lenses <ul style="list-style-type: none"> • covered in full • covered in full • covered in full • covered in full • Provided under the plan at the actual wholesale cost plus 25% • up to \$600 maximum • up to \$100 maximum (participating providers will charge UCR less 25% for contacts which are in lieu of glasses)

DISCOUNT VISION (RETIREES and COBRA ONLY)

You may elect the following discount vision benefit or elect no discount vision. This election is independent of any other benefit election. Below is a brief description of the program:

The discount vision program has a network of participating ophthalmologists, optometrists, and opticians from whom you may obtain service. By presenting your identification card to a participating provider, you may receive routine eye exams, lenses and frames at discount prices. The level of discounts may vary by region of the country.

OPTIONAL LIFE INSURANCE

In addition to your basic life insurance, you may purchase optional term life insurance in amounts equal to 1, 2, 3, 4, 5, 6, 7 or 8 times your basic annual earnings, subject to a maximum of \$1,000,000. Included with your optional term life election is an equivalent amount of AD&D subject to the same \$1,000,000 maximum.

You pay the full cost of the optional life insurance. The group rates are based on your age and you must be actively at work for any new coverage amounts to be in effect.

There are no evidence of insurability requirements for this optional life insurance if:

- * You elect optional life insurance as a new hire within 60 days of your hire date and are actively at work on the coverage effective date. This applies only to coverage for 1-4 times your basic annual earnings or up to \$400,000 if less.
- * You are currently enrolled in optional life insurance and elect to increase your coverage within 60 days of marriage, birth, adoption or placement for adoption of a child, and are actively at work on the coverage effective date. This applies only to coverage for 1-4 times your basic annual earnings or up to \$400,000 if less
- * You are currently not enrolled in optional life insurance and elect to increase your coverage within 60 days of marriage, birth, adoption or placement for adoption of a child, and are actively at work on the coverage effective date. This applies only to coverage for 1-4 times your basic annual earnings or up to \$400,000 if less.

However, satisfactory evidence of insurability will be required in all other situations, such as:

- * You fail to elect optional life insurance within 60 days of your hire date and later wish to do so.
- * You currently have 1, 2, 3 or 4 times your basic annual earnings in optional life insurance and later wish to increase your amount of coverage to a higher multiple above \$400,000 of basic annual earnings than that which you currently carry.
- *
- * You are not currently enrolled in optional life insurance and later wish to elect or re-elect optional life insurance.
- * You are currently enrolled in optional life insurance and elect to increase your coverage, to between 5-8 times your basic annual earnings or above \$400,000, within 60 days of marriage, birth, adoption or placement for adoption of a child, and are actively at work on the coverage effective date.

You are currently not enrolled in optional life insurance and elect to have coverage between 5-8 times your basic annual earnings or over \$400,000, within 60 days of marriage, birth, adoption or placement for adoption of a child, and are actively at work on the coverage effective date.

DEPENDENT LIFE INSURANCE

Dependent life insurance covers your spouse and eligible dependent children. You may elect one of the following options or choose no coverage at all:

Option 1 -

- Eligible spouse.....\$2,000
- Children under 26 years old:
 - under 31 days.....\$1,000
 - over 30 days but under 26 years.....\$1,000

Option 3 -

- Eligible spouse.....\$10,000
- Children under 26 years old:
 - under 31 days months.....\$1,000
 - over 30 days but under 26 years..\$5,000

Option 2 -

- Eligible spouse.....\$4,000
- Children under 26 years of age:
 - under 31 days.....\$1,000
 - over 30 days under 26 years.....\$2,000

You are automatically the beneficiary for this insurance. *Please note: If both you and your spouse are eligible for Montgomery County sponsored dependent life insurance, and both of you elect dependent life insurance, benefits for an eligible dependent child will be payable either under your coverage or your spouse's, but not both.*

PRESCRIPTION (Rx)

With the exception of the Kaiser Permanente option, which provides prescription coverage (see page 30), the medical plans do not provide prescription drug coverage. However, you have the option to elect prescription drug coverage under a separate “stand alone” prescription plan offered through Caremark. Any claims for services must be submitted within one year following the date of service.

Caremark Prescription Plans

There are three Caremark prescription plan options:

- Caremark High Option \$4 / \$8 Prescription Plan (available to IAFF and MCGEO)
- Caremark High Option \$5 / \$10 Prescription Plan (available to unrepresented, FOP and retirees)
- Caremark Standard Option Prescription Plan

For a summary of benefits for these plans, see the chart on page 48.

Note: If you are a retiree and eligible for Medicare, please note the important information regarding the coordination of Medicare with the Prescription Plan on page 28.

Coverage for maintenance medications through Maintenance Choice

A maintenance medication is a medicine taken regularly for chronic conditions or long-term therapy, such as prescriptions for high blood pressure, asthma or diabetes. For the price of one copayment for up to a 90-day supply, you and your covered dependents have the choice of purchasing your

maintenance medications via a CVS/pharmacy retail location or Caremark's Mail Service Pharmacy. This program is called "Maintenance Choice."

Note: If you fill a 30-day prescription for a maintenance medication at a participating retail pharmacy more than two times (original fill plus one refill), you must still pay the copayment *plus* the cost difference between mail service and retail pharmacy each time you fill the prescription thereafter. To avoid this extra cost, submit a 90-day script through Maintenance Choice (either at a retail CVS/pharmacy retail location or through mail service).

Limit to drugs prescribed to treat Erectile Dysfunction (ED)

You and your covered dependents are limited to a maximum of 6 doses per month for any drug specifically approved by the Food and Drug Administration (FDA) for the treatment of erectile dysfunction. Any amount above this limit will be paid in full by you. These rules also apply if you take a daily low-dose pill to treat ED.

Coverage for brand name medications that have generic equivalents

You or your covered dependent must receive generic prescription drugs, if available. If you or your covered dependent chooses to receive a brand name drug that has a generic equivalent, you must pay the generic drug copayment plus the difference between the cost of the brand-name drug and the generic drug. This requirement may be waived only if your or your covered dependent's doctor certifies in a separate letter that it is medically necessary to use a brand name drug instead of its generic equivalent.

Follow the steps below to submit a letter of medical necessity to Caremark.

1. Request a letter of medical necessity from your doctor for your brand name prescription. The letter must be written on the doctor's official letterhead (not on the prescription) and must contain your name, date of birth, Caremark plan card ID number and employer name (Montgomery County Government). It must also include details of the medical reason for prescribing the brand name drug in place of the generic drug. It cannot simply state that in his/her medical opinion brand name drugs are better than generic drugs. Also, it is not sufficient to write "dispense as written" or "medically necessary" on the prescription
2. Submit the letter of medical necessity to:

CVS/Caremark, Inc.,
Department of Appeals, MC109
P.O. Box 52084
Phoenix, AZ 85072-2084

You can also fax the letter to Caremark at 1-866-689-3092 or 1-866-443-1172.

3. If the waiver is approved by the Pharmacy Benefit Manager, you will be charged the brand name drug copayment. CVS/Caremark requires yearly updates of medical necessity. If the waiver is not approved, you can appeal the decision at the address/fax listed above.

Caremark High & Standard Option Prescription Plans *At-a-Glance*

<p>Where / how</p>	<p>Retail Pharmacy Network To purchase up to a 30-day supply of a short-term medication, use your Caremark member ID card at over 64,000 participating retail pharmacies (e.g., a CVS, Target, Giant, Safeway, Walgreens or Walmart pharmacy).</p> <p>Maintenance Choice® To purchase up to a 90-day supply of a maintenance medication, use your Caremark member ID card at one of the 7,100 CVS/pharmacy retail locations <u>or</u> use Caremark’s Mail Service Pharmacy.</p> <p>Important: If you fill a 30-day prescription for a maintenance medication at a participating retail pharmacy more than two times (original fill plus one refill), you pay the copayment <i>plus</i> the cost difference between mail service and retail pharmacy each time you fill the prescription thereafter. To avoid this, submit a 90-day script with 3 refills through Maintenance Choice (either at a CVS/pharmacy retail location or through mail service).</p>								
<p>High Option \$4 / \$8 Plan Copayments IAFF & MCGEO</p>	<table border="0"> <tr> <td>Generic drugs:</td> <td>\$4</td> </tr> <tr> <td>Brand name drugs with no generic:</td> <td>\$4</td> </tr> <tr> <td>Brand name drugs that have a generic:</td> <td>\$8, if you have an approved letter of medical necessity on file with Caremark. (If not, the cost is \$4 <i>plus</i> the difference between the brand name and generic drug costs.)</td> </tr> </table>	Generic drugs:	\$4	Brand name drugs with no generic:	\$4	Brand name drugs that have a generic:	\$8, if you have an approved letter of medical necessity on file with Caremark. (If not, the cost is \$4 <i>plus</i> the difference between the brand name and generic drug costs.)		
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<p>High Option \$5 / \$10 Plan Copayments Unrepresented and, FOP and retirees</p>	<table border="0"> <tr> <td>Generic drugs:</td> <td>\$5</td> </tr> <tr> <td>Brand name drugs with no generic:</td> <td>\$5</td> </tr> <tr> <td>Brand name drugs that have a generic:</td> <td>\$10, if you have an approved letter of medical necessity on file with Caremark. (If not, the cost is \$5 <i>plus</i> the difference between the brand name and generic drug costs.)</td> </tr> </table>	Generic drugs:	\$5	Brand name drugs with no generic:	\$5	Brand name drugs that have a generic:	\$10, if you have an approved letter of medical necessity on file with Caremark. (If not, the cost is \$5 <i>plus</i> the difference between the brand name and generic drug costs.)		
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<p>Standard Option Plan Copayments</p> <p>➤➤➤ This Plan has an annual deductible of \$50 per individual or family.</p>	<table border="0"> <tr> <td>Generic drugs:</td> <td>\$10</td> </tr> <tr> <td>Brand name PDL[Ⓞ] drugs with no generic:</td> <td>\$20</td> </tr> <tr> <td>Brand name non-PDL[Ⓞ] drugs with no generic:</td> <td>\$35</td> </tr> <tr> <td>Brand name drugs that have a generic available:</td> <td>\$20 or \$35, if you have an approved letter of medical necessity on file with Caremark. (If not, the cost is \$10 <i>plus</i> the difference between the brand name and generic drug costs.)</td> </tr> </table>	Generic drugs:	\$10	Brand name PDL [Ⓞ] drugs with no generic:	\$20	Brand name non-PDL [Ⓞ] drugs with no generic:	\$35	Brand name drugs that have a generic available:	\$20 or \$35, if you have an approved letter of medical necessity on file with Caremark. (If not, the cost is \$10 <i>plus</i> the difference between the brand name and generic drug costs.)
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Ⓞ Caremark’s quarterly Performance Drug List (PDL) is available at www.montgomerycountymd.gov/ohr; click Benefits, then Employee or Retiree Health Insurance; scroll down to the Prescription Drug information.

FLEXIBLE SPENDING ACCOUNTS

Both the health care and dependent care flexible spending accounts allow you to use before-tax dollars to pay for certain eligible health and dependent care expenses.

With each account, you set aside a certain amount of your money from each paycheck before taxes are calculated. After you incur eligible expenses, you submit a claim with supporting evidence, such as bills or receipts, to the County's third party administrator for reimbursement. You have until April 30th of the following year to submit claims for expenses incurred during each calendar year and until the March 15th following the end of the calendar year to incur expenses applicable to the prior year's election.

The health care and dependent care flexible spending accounts are separate. You must enroll separately in each account and you may not transfer contributions between accounts. Also, in order to participate in these accounts, you must enroll each year. *If you do not make an election, you may not participate in either the health care or dependent care flexible spending account for the upcoming calendar year.*

Health Care Flexible Spending Account

Medical, prescription, dental and vision benefits seldom pay for everything. The health care flexible spending account is for reimbursement of eligible expenses not covered by these benefits, as well as the deductibles and copayments associated with these benefits. The expenses may be incurred by you or any person who qualifies as your dependent under the applicable provisions of the Internal Revenue Code. A list of eligible expenses is available in the Internal Revenue Service Publication 502 (*please note that certain expenses associated with premium payments are not eligible under the health care flexible spending account*). You may contribute up to \$2,550 for the year, in whole dollar amounts.

Expenses incurred for over the counter drugs, with the exception of insulin, may not be reimbursed unless you have a doctor's prescription.

Dependent Care Flexible Spending Account

The dependent care flexible spending account is for reimbursement of eligible expenses associated with the care of qualifying individuals that enables you (and your spouse, if you are married) to work.

Qualifying individuals include:

- * Your dependent children under the age of 13. However, in the case of divorced parents, the non-custodial parent cannot receive reimbursements even if the parent claims the exemption and the custodial parent may be entitled to receive reimbursements.
- * Your spouse who is physically or mentally incapable of self care, who resides with you for more than half the year.
- * Your dependent who is physically or mentally incapable of self care, who resides with you for more than half the year.

Eligible expenses are those expenses you pay for household services and for the care of qualifying dependents, provided such expenses enable you (and your spouse, if you are married) to work. If you are married, you and your spouse both must earn income, unless your spouse is disabled or a student. If one spouse earns less than \$5,000 then the benefit is limited to whatever that spouse earned. Examples of eligible expenses include:

- * Household services such as a domestic maid or cook, if those services are provided to qualifying dependents.
- * Day care centers, if they are fully licensed.
- * Babysitters in your home or dependent care provided in the babysitter's home while you (and your spouse, if you are married) are working.

A list of eligible expenses is available in the Internal Revenue Service Publication 503. You may contribute up to \$5,000 for the year, in whole dollar amounts. Payments may not be made to certain individuals, including, someone you can claim as your dependent, or to your child who is under age 19 even if he or she is not your dependent. The payment also can not be to your spouse or to the parent of your child.

Important Internal Revenue Service Rules - The Internal Revenue Service requires you to follow certain rules when participating in either the health care or dependent care flexible spending account:

- * “Use it or lose it” - It is important to carefully estimate your anticipated eligible expenses for the upcoming calendar year. You may incur expenses up until the March 15th following the end of the calendar year. You must request reimbursement by April 30th following the end of the calendar year. If you do not have expenses or request reimbursement by the deadline dates, you will forfeit any money remaining in your account. Leftover money *cannot* be returned to you, nor can it be used the following year.
- * Limited changes to your contributions - The amount you elect for the health care and dependent care flexible spending accounts during Open Enrollment cannot be changed during the year, except under the qualified status change provisions of the Plan. You cannot decrease your contributions to your health care flexible spending account under any circumstance. Therefore, you should plan your contributions carefully.
- * You may be subject to special federal tax filing requirements if you participate in the dependent care flexible spending account. If you use the Dependent Care Flexible Spending Account, you may not claim the dependent care credit on your tax return. It is important to consult a tax professional to determine how these requirements may affect you.

PROOF OF ELIGIBILITY REQUIREMENTS FOR DEPENDENTS

Below are the types of documentation required to prove dependent eligibility for coverage:

For Spouse or Domestic Partner	For Children	For Legal Custody
<p>To add a Spouse: Official State Marriage Certificate (certified by appropriate State or County Official)</p> <p>To add a Domestic Partner: County's Domestic Partner Affidavit or an official copy of a State issued Domestic Partnership Registration</p>	<p>For a Biological Child: State Birth Certificate (must show employee/retiree or spouse/domestic partner as parent).</p> <p>For newborns, OHR will accept hospital discharge papers for first 60 days (State birth certificate must then be submitted).</p>	<p>Copy of Court Order granting legal custody</p>
<p>To remove a Spouse: Divorce Decree</p>	<p>For an Adopted Child: Copy of Adoption or Placement for Adoption Papers</p>	
<p>To remove a Domestic Partner: County's Dissolution of Domestic Partnership Affidavit</p>	<p>For a Step Child: State Birth Certificate (must show employee/retiree or spouse/domestic partner as parent), Marriage Certificate and Divorce Decree or Custody Papers</p>	
	<p>For a Disabled Child: Medical plan verification of disability prior to age 26</p>	

Documentation supporting dependent eligibility is required for initial enrollments of dependents and re-enrollment of dependents after a period of ineligibility. Failure to provide proof of eligibility and supporting documentation will result in termination of coverage. Coverage will not be reinstated except during Open Enrollment or in the event of a qualified status change.

Qualified Domestic Partner Proof of Eligibility requirements are detailed in the separate *Domestic Partner Benefits* Affidavit document.

You are responsible for notifying the OHR Health Insurance Team when your dependents are no longer eligible for coverage. If you do not do so within 60 days, this will be considered fraud and you will be responsible for 100% of any claims incurred.

HIPAA PRIVACY NOTICE

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.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information. This information, known as protected health information, includes virtually all individually identifiable health information held by the Plan — whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of the following plans:

Medical POS Plans, including the Out-of Area Components (2)
HMO Medical Plans (2)
Dental PPO Plan
Dental HMO Plan
Vision Plan for actives
Discount Vision Plan for retirees
Prescription Plans (2)
Health FSA Plan
Employee Assistance Plan

The plans covered by this notice may share health information with each other to carry out Treatment, Payment, or Health Care Operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

The Plan's duties with respect to health information about you

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important to note that these rules apply to the Plan, not Montgomery County as an employer — that's the way the HIPAA rules work. Different policies may apply to other Montgomery County programs or to data unrelated to the health plan.

How the Plan may use or disclose your health information

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of Health Care Treatment, Payment activities, and Health Care Operations. Here are some examples of what that might entail:

- **Treatment** includes providing, coordinating, or managing health care by one (1) or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. *For example, the Plan may share health information about you with physicians who are treating you.*

- **Payment** includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations and provide reimbursement for health care. This can include eligibility determinations, reviewing services for medical necessity or appropriateness, utilization management activities, claims management, and billing; as well as “behind the scenes” plan functions such as risk adjustment, collection, or reinsurance. *For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan in order to coordinate payment of benefits.*
- **Health Care Operations** include activities by this Plan (and in limited circumstances other plans or providers) such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include vendor evaluations, credentialing, training, accreditation activities, underwriting, premium rating, arranging for medical review and audit activities, and business planning and development. *For example, the Plan may use information about your claims to review the effectiveness of wellness programs. However, the Plan may not use genetic information for underwriting purposes.*

The amount of health information used or disclosed will be limited to the “Minimum Necessary” for these purposes, as defined under the HIPAA rules. The Plan may also contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

How the Plan may share your health information with Montgomery County

The Plan, or its health insurer or HMO, may disclose your health information without your written authorization to Montgomery County for plan administration purposes. Montgomery County may need your health information to administer benefits under the Plan. Montgomery County agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. Montgomery County Office of Human Resources, Department of Finance and County Attorney’s Office staff are the only Montgomery County employees who will have access to your health information for plan administration functions.

Here’s how additional information may be shared between the Plan and Montgomery County, as allowed under the HIPAA rules:

- The Plan, or its Insurer or HMO, may disclose “summary health information” to Montgomery County if requested, for purposes of obtaining premium bids to provide coverage under the Plan, or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants’ claims information, but from which names and other identifying information have been removed.
- The Plan, or its Insurer or HMO, may disclose to Montgomery County information on whether an individual is participating in the Plan, or has enrolled or disenrolled in an insurance option or HMO offered by the Plan.

In addition, you should know that Montgomery County cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by Montgomery County from other sources, for example under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation is *not* protected under HIPAA (although this type of information may be protected under other federal or state laws).

Other allowable uses or disclosures of your health information

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information describing your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made, for example if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan is also allowed to use or disclose your health information without your written authorization for the following activities:

Workers' compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with such laws
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (including disclosures to the target of the threat); includes disclosures to assist law enforcement officials in identifying or apprehending an individual because the individual has made a statement admitting participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request, or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)

Law enforcement purposes	Disclosures to law enforcement officials required by law or pursuant to legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosure about a death that may have resulted from criminal conduct; and disclosure to provide evidence of criminal conduct on the Plan's premises
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death
Research purposes	Disclosures subject to approval by institutional or private privacy review boards, and subject to certain assurances and representations by researchers regarding necessity of using your health information and treatment of the information during a research project
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
HHS investigations	Disclosures of your health information to the Department of Health and Human Services (HHS) to investigate or determine the Plan's compliance with the HIPAA privacy rule

Except as described in this notice, other uses and disclosures will be made only with your written authorization. For example, in general and subject to specific conditions, we will not use or disclose your psychiatric notes; we will not use or disclose your health information for marketing; and we will not sell your health information unless you give us a written authorization. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization if the Plan has taken action relying on it. In other words, you can't revoke your authorization with respect to disclosures the Plan has already made.

Breach of Unsecured Protected Health Information

You must be notified in the event of a breach of unsecured protected health information. A "breach" is the acquisition, access, use or disclosure of protected health information in a manner that compromises the security or privacy of the protected health information. Protected health information is considered compromised when the breach poses a significant risk of financial harm, damage to your reputation, or other harm to you. This does not include good faith or inadvertent disclosures or when there is a reasonable way to retain the information. You must receive a notice of the breach as soon as possible and no later than 60 days after the discovery of the breach.

Your individual rights

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the Contact section at the end of this notice for information on where to submit requests.

Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse

You have the right to ask the Plan to restrict the use and disclosure of your health information for Treatment, Payment, or Health Care Operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. In addition, you have the right to restrict disclosure of health information to the Plan for payment or healthcare operations (but not for carrying out treatment) in situations where you have paid the healthcare provider out-of-pocket in full. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction, except where you have paid the healthcare provider out-of-pocket in full as described above. In this case, the Plan is required to implement the restrictions that you request. And if the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

Right to receive confidential communications of your health information

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your health information

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a “Designated Record Set” including your health information maintained in electronic format. If your health information is available in an electronic format, you may request access electronically and that this be transmitted directly to someone you designate. This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. In addition, the Plan may deny your right to access, although in certain circumstances you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible onsite), the Plan will provide you with:

- The access or copies you requested;
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint; or
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan may also charge reasonable fees for copies or postage. But these fees must be limited to the cost of labor involved in responding to your request if you requested access to an electronic health record.

If the Plan doesn’t maintain the health information but knows where it is maintained, you will be informed of where to direct your request.

Right to amend your health information that is inaccurate or incomplete

With certain exceptions, you have a right to request that the Plan amend your health information in a Designated Record Set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the Designated Record Set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will:

- Make the amendment as requested;
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint; or

- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

Right to receive an accounting of disclosures of your health information

You have the right to a list of certain disclosures the Plan has made of your health information, including a disclosure involving an electronic health record. This is often referred to as an “accounting of disclosures.” You generally may receive an accounting of disclosures if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information going back for six (6) years (three (3) years on the case of a disclosure involving an electronic health record) from the date of your request, but not earlier than April 14, 2003 (the general date that the HIPAA privacy rules are effective). You do not have a right to receive an accounting of any disclosures made:

- For Treatment, Payment, or Health Care Operations (note: this exception does not apply to electronic health records);
- To you about your own health information;
- Incidental to other permitted or required disclosures;
- Where authorization was provided;
- To family members or friends involved in your care (where disclosure is permitted without authorization);
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances; or
- As part of a “limited data set” (health information that excludes certain identifying information).

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one (1) request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You’ll be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to obtain a paper copy of this notice from the Plan upon request

You have the right to obtain a paper copy of this Privacy Notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

Changes to the information in this notice

The Plan must abide by the terms of the Privacy Notice currently in effect. This notice takes effect on September 23, 2013. However, the Plan reserves the right to change the terms of its privacy policies as described in this notice at any time, and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised Privacy Notice mailed to your home address.

COMPLAINTS

If you believe your privacy rights have been violated, you may complain to the Plan and to the Office for Civil Rights of the U. S. Department of Health and Human Services. You won't be retaliated against for filing a complaint. To file a complaint to the Plan, write:

Montgomery County
Office of Human Resources – Health Insurance Team
Executive Office Building 7th Floor
101 Monroe Street
Rockville, Maryland 20850

You may also fax the Plan at: 240-777-5131

CONTACT

For more information on the Plan's privacy policies or your rights under HIPAA, contact MC311 Customer Service Representatives, Monday-Friday, 7:00 a.m. – 7:00 p.m.: 240-777-0311 (311 locally) or 1-877-613-5212 toll free 301-251-4850 TTY; any questions MC311 representatives cannot answer are immediately routed via a service request to the OHR Health Insurance Customer Care Center, Monday through Friday, open 8:00 am – 5:00 pm.

NOTICE OF CREDITABLE COVERAGE

Important Notice from Montgomery County 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 Montgomery County and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

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

- 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.
- Montgomery County has determined that the prescription drug coverage offered by the County's group insurance 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.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

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

At this time, the County offers Medicare eligible retirees the following prescription plans:

- Caremark High Option Prescription Plan.
- Caremark Standard Option Prescription Plan.
- Prescription coverage available through the Kaiser's Medicare Plus plan.*

If you (and/or your dependents) are eligible for Medicare (including due to disability) and elect to participate in the Caremark High Option Prescription Plan or Standard Option Prescription Plan, you (and/or your dependents) will automatically be enrolled in Medicare Part D. Medicare requires that you have a 21 day period to opt out of Medicare Part D participation. However, if you opt out, you (and your dependents, if applicable) will not have any prescription drug coverage through the County's prescription drug plans. If you elect to participate in the Kaiser plan, this is not applicable.

If you or your Medicare eligible dependent decide to join a Medicare drug plan, coverage under the County plan will terminate for that individual. Therefore, please note that if **you** join a Medicare drug plan, and as a result your County coverage is terminated, **coverage for your dependents will also terminate.** .

If you decide to join a Medicare drug plan and you decide to drop your current County coverage, be aware that you and your dependents will only be able to elect coverage at open enrollment..

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 coverage with the County and don't enroll in Medicare prescription drug coverage within 63 days after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage determined to be Creditable Coverage, your monthly premium may go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may always be at least 19% higher. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

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

The Office of Human Resources, Health Insurance Team
101 Monroe Street, 7th floor
Rockville, Maryland 20850

Contact MC311 Customer Service Representatives, Monday-Friday, 7:00 a.m. – 7:00 p.m.: 240-777-0311 (311 locally) or 1-877-613-5212 toll free 301-251-4850 TTY; any questions MC311 representatives cannot answer are immediately routed via a service request to the OHR Health Insurance Customer Care Center, Monday through Friday, open 8:00 am – 5:00 pm.

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 Montgomery County changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

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

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

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you 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 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).

October 2015
Montgomery County Office of Human Resources, Health Insurance Team
101 Monroe Street, 7th floor
Rockville, Maryland 20850

NOTICE OF GRANDFATHERED HEALTH PLAN STATUS

Montgomery County Government believes the Plan is a grandfathered health plan under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the OHR Health Insurance Team by contacting MC311 Customer Service Representatives, Monday-Friday, 7:00 a.m. – 7:00 p.m.: 240-777-0311 (311 locally) or 1-877-613-5212 toll free 301-251-4850 TTY; any questions MC311 representatives cannot answer are immediately routed via a service request to the OHR Health Insurance Customer Care Center, Monday through Friday, open 8:00 am – 5:00 pm. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

Women's Health and Cancer Rights Act of 1998

The Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call the Health Insurance Team for more information.

Newborns' and Mothers' Health Protection Act of 1996

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 not in excess of 48 hours (or 96 hours).