COUNTY FLEX

Howard County Government's Flexible Benefits Enrollment Guide*

Plan Year January 1, 2022 – December 31, 2022

*This booklet is intended as a summary only. The County's benefits are governed by the terms of the respective plan documents and/or insurance contracts. If there is a discrepancy between the information in this summary and the plan documents or insurance contracts, the plan documents or insurance contracts will prevail. The County reserves the right to amend, modify, or terminate any benefit at any time at its sole discretion.

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How CountyFlex Works

CountyFlex Offers You Flexibility ***PLUS*** Choice!

Benefits are an important part of the total compensation program offered by Howard County. CountyFlex, our flexible benefits program, offers you flexibility and choice. Because Howard County recognizes that not all employees have the same need for benefits, CountyFlex lets you choose the benefits that best meet your personal needs. CountyFlex also provides the opportunity for you to review your benefit choices annually and make changes to meet your changing needs.

Who is Eligible for CountyFlex

Full-time and part-time benefited employees are eligible to participate in the CountyFlex plans described in this Enrollment Guide. You may also enroll your eligible dependents, which includes your legal spouse (opposite or same sex) and your dependent children to the end of the month that they turn age 26. (Page 27 has more details on dependent eligibility). ***You must furnish appropriate proof of dependent eligibility for any dependent you enroll in the health insurance plans.***

Open Enrollment Period

The CountyFlex open enrollment period occurs annually for the upcoming plan year. Open enrollment typically occurs in the fall with open enrollment selections effective for January 1 of the following calendar year.

How to Enroll on-line

You will need to enroll in your benefits using the Benelogic enrollment website online at **www.howardcounty.benelogic.com**. Sign in using your first initial, last name and last four digits of your Social Security number. Your password is the last four digits of your Social Security number. Once you log in, just follow the online instructions for enrolling in your benefits. Be sure to print your confirmation statement.

When Your Benefits Start

Your benefits begin on the first of the month following your hire date. You must complete your enrollment no later than the enrollment deadline as stated in your benefit enrollment information.

How to Get More Information About Your Benefits Online

In addition to this enrollment guide, detailed summaries and descriptions of the benefits are posted on the Howard County benefits intranet website at https://myhoco.howardcountymd.gov. Go to **"Departments",** select **"Human Resources"**, select **"Employee Benefits Information"**. ***We strongly advise that you review the information on this website prior to making your enrollment decisions!***

How CountyFlex Works

Pre-Tax Contributions

Your portion of the cost of your benefit selections are paid with pre-tax dollars. This means you pay less income tax, since the tax withholdings are based on your income after your pre-tax contributions have been deducted. Any pre-tax contributions are deducted from your paycheck 24 times each year. No deductions are made from a third paycheck in a month.

How Pre-tax Contributions Save You Money in Taxes

By paying for your CountyFlex benefits with pre-tax dollars, you take home more pay compared to paying with after-tax dollars. This is because pre-tax deductions *reduce* your taxable salary. Here's an example of the tax savings. For this example, we assume the employee's annual salary is $32,000 and their tax bracket is 32%. Their benefit deductions are $100/month.

	After-Tax Method	
Taxable Salary	$32,000	
Tax withholding	$10,240	($32,000 x 32%)
Benefit Deductions	$ 1,200	
Annual take home pay	$20,560	($32,000 - $10,240 - $1200)

	Pre-tax Method	
Salary	$32,000	
Benefit Deductions	$ 1,200	
Taxable salary	$30,800	($32,000 - $1200)
Tax withholdings	$ 9,856	($30,800 x 32%)
Annual take home pay	$20,944	($30,800 - $9856)
Increase in take home pay	**$ 384**	($20,944 - $20560)

You can see in this example that having the benefit deductions withheld on a pre-tax basis increases the annual take-home pay by **$384!**

Pre-tax deductions and Social Security

Social Security benefits are based on the Social Security taxable earnings on which you and your employers pay taxes while you work. Because pre-tax deductions lower your Social Security taxable wages, your future Social Security benefits may be slightly reduced. However, the tax savings advantage of pre-tax contributions typically offsets any potential reduction in future Social Security benefits. In addition, you can take the amount of your tax savings and contribute that to the County's 457(b) deferred compensation program, thereby increasing your own future retirement income savings.

Medical Benefit Choices

CountyFlex offers three medical plan choices:

- **Kaiser Permanente HMO Select**
- **Aetna Select Open Access**
- **Aetna Open Choice PPO**

A general description of each medical plan is provided on the following pages. Also, please refer to the benefits comparison charts and plan summaries available on the County intranet site as noted on Page 2 of this guide.

Each of the medical plans offered include coverage for outpatient prescription drugs and routine vision care benefits. For the Aetna medical plans, the vision care benefits are provided by Vision Service Plan (VSP). If you elect an Aetna medical plan, you will automatically be covered by the VSP plan. If you select the Kaiser HMO, your vision benefits will be provided within the Kaiser plan.

All medical plans have an unlimited lifetime maximum benefit.

Transgender Benefit Coverage

All medical plan options provide transition-related health care coverage, including gender confirmation surgery, hormone therapy, and mental health counseling, among other transition-related procedures, as it relates to treating gender dysphoria. Complete details can be obtained from the Office of Human Resources.

Kaiser Permanente – HMO Select

Kaiser Permanente is a Health Maintenance Organization (HMO) that provides members with a full range of medical care benefits including preventive care services. Members of Kaiser Permanente must select a Primary Care Physician (PCP) from the over 900 physicians who practice in the District of Columbia, Northern Virginia, and Maryland, including Howard and Baltimore counties, or may select one of the over 12,000 community participating Primary Care and Specialty Physicians. It is important that you choose a PCP when you enroll, as this doctor will serve as your good-health advocate and coordinate your care. If you do not choose one when you enroll, Kaiser Permanente will select a PCP for you from those doctors who practice in a medical center nearest to your home. You will be able to change your PCP for any reason at any time by contacting the Kaiser Permanente member services department.

Kaiser Permanente Physicians

For help in choosing a primary care physician (PCP), review the physicians listed in the Kaiser Permanente Provider Directory or online at www.kp.org . You can change your PCP for any reason at any time by contacting Member Services at 800-777-7902. PCP changes may also be completed by registering for a KP.org member account.

The list of Kaiser Permanente physicians also includes where the physician went to school, where they did their residency, their board certification, and if they speak any foreign languages. This information should help you select a physician that best matches the needs of you and your family.

You may select a PCP for yourself and each member of your family. You can opt to have a single physician for your entire family or choose a different physician for each family member. Your PCP will work with you to coordinate your care, referring you for specialty care as needed and acting as your good health advocate, guiding you through the preventive care services aimed at keeping you healthy through all your stages of life.

Prescription Benefits

Prescription drugs are covered at a *plan* pharmacy for up to a 30-day supply after a $10 copay for generic, $30 copay for preferred brand name, and $50 for non-preferred brand; at *network* pharmacies the copay is $30 for generic, $50 for preferred brand name, and $75 for non-preferred brand name.

A mail order program is also available, which allows you to receive up to a 90-day supply of maintenance drugs for two copays.

When you fill your prescriptions at a Kaiser Permanente Medical Center pharmacy, you will pay the smallest copay amount. Prescriptions can also be filled at participating community pharmacies, such as Giant, Safeway, Rite Aid, Target, Wal-Mart, and K-Mart. Prescription copays are higher when filled at participating community pharmacies than when you obtain your drugs at a Kaiser Permanente medical center.

Members are also able to order prescription refills online though the members-only section of Kaiser Permanente Web site, **www.kp.org.**

Wellness Services

Kaiser Permanente offers a variety of services aimed at preventing illness. Your PCP can encourage you to attend the "Be Well" classes offered in the Kaiser Permanente medical centers. The list of the classes offered is printed in your provider directory and includes classes covering such topics as asthma management for children, heart failure, pediatric weight management, prenatal care/breastfeeding, prenatal care, smoking cessation, managing high blood pressure and more.

Members can also access a number of online services that Kaiser Permanente offers to aid in weight complications management, smoking cessation and relaxation. For more information, visit www.kp.org/healthylifesyles.

Other Plan Features

- Video visits are available for a $0.00 copay. Services include PCP, some specialist services and certain urgent care condition. Register at kp.org and you can make most video appointments on-line 24/7 from your computer or mobile device.
- For children up to age five, the copay for PCP visits are waived (PCP visits are covered in full).
- $0 copay for preventive services (i.e., mammograms, age-based immunizations, routine physical, well-women examinations, etc.)
- Kaiser Permanente offers discounted programs for alternative medical services. Acupuncture, chiropractic and massage therapy are some examples of those services. Just go to www.kp.org/choosehealthy
- Managed Health Services are coordinated through the plan
- www.kp.org (My Health Manager) allows access 24/7 365 days a year to your electronic health record featuring; e-mailing your doctor's office, prescription refills, view lab results, manage your appointments and much more.
- Kaiser Permanente offers discounts to members on new health club membership when they join through Global fit. Visit **globalfit.com/Kaiser**.
- Discounts of Weight Watchers memberships are also available through Kaiser Permanente. Members can get discounts on community meetings, online subscriptions and the Weight Watcher At Home Kit. For more information, visit **www.kp.org/weightwatchers**

Kaiser Permanente Medical Centers and After Hour Services

- Kaiser Permanente maintains a 24 hour, 7 day/week Medical Advice help line at 800-777-7904. The medical advice help line is staffed by registered nurses who have access to your personal health record. Nurses can answer urgent as well as routine medical questions over the phone.
- Kaiser Permanent medical centers have multiple specialties under the same roof. Most have primary care services, such as pediatrics, obstetrics/gynecology and internal medicine, and specialty care services in the same location.
- Most Kaiser Permanente medical centers also provide services including laboratory, radiology, and pharmacy in a single convenient location.
- For specialty referrals from a Kaiser Permanente physician, the specialist is often available within the same medical center or another area Kaiser Permanente medical center.
- Kaiser Permanente maintains a 24-hour, 7 day/week Medical Advice help line that is staffed by registered nurses who are available to answer urgent, as well as routine, medical questions over the telephone.
- The South Baltimore center offers Urgent Care After-Hours. On weekends and holidays, members who need to be seen due to an urgent medical condition can call the Appointments Line and arrange an urgent care appointment at one of the designated Urgent Care centers. The hours available for these urgent care centers can be found in the provider directory.

Points to Consider

There are a few points to keep in mind when you consider joining Kaiser Permanente:

- There are no annual deductibles or coinsurance payments.
- Office visits for primary care are covered in full after a $10 copay; visits to specialists require a $20 copay.
- As a Select Plan member, you have access to physicians in the Mid-Atlantic Permanente Medical Group, along with network physicians who do not practice in our medical centers but are in private practice.
- No claim forms are required.
- Vision coverage is included.
- If you are outside of the Kaiser Permanente Mid-Atlantic region or have dependents who do not live with you (such as children attending school outside the Mid-Atlantic region), the Kaiser Permanente HMO will provide coverage for urgent and emergency situations.

If you're comfortable using the medical professionals and hospitals which are part of the Kaiser Permanente HMO, then you should consider enrolling in this Plan.

Remember, all benefits must be provided or pre-authorized by a Kaiser HMO physician; otherwise, you will be responsible for the full cost of treatment or services.

If you enroll in the Kaiser Permanente plan, each covered family member selects his or her own primary care physician from the Kaiser network of participating physicians.

Open Access Aetna Select

The **Open Access Aetna Select** gives you the freedom to seek care from *any* of the approximately 60,000 physicians, 109 hospitals in the Baltimore area.. There is never a need to file a claim form. Your doctors handle all medical claims.

Your Primary Care Physician

Your Aetna plan gives you the choice to visit any doctor in the Aetna network, ***without a referral!*** You can choose a primary care physician (PCP) for you and your family, but it is ***not*** required. The advantage of selecting a PCP is that it allows you to form a relationship with a doctor who will get to know your personal health care needs.

Visit Your Physician

- Although you are encouraged to choose a PCP, you may seek care from any Aetna network provider.
- For specialty care, ***no referrals are ever required***.
- You will make applicable co-payments at the time of service - $10 copay for a primary care physician; $20 copay for specialist

How to find a doctor within Aetna's national network

To find out if a physician participates in Aetna's extensive national network of doctors, you can use Aetna's online provider directory located at www.aetna.com. If you need a printed directory, you can call Member Services at the toll-free number on your ID card.

DocFind®

DocFind allows you and your family members to search for physicians by:

- City, state and zip
- Specialty
- Hospital affiliation
- Provider name
- Gender

You can also get extra information, like:

- Plans in which each doctor participates
- Medical schools attended
- Board certification status
- Languages spoken

You can also get information about office locations, handicap access, maps and driving directions.

Resources at Your Fingertips

Aetna Member Website
Go to **www.aetna.com**, click on "Member Log In" and then "Take a Tour" to learn more."

- **Interactive Personal Health Record –** Your secure online personal health record stores and continuously updates your health history. It also reminds you to get needed preventive care and brings critical healthcare messages to your attention. You can even print out your health profile to share it with your doctor.
- **Member Services –** Member Services is available at the toll-free number on your ID card from 8:00 a.m. – 6:00 p.m. Eastern Time. If you prefer self-service, you can access the voice-activated telephone system 24 hours a day, 7 days a week.
- **Nurse Line –** Aetna's Informed Health® Line is staffed around-the-clock with registered nurses who provide callers with free information on prevention strategies, self-care skills, chronic medical conditions, and complex medical situations. They can also provide follow-up information and can perform research where appropriate. The toll-free number is 1-800-556-1555.

Aetna Open Choice PPO

The Aetna Open Choice PPO plan gives you two ways to seek care. You have the freedom to visit *any* of the approximately 60,00 physicians and 109 hospitals in the Baltimore area, or you can visit *any* doctor, *anywhere* – without a referral!

IN-NETWORK

Visit *any doctor in the Aetna network* without a referral.

■ You will make applicable co-payments at the time of service.

■ Your network doctor will handle your medical claims.

■ You enjoy the convenience of not being billed for additional payments.

OUT-OF-NETWORK

See *any doctor outside the Aetna network* without a referral.

When you visit a doctor who is not part of the Aetna network, you will:

■ Meet your annual deductible.

■ Pay the full amount at the time of service.

■ Receive reimbursement after meeting the deductible.

You may also have to pay the difference between the amount covered by your plan and the amount charged by your doctor.

How to find a doctor within Aetna's national network

To find out if a physician participates in Aetna's extensive national network of doctors, you can use Aetna's online provider directory located at www.aetna.com.

DocFind®
DocFind allows you and your family members to search for physicians by:
■ City, state and zip
■ Specialty
■ Hospital affiliation
■ Provider name
■ Gender

You can also get extra information, like:
■ Which plan each doctor accepts
■ Medical schools attended
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You can also get information about office locations, handicap access, maps and driving directions.

Resources at Your Fingertips

There are several ways to get assistance with your plan.

Aetna Member Website
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In-Network Benefits

If you use an Aetna Preferred Provider, which is one of the doctors, hospitals and other health care providers who are part of the Aetna Preferred Provider Network, benefits are generally covered at 90% of the preferred provider allowed plan benefit (after a deductible of $250 per person, $500 per family per calendar year). Some preferred provider services require a copayment, usually $20. Your annual maximum out-of-pocket expense for preferred provider services (including mental health) is $1,500 per person ($3,000 per family) per calendar year.

Out-of Network Benefits

If you do not use an Aetna Preferred Provider, most covered services are subject to an annual deductible of $500 per person ($1000 per family) per calendar year and are then covered at 70% of the reasonable and customary charge. Your maximum out-of-pocket expenses for non-preferred provider covered services are $4,000 per person ($8,000 per family) per calendar year.

information about this program, refer to the information located on the benefits website listed on page 2 of this guide or at www.aetna.com.

Additional Features- Aetna Open Choice PPO and Open Access plans

- **Teladoc** is a 24/7/365 telemedicine feature allows you to confer with board-certified physicians and pediatricians via phone or online video for the price of an office visit copay. Go to Teladoc.com/Aetna or call 1-855-Teladoc for more information.
- Online **Healthy Living Programs**, including Fitness Planner, Walking Tracker, Diet Manager, Meal Planner, and Food Journal.
- **Informed Care Decisions**, a decision-support tool that provides the latest clinical information for more than 40 diseases and conditions.
- An online **Health Assessment** which serves as a tool for members to evaluate their family history, personal health status, and lifestyle choice.
- **Wellness Counselor** to provide health coaching services to members who complete an online health assessment.
- Discounts on **Jenny Craig® Weight Loss** programs and products.
- Access to the **GlobalFit™** network of more than 2,000 fitness clubs at preferred rates.
- Vision and hearing discount programs.
- Discounts to over-the-counter vitamins, dietary supplements, and natural products.

Prescription Drug Benefits

Both the Aetna PPO and Open Access plans provide prescription coverage through CVS. This plan covers prescription drugs at the following copay levels:

Tier 1 Generic drugs: $10 copay for 30 day supply
Tier 2 Preferred Brand drugs: $30 copay for 30 day supply
Tier 3 Non-preferred Brand drugs: $50 copay for 30 day supply

The prescription plan also provides for maintenance medications to be filled by the CVS mail order service. You can receive a 90 day supply of maintenence medication for one copay based on the drug tier.

The prescription drug plan allows you to use your prescription drug card at any pharmacy. Employees who enroll in the Aetna plans automatically receive the CVS prescription drug plan.

Vision Benefits

All Medical Insurance Plans include vision benefits that cover routine examinations, frames and lenses.

Vision Service Plan (VSP) is the carrier for the vision plan that is packaged with the Aetna Medical plans. So, if you enroll in an Aetna Medical plan, you will also be enrolled in the VSP vision plan. Remember, you must enroll in an Aetna medical plan to receive this vision coverage. ***Note: Kaiser participants receive their vision care benefits through the Kaiser HMO – refer to the Kaiser plan benefit summary for more information.***

About the VSP Plan

Benefits are provided through Vision Service Plan's (VSP) national network of optometrists and opthamologists. Please visit the VSP website at www.vsp.com to locate participating providers. The plan is designed to protect your visual wellness. Consequently, you may have to pay extra if you choose certain cosmetic or elective eyewear options. Before selecting your eyewear, ask your doctor what is fully covered by your VSP plan. The following chart summarizes the main benefits of your plan:

Benefit	Frequency	Co-pay	From VSP Doctor	From Out-of-network Provider*
Examination	12 months**	$10	Covered	Covered up to $52
Lenses	12 months **	Combined with exam	Covered	Covered up to $55/single vision; $75/bifocal; $95 trifocal
Frame	12 months **		Covered up to $150 retail	Covered up to $70
Contact Lenses***	12 months**	None	Covered up to $150	Covered up to $105
Laser Vision Correction			Discounted services****	None
Additional VSP Benefits Your plan provides a 20 percent discount on non-covered complete pairs of prescription glasses when provided by a VSP doctor.				

**Claims must be submitted within 6 months of the date of service.*
***Based on calendar year.*
****Patients choosing contacts use their eligibility for a frame and lenses. Your plan includes a 15% discount off the VSP doctor's professional services when buying contact lenses. Materials are provided at the customary fees. Your VSP doctor must get prior approval from VSP for medically necessary contact lenses.*
*****Laser vision correction (PRK and LASIK surgery) is available through contracted laser centers. Must see a VSP provider for a referral. Call 888-354-4434 for information.*

How the VSP Plan Works

To use a Vision Service Plan provider:

Step 1: Call VSP at (800) 877-7195 or visit VSP's website at www.vsp.com to locate a participating optometrist or ophthamologist.

Step 2: When making an appointment, identify yourself as a VSP member. The participating doctor will also need the last four digits of your Social Security number and last name so that your eligibility may be verified with VSP.

Important Note: The vision plan is offered through VSP. No identification card is necessary. Do not offer your medical health insurance identification card to a VSP provider.

Step 3: At your appointment, the participating doctor will provide an eye examination and determine if eyewear is necessary. Simply pay your co-payment(s) listed on the above chart.

To use a non-participating provider:

Step 1: Select any licensed vision care provider of your choice.

Step 2: Pay for the services when they are rendered.

Step 3: Submit a claim to VSP for reimbursement within six months. The reimbursement schedule does not guarantee full payment when services are provided by a non-participating provider. Your claim must include your name, address, Social Security number, group name the name and relationship of the patient, the itemized bill and receipt. Please keep a copy of the information for your records and send the originals to the following address:

Vision Service Plan
Attn: Out-of-network Claims
P.O. Box 997105
Sacramento, CA 95899-7105

Choosing the Medical Plan that is Right for You

How do you decide which medical plan is right for you?

Consider the following questions:

- What part of the medical cost does the plan pay?
- What part must you pay?
- What services are covered?
- What is the plan's price tag?
- What are your contributions?

Assess Your Needs

- What type of medical services are you and your family likely to need during the year?
- How much are these services likely to cost?
- In the event of a major, unplanned medical need, how much could you personally afford to pay?
- How much insurance protection do you need?

Evaluate the Plans

- Review the provider networks and determine if you would be comfortable using the plan's network doctors and hospitals

Consider other sources of Coverage

- If you are married and your spouse is employed, you may have medical insurance coverage through your spouse's employer.
- You may have medical coverage from a private plan.

Consider the Health Care Spending Account

- Through the CountyFlex health care spending account, described later in this enrollment guide, you can pay for medical expenses not covered by your medical plan on a pre-tax basis.

Delta Dental PPO

The Delta Dental PPO plus Premier program allows you the freedom to visit any licensed dental provider, including a dentist from our large network of providers. Delta Dental has one network with two levels of discounts. You will maximize your savings with a dentist in the PPO network; you'll save a moderate amount by using a dentist in our Premier network; and you'll save the least with a non-participating dentist. Please refer to the summary of benefits posted at the benefits intranet website at https://myhoco.howardcountymd.gov for details on plan coverage.

Check your eligibility and benefits online

You can visit Delta Dental's secure online web site at www.deltadentalins.com/howardgov to get information about your benefits and claims payments. If you are visiting the web site for the first time, you will need to complete a one-time registration. Once you are logged in you can verify your eligibility, check your benefits for covered services and view benefit maximums and deductible information. You may also print an ID card, although it is not required to receive services. You may simply provide the dental office with your group number and the primary enrollee ID number.

You can also visit our mobile app on your smartphone. You can find participating dentists in your area, search by specialty or look for dentists by name. Save paper and time by presenting ID cards straight from your smartphone, view plan information including annual deductibles and maximums, check status of claims and view pre-treatment estimates & manage preferences such as paperless billing and account information.

Find a PPO dentist

A current listing of dental offices that are part of Delta Dental's networks can be found using the online provider directory.

Visit and www.deltadentalins.com and

- Click "Find a Dentist"
- Enter your zip code
- Select "Delta Dental PPO" in the "Select a Network" drop down, then click "Submit"

Each dentist listed in the directory has been credentialed by Delta Dental, which includes license and insurance coverage verification, specialty certification and compliance with the dental profession's health, hygiene and safety standards.

When you can't find a PPO dentist

The Delta Dental Premier network — the larger network — provides cost-savings features and is the next best option when you can't find a PPO dentist. If you must visit a non-PPO dentist, a Delta Dental Premier dentist will likely save you more money than if you visit a non-Delta Dental dentist. While Premier dentists' contracted fees are often slightly higher than PPO dentists' fees, Premier dentists will not balance bill you above the Delta Dental Premier Maximum Plan Allowance or the dentist's actual fee, whichever is less ("Allowed Amount"); non-Delta Dental dentists may balance bill you up to their full fees. You may find a Premier dentist using the online provider directory.

Transitioning from another plan?

If you have dental treatment in progress when your coverage begins — such as root canals, crowns and bridgework — your former dental plan should assume responsibility. Delta Dental will cover care started and completed after your plan's effective date. If your current Delta Dental plan includes orthodontic benefits, a claim form should be submitted for evaluation. Delta Dental will prorate the remaining amount based on the total case fee less the amount previously paid by your former dental plan.

Talk to your dentist about your health and treatment options

When you visit the dentist, be sure to share your dental and medical history and any prior complications. Dentists can identify signs of more serious health conditions and should be made aware of health information that may be critical to your dental care. Your hygienist is a great resource for dental health information to help you guard against tooth decay and gum disease. Ask your dentist to explain the pros and cons of each dental treatment option, including the future costs or consequences of postponing or avoiding treatment.

Predeterminations/Pre-treatment estimates

Determine costs ahead of time by asking your dentist to submit the treatment plan to Delta Dental for a predetermination of benefits before any treatment is provided. Delta Dental will verify your specific plan coverage and the cost of the treatment and provide an estimate of your copayment/coinsurance and what Delta Dental will pay. Delta Dental recommends predeterminations for services expected to exceed $300. Predeterminations are free and help you and your dentist make informed decisions about the cost of your treatment.

Claim submission

Delta Dental dentists will submit claims for you. If you visit a non-Delta Dental dentist, you may need to submit your own claim. You can download a form from the web site.

Dual coverage/Coordination of Benefits

If your spouse has coverage with another company and you are covered by both dental plans, the two carriers will coordinate benefits to potentially lower your out-of-pocket costs.

If separate dental benefits are available to you and your spouse, or a dependent child under other programs, except ones available to you, your spouse or a dependent child because you, your spouse or a dependent child are employed by the same employer, there are specific conditions applicable to determination of payment. The ratio of each carrier's liability to total cost incurred is reviewed. Payment is made according to the "birthday" rule adopted by most insurance carriers, but in no case does Delta Dental pay in excess of its total contractual obligation, if it were the only carrier involved. If the other carrier determines its benefits first, Delta Dental will pay any difference between the amount paid by the other carrier and the amount of Delta Dental would have paid had it been the primary carrier. If separate dental benefits are available to you because you, your spouse or a dependent child are employed by the same employer, payment is made by Delta Dental according to the Delta Dental program covering you, your spouse or a dependent child as an employee without reference to the other programs of the same employer.

If separate dental benefits are available for a dependent child of you and your spouse as employees of the same employer, payment is made by Delta Dental according to the Delta Dental program of the employee indicated by the birthday rule without reference to the other programs of the same employer.

Ask your dentist to indicate the other carrier's information on the claim form submitted to Delta Dental. Group-specific exceptions may apply. Please review your Evidence of Coverage or Summary Plan Description for details specific to your plan's coordination of benefits, including rules for determining primary and secondary coverage.

General information about choosing a dentist

Don't wait until you have a serious dental concern before you visit a dentist. Schedule regular dental visits for cleanings and exams — professional care can keep your teeth healthy and keep treatment costs down. To find a dentist, seek recommendations from friends, family or co-workers. You may contact the local or state dental society for independent referrals or questions about individual dentists.

Types of dentists/specialists:

- **General dentists** provide a full range of services for the entire family and may refer you to a specialist if your dental treatment requires specialized skills, experience or equipment. Your general dentist should share your dental records (charts, x-rays) with any specialist you need to see.
- **Endodontists** specialize in diseases and injuries of the tooth pulp, performing such services as root canals.
- **Oral surgeons** remove impacted teeth and repair fractures of the jaw and other damage to the bone structure around the mouth.
- **Orthodontists** correct misaligned teeth and jaws, usually by applying braces.
- **Pediatric dentists** limit their practices to children and teenagers.
- **Periodontists** treat diseases of the tissues that support and surround the teeth.
- **Prosthodontists** specialize in the restoration of natural teeth and/or the replacement of natural teeth with crowns, bridges, dentures, implants and other procedures.

Questions about your plan?

If you have questions about your PPO plan, visit the web site at www.deltadentalins.com or contact one of the Customer Service representatives Monday through Friday, from 8 a.m. to 8 p.m., at 800-932-0783. You may also get benefits and eligibility information 24 hours a day, seven days a week from Delta Dental's automated information line at 800-932-0783. Sign up on Delta Dental's web site for the free dental health newsletter, *Grin! E-magazine*, for valuable dental health topics and information about maximizing your benefits.

DeltaCare USA DHMO Plan

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What is DeltaCare USA?

DeltaCare USA is a closed network plan that features set co-payments for listed procedures, no annual deductibles and no maximums for covered benefits. You select a primary care dentist in the DeltaCare USA network from which you receive treatment, as in a traditional HMO.

How does the DeltaCare USA plan work?

The DeltaCare USA plan has a limited network, the DeltaCare USA network. You must access care through your designated primary care dentist within the DeltaCare USA network in order to have coverage. If you do not select a primary care dentist, Delta Dental will select one for you. Your primary care dentist can directly refer you to a specialist if treatment is needed beyond the scope of your general dentist.

You can change your DeltaCare USA dentist by registering online at www.deltadentalins.com or by contacting a DeltaCare USA Customer Service representative by calling 800-422-4234. Dentist changes made by the 21st of the month will take effect on the first of the following month. No ID card is needed to receive dental services. Just provide your dentist with your name, DOB and SSN or enrollee ID and they can verify your coverage. There are no claim forms to submit and predictable dental care costs based on a set copayment schedule available.

Once you register online at www.deltadentalins.com you can: - View benefits - Verify eligibility - View the assigned DeltaCare USA dentist for each family member - Search for a DeltaCare USA primary dentist and/or change dentists - Print ID card

How much will my treatments costs? How do I pay?

With your DeltaCare USA plan, some services are covered at no cost, while others have a copayment (amount you pay) for certain services. To find out how much a treatment will cost, refer to the "Description of Benefits and Copayments" for a list of covered services available on the County internet at www.howardcountymd.gov/human-resources/benefit-plans

Flexible Spending Accounts (FSAs)

There are two kinds of flexible spending accounts (FSAs) available in CountyFlex: one for health care expenses, and one for dependent care expenses. Both accounts let you pay for certain eligible out-of-pocket expenses with money that is tax free. You may enroll in both FSAs or just one. If you enroll in an FSA, you contribute to your account with pre-tax dollars deducted from your paycheck in equal installments over 24 pay periods each year. Please refer to the FSA Enrollment Guide posted on the County intranet website.

Important Information about FSAs:

- You can only be reimbursed for expenses you incur during the plan year regardless of when the service is paid. The plan year is January 1 – December 31.
- You cannot change the amount you decide to contribute to an account until the next open enrollment period, unless you have a change in status (see **Important Definitions & Information section** in this Enrollment Guide).
- You may not transfer money from one account to the other.

Important Note

Health care expenses that you pay from your health care spending account may not be deducted on your federal income tax return. This affects individuals whose medical expenses are more than the current income tax reporting year's allowable percentage of adjusted gross income.

IRS Publications #502 (medical and dental expenses) and #503 (child and dependent care expenses) offer additional detail related to specific expenses that may or may not be reimbursed from flexible spending accounts. These publications are available on the Internet at **http://www.irs.gov**.

You may also wish to consult a tax advisor concerning your decision to enroll in a health care and/or dependent care spending account.

Health Care FSA

Estimate your Eligible Expenses

Begin by estimating the eligible out-of-pocket health care expenses for services that you will incur during the coming plan year (January 1 – December 31). You can use your health care account to pay for medical and dental expenses that are not fully paid by your medical and dental plans, including deductibles, coinsurance and copayments, expenses not reimbursed for orthodontics, vision, hearing and other services, and any other health care service that would qualify as a medical deduction under IRS rules. Generally, eligible expenses must be for medically necessary services. Expenses for services considered cosmetic in nature are not eligible.

Note: A partial listing of eligible health care expenses is included on the next page to assist you in planning your FSA contribution. Refer to IRS Publication 502 for more details regarding eligible expenses.

Eligible Dependents' Health Care Expenses

The health care expenses may be for you, your spouse, or your eligible dependents – even though they may not be enrolled under CountyFlex medical and/or dental plans – provided you claim them as dependents on your federal tax return.

How Much You Can Contribute

You can contribute from $180 to $2,750 per year in the health care spending account.

How it Works

You will receive a Debit Card that you may use at the time you incur an eligible out-of-pocket health care expense. The debit card electronically pays the expense from funds in your FSA account, at the point of sale. This eliminates the need to have to pay up-front and submit for reimbursement. The debit card will be loaded with your full annual health care FSA election, so your entire account balance is available even if you have not contributed that much to your account. If for any reason you are unable to use your debit card, you may submit a claim to the FSA administrator and they will reimburse you directly.

Debit Card Substantiation - Please be aware that the debit card is a convenience feature that eliminates the need to submit claims for manual reimbursement. Under IRS rules, you must still be able to verify every debit card transaction with applicable receipts, ***so it's very important to keep the receipts for all debit card transactions*****!** The FSA administrator may request receipts from you from time to time to verify your debit card transactions.

Use it or Lose it Rule & Rollover of Funds

Under IRS regulations, up to $550.00 of unused funds will automatically be rolled over to your Healthcare FSA account for the following year. Any unused funds in over $550.00 will be forfeited. Rollover funds do not count against the maximum contribution available for that plan year.

Eligible Health Care Expenses – Health Care FSA

The following is a partial list of the types of out-of-pocket healthcare expenses you can pay with a healthcare FSA. This list is not meant to be all-inclusive. Eligible healthcare expenses are governed by Internal Revenue Code regulations. Please refer to IRS Publication 502 for more information regarding eligible expenses or contact the plan's FSA administrator.

Examples of Eligible Expenses:

Acupuncture
Alcoholism, treatment of
Ambulance
Artificial Limb
Braille Books and Magazines
Chemotherapy
Chiropractors
Co-payments & co-insurance
Contact lenses
Crutches
Deductibles
Dental Care
Diabetic Supplies
Diagnostic tests and fees
Drug Addiction treatment
Eye Exams
Eye Glasses
Flu Shots
Guide Dog
Hearing Aids & Batteries
Hearing Exams
Hospital Services
Immunizations
Insulin
Lab Fees
Laser eye surgery
Learning Disability treatment
Prescription medications
Medical equipment & supplies
OB/GYN expenses
Ophthalmologist & Optometrist
Orthodontics
Over-the-counter medications
Oxygen equipment
Prescription sunglasses
Physical exams
Therapy, occupational, physical, speech
Prosthesis
Psychologist
Psychiatrist
Special education tuition
TTY equipment for phone
Vitamins requiring prescription
Wigs for medical condition
Wheelchair
X-ray fees

Some <u>non</u>-eligible expenses:

- Cosmetics
- Cosmetic procedures not medically necessary
- Electrolysis
- Health club dues
- Insurance premiums
- Nutritional and herbal supplements that contribute to general health and well-being
- Teeth bleaching
- Toiletries
- Tooth bonding, not medically necessary
- Reimported U.S. made prescription drugs

Dependent Care FSA

If you are part of a two-income family with dependent children or parents, or a single parent, you may want to consider enrolling in the dependent care FSA. A dependent care account lets you set aside part of your salary on a pre-tax basis to pay for dependent care expenses that you incur so you can be at work. Expenses such as pre-school care, after-school care, and summer camp (not overnight camp) are examples of eligible expenses that you can pay for through your dependent care account. The amount you contribute to the FSA is not taxed, thus giving you a tax break on those out-of-pocket dependent care expenses.

Estimate your Eligible Expenses

Begin by estimating the eligible dependent care expenses you expect to incur during the coming plan year (January 1 – December 31). You can use the dependent care account to pay for child care and adult day care required so you can be at work. These expenses include day care centers, preschool tuition, after school care, summer day camp and care provided inside or outside your home by someone age 19 or older who is not your dependent.

Eligible Dependents

An eligible dependent is anyone under age 13 whom you claim on your federal tax return. Other dependents, such as your parents, your spouse, or an older child, may qualify if they are unable to care for themselves, require full-time care, and you claim them as dependents on your tax return.

How Much You Can Contribute

The annual contribution limit is the lesser of $5,000 married filing jointly or single parent ($2,500 if filing separately), the employee's earned income for the year or the spouse's earned income. The minimum annual contribution is $180.

How It Works

You will receive a Debit Card that you may use at the time you incur an eligible out-of-pocket health care expense. The debit card electronically pays the expense from funds in your FSA account, at the point of sale. This eliminates the need to have to pay up-front and wait for reimbursement. The debit card will only reimburse for expenses up to the amount accrued in your dependent care account, so there may be situations where the card will not work if your reimbursement request exceeds the balance in your account. If for any reason you are unable to use your debit card, you may submit a claim to the FSA administrator and they will reimburse you directly. **Debit Card Substantiation** - Please be aware that the debit card is a convenience feature that eliminates the need to submit claims for manual reimbursement. Under IRS rules, you must still be able to verify every debit card transaction with applicable receipts, ***so it's very important to keep the receipts for all debit card transactions*****!** The FSA administrator may request receipts from you from time to time to verify your debit card transactions.

Use it or Lose it Rule

Any unused funds in your dependent care FSA at the end of the year will be forfeited (there is no rollover feature under the Dependent Care FSA account).

Supplemental and Dependent Life Insurance

Supplemental group term life insurance provides affordable group term life insurance. You may elect Supplemental Life coverage in amounts of one (1) times, two (2) times or three (3) times your base annual salary to a maximum of $500,000. New employees are eligible for one (1) times salary if enrolled within 31 days of date of hire without life insurance carrier approval. Supplemental life insurance amounts of two (2) times or three (3) times salary must be approved by the life insurance carrier. Supplemental life insurance is in addition to the county-paid basic life insurance of two (2) times your base annual salary.

Coverage is portable. If you leave employment or retire, you can keep coverage by purchasing it directly from the life insurance carrier.

Rates are based on five-year age bands and the amount of life insurance coverage you elect. The age rate will be based on your age as of your birth date. The rate will change when you reach the next age band.

Supplemental Term Life Insurance Coverage Options

For You	1 times, 2 times, or 3 times your basic annual earnings, to a maximum of $500,000
For Your Legal Spouse	$20,000
For Your Dependent Children*	From birth to age 26: $10,000

*Child(ren)'s Eligibility: Dependent children ages from birth to the end of the calendar month the dependent turns 26.

Conversion

You can generally convert your Basic Term Life insurance benefits to an **Individual Whole Life** insurance policy if your coverage terminates in whole or in part due to your retirement, termination of employment, or, a change in your employee class. Conversion is available on all Group Life insurance coverages. Please note that conversion is **not** available on AD&D coverage.

Portability

Should you leave the Howard County Government for any reason, and your Supplemental and Dependent Term Life insurance under this plan terminates, you will have an opportunity to continue group term coverage ("portability") under a different policy, subject to plan design and state availability. Rates will be based on the experience of the ported group and the insurance provider will bill you directly. Rates may be higher than your current rates.

Generally, there is no minimum time for you to be covered by the plan before you can take advantage of the portability feature. Please see your plan certificate for specific details.

Dependent Life Insurance

You may elect Dependent Life coverage on your family, provided you are covered under the basic life insurance and/or the supplemental life insurance for yourself. Your spouse will be covered for $20,000 of term life insurance and each child up to age 26 will be covered for $10,000 of term life insurance. Coverage is also portable for dependent life.

If you elect Dependent Life when you are first eligible your spouse and children do not need approval by the life insurance company. If you elect Dependent Life after you are first eligible then your spouse and children must be approved for coverage by the life insurance carrier.

Additional Life Insurance Information

For details regarding the specific provisions of the life insurance benefit, please refer to the life insurance booklet located on the County intranet.

Beneficiary Designations

You should designate at least one (1) primary beneficiary for your life insurance benefits. You can also designate contingent beneficiaries. Contingent beneficiaries receive the life insurance proceeds if your primary beneficiary is not living at the time of your death.

It is very important to keep your life insurance beneficiary designation up-to-date. You can change your beneficiary designations at any time by contacting Human Resources for the appropriate form.

If there is no beneficiary designation on file for you, the life insurance carrier provides an order of payment for the life insurance proceeds.

Taxation of Life Insurance

Under IRS regulations, the value of group term life insurance in excess of $50,000 is considered taxable income and, as such, is reported annually on your W2 as "imputed income". The value of group term life insurance is determined by age and cost outlined in Table 1 of Treasury Regulation Section 1.79-3 (see below). While the value is subject to federal, state and FICA taxes (Social Security/Medicare taxes), the County is only required to withhold FICA taxes. This is reported on your paycheck as "Excess Life".

IMPUTED INCOME RATES

Your Age on December 31	Monthly Rate Per $1,000 of Life Insurance
<25	0.05
25 - 29	0.06
30 - 34	0.08
35 - 39	0.09
40 - 44	0.10
45 - 49	0.15
50 - 54	0.23
55 - 59	0.43
60 - 64	0.66
65 - 69	1.27
70+	2.06

Imputed Income Calculation Example:

Employee age 45
$125,000 group term life insurance coverage elected
Table rate for age 45 is 15 cents per $1,000 of coverage per month

$125,000 group term life insurance coverage
- 50,000
$ 75,000 group term life insurance coverage in excess of $50,000

Imputed Income per month: $ 11.25 ($0.15 x 75)
Imputed Income annually: $135.00 ($11.25 x 12)
Imputed Income per paycheck: $ 5.63 ($135.00 / 24 pay periods)*

FICA tax withheld per paycheck: $ 0.43 ($5.63 x .0765 - FICA rate**)
Amount of Imputed Income reported on W2: $135.00

Federal and state income tax liability will depend on your personal circumstances. * Please note while you are paid over 26 pay periods, benefit costs are applied on 24 pay periods.

Making Your Benefit Selections

Once you have considered your options and decided which CountyFlex benefit plans best meet the needs of you and your dependents(s), follow the step-by-step instructions provided below to enroll online.

HOW TO ENROLL FOR BENEFITS ONLINE

1. Access the Internet and go to https://howardcounty.benelogic.com
2. Enter your Employee ID Number: **First initial, last name, last four digits of your Social Security number (example: JSmith1234)**
3. Enter your Password: **Last four digits of your Social Security number**
4. You will be prompted to change your password (if you log into the Benelogic website again, you will need this new password).
5. Follow the instructions on the screens to enroll in your benefits.
6. Click the "**Submit"** button to save your elections.
7. Review your confirmation statement.
8. Print your confirmation statement for your records.

If you have any questions, please contact:

Office of Human Resources
benefits@howardcountymd.gov

(410) 313-2033

Important Definitions and Information

Coverage Tiers: Employees may enroll in the following health insurance coverage tiers:

- **Employee:** Employee only
- **Employee/Child(ren):** Employee plus one child or Employee plus children
- **Employee/Spouse:** Employee plus spouse
- **Family:** Employee, spouse and one or more children

CountyFlex Online Enrollment:

All employees must enroll online at www.howardcounty.benelogic.com. The online enrollment will authorize payroll deductions and will enroll you and applicable family members in the plans you select.

Eligible Dependents:

The following dependents are eligible to be enrolled on your medical and dental plans:

- Your legal spouse (opposite sex or same sex)
- Your biological children through end of the month they turn age 26
- Your step-children through end of the month they turn age 26
- Your legally adopted through end of the month they turn age 26
- Your foster children through end of the month they turn age 26
- Child for whom you are responsible under court order through end of the month they turn age 26
- Grandchildren for which you have court-ordered legal custody through end of the month they turn age 26

You must furnish proof of dependent eligibility status for any dependent that you enroll on the health insurance plans. Unless someone meets one of the above criteria, they are not eligible to be enrolled on your medical or dental plan. Enrollment of an ineligible dependent on your medical or dental plan could result in disciplinary action up to and including termination of employment.

Flexible Spending Accounts:

Pre-tax accounts for health care and dependent care expense reimbursement.

Open Enrollment Period:

The annual period during which you can make changes to your benefits selections for the upcoming plan year.

Qualifying Status Changes:

You may change your benefit plan choices only during the annual open enrollment period. Once the open enrollment period is over, you may not change your selections unless you experience a "qualifying status change" as permitted under IRS regulations. You may only make changes that are on account of, and consistent with, the status change. Examples of qualifying status changes include:

- Marriage
- Birth or adoption of a child
- Divorce or legal separation*
- Dependent gains or loses eligibility for coverage
- Death of a spouse or dependent child
- Change in employment status of the employee, spouse, or dependent caused by termination or commencement of employment, increase or decrease in hours of employment, or switch between full-time and part-time status
- Your spouse is carrying the medical coverage for the family & loses or changes his or her job

- Your spouse's benefit open enrollment period differs from yours (the 30 calendar day notification requirement begins with the 1st day of your spouse's open enrollment period)
- Reduction in work hours or change in your residence or worksite.

*The State of Maryland does not recognize a status of "legal separation". Enrollment changes may be made upon "divorce."

Important **- If you have a change in status, you must notify the Office of Human Resources within 30 calendar days of the event. If your change meets IRS requirements, you must complete a Change Form and provide documentation of the event as required. Failure to notify Human Resources within thirty (30) calendar days may result in having to wait until the next annual open enrollment period in order to make the change.**