PUTTING the PIECES TOGETHER

**Open Enrollment 2012 – 2013 Member Information**

MARYLAND

DEPARTMENT OF BUDGET & MANAGEMENT
Employee Benefits Division
301 West Preston Street
Room 510
Baltimore, MD 21201

State of Maryland
Participating Active & Satellite Agency Employees and State Retirees

**Open Enrollment 2012– 2013**
**April 17, 2012 – May 1, 2012**
**Correction Period**
**May 9, 2012 – May 16, 2012**

Open Enrollment is your opportunity to make certain changes to your benefits coverage elections

Refer to the Open Enrollment materials mailed to your home or provided to you by your Agency Benefits Coordinator

DETAILED OPEN ENROLLMENT INFORMATION IS AVAILABLE ON OUR WEBSITE AT:

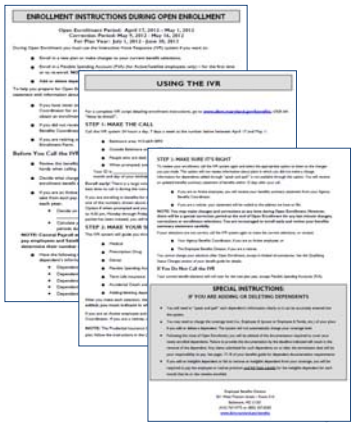
www.dbm.maryland.gov/benefits
Department of Budget & Management
Employee Benefits Division
410.767.4775 or 1.800.307.8283 or EBDmail@dbm.state.md.us

- OE Packet
  - –Will contain Guide, enrollment instructions, summary statement, What's New document, rate sheet, and wellness pamphlet
  - –March 21 – Mailing to home address for Retirees and Direct Pay
  - –March 27 – Active and Satellite packets sent to Agency Benefit Coordinator (ABC). ABCs will then distribute.



## Changes to OE Enrollment Instructions

- Open Enrollment Instructions will not be included in the Benefit Guide. They will be in your OE packet as an individual document.



## Summary Statements

- A Summary Statement will be provided to you after you make changes during OE to allow you to review your changes for accuracy.
- If you call the IVR on Monday, entry to the Benefit Administration System will occur on Tuesday, and a new Summary Statement will be available on Wednesday.
- Active employees should receive a copy from their ABC. Retirees and Direct Pay will receive in mail from EBD.



## Inside Front Cover of Benefit Guide

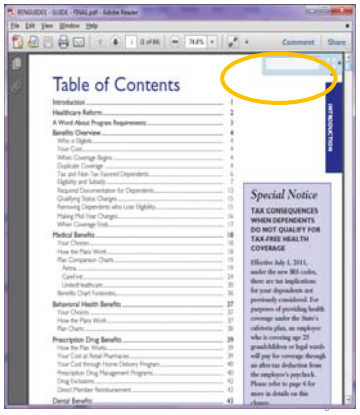
- Contact info for each of our carriers and for the main EBD customer service department.
- Please utilize these resources to contact the carrier directly for claims resolutions, ordering new ID cards, requesting copies of EOBs, etc.
- EMPOWER yourself! Be an active participant in your healthcare administration needs and be proactive in resolving any concerns you may have regarding providers, claims, etc.

| Plan | Phone | | Website |
|---|---|---|---|
| MEDICAL PLANS | | | |
| Aetna Select® EPO, Choice® POS II | 1-800-551-9637 | 1-800-551-9637 (TTY/TDD) | www.aetnaus.com |
| CareFirst BlueCross BlueShield EPO, POS, PPO | 1-800-225-0131 | 1-800-735-2258 (TTY) | www.carefirst.com/company |
| UnitedHealthcare Select EPO, ChoicePlus POS, Choice PPO | 1-800-382-7513 | 1-800-513-7139 (TTY/TDD) | www.uhcmaryland.com |
| BEHAVIORAL HEALTH PLAN (FOR MEMBERS IN PPO AND POS HEALTH PLANS – EPO MEMBERS USE EPO) | | | |
| APS Healthcare | 1-877-229-1458 | | www.APSHealthcare.com PEO State Code: SOPQ8M3 |
| PREDCRIPTION DRUG PLAN | | | |
| Express Scripts, Inc. | 1-877-213-3867 | | www.express-scripts.com |
| DENTAL PLANS | | | |
| United Concordia DHMO and DPPO | 1-888-PEO-TEETH (1-888-638-3384) | | www.unitedconcordia.com/company |
| FLEXIBLE SPENDING ACCOUNTS | | | |
| ConnectYourCare | 1-866-971-4646 | | www.connectyourcare.com/company |
| TERM LIFE INSURANCE PLAN | | | |
| MetLife | 1-866-492-6982 | 1-877-615-2954 | www.metlife.com/mybenefits (group name: State of Maryland) |
| ACCIDENTAL DEATH AND DISMEMBERMENT PLAN | | | |
| MetLife | 1-866-492-6982 | 1-877-615-2954 | www.metlife.com/mybenefits (group name: State of Maryland) |
| LONG TERM CARE INSURANCE | | | |
| The Prudential Insurance Company of America | 1-800-752-0414 | | www.prudential.com/groupsales/ maryland |
| HELPFUL CONTACTS | | | |
| State Retirement Pension System | 410-625-5555 or 1-800-492-1909 | | www.sra.state.md.us |
| Social Security Administration (Medicare) | 1-800-772-1213 | | www.ssa.gov |
| EMPLOYEE BENEFITS DIVISION | | | |
| 301 West Preston Street Room 510 Baltimore, MD 21201 | 410-767-4775 Fax: 410-333-7104 1-800-30-STATE (1-800-307-8283) Email us at: ebdmail@dbm.state.md.us | | www.dbm.maryland.gov/benefits (or scan the QR code to the left to go directly to our website) |



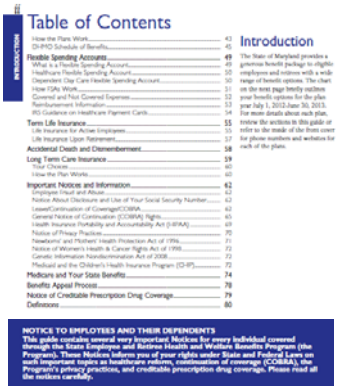
## Looking for Something?

- Searching for something that you just cannot seem to find in the Guide? – Did you know there's a "Search and Find" tool available to you?
- Just like any basic web search function, you type the word or phrase you are searching for into the search bar and it will be found for you throughout the document!



## A Few Opening Notes

- Though we STRONGLY ENCOURAGE you to read this entire Guide, we realize sometimes that may not be feasible. Using the Table of Contents will allow you to skip to specific sections for immediate answer to most of your questions.
- We urge you, prior to contacting EBD Customer Service, to reference your Guide and attempt to find the answer to your question.



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Introduction

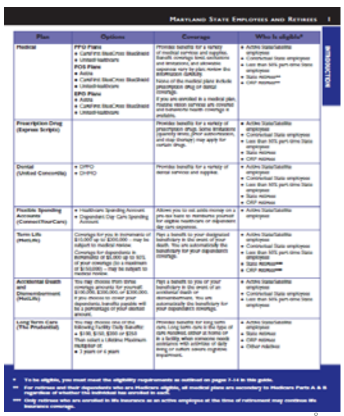
The State of Maryland provides a generous benefit package to eligible employees and retirees with a wide range of benefit options. The chart on the next page briefly outlines your benefit options for the plan year July 1, 2012-June 30, 2013. For more details about each plan, review the sections in this guide or refer to the inside of the front cover for phone numbers and websites for each of the plans.

**NOTICE TO EMPLOYEES AND THEIR DEPENDENTS**
**This guide contains several very important Notices for every individual covered through the State Employee and Retiree Health and Welfare Benefits Program (the Program). These Notices inform you of your rights under State and Federal Laws on such important topics as healthcare reform, continuation of coverage (COBRA), the Program's privacy practices, and creditable prescription drug coverage. Please read all the notices carefully.**



## Plan Offerings

- In general, plan offerings for this year remain the same
- Details on changes to follow in this presentation.



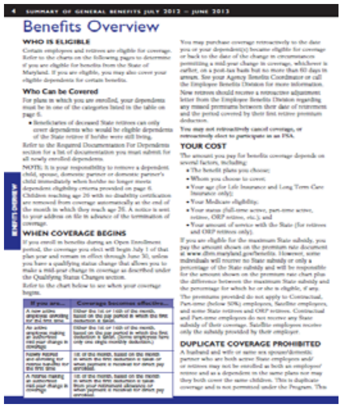
MARYLAND STATE EMPLOYEES AND RETIREES 1

| Plan | Options | Coverage | Who Is eligible* |
|---|---|---|---|
| Medical | PPO Plans; POS Plans; EPO Plans [illegible] | [illegible] | [illegible] |
| Prescription Drug (Express Scripts) | | [illegible] | [illegible] |
| Dental (United Concordia) | DPPO; DHMO | [illegible] | [illegible] |
| Flexible Spending Accounts (ConnectYourCare) | Healthcare Spending Account; Dependent Day Care Spending Account | [illegible] | [illegible] |
| Term Life (MetLife) | [illegible] | [illegible] | [illegible] |
| Accidental Death and Dismemberment (MetLife) | [illegible] | [illegible] | [illegible] |
| Long Term Care (The Prudential) | [illegible] | [illegible] | [illegible] |



## Benefits Overview

- No Duplicate Coverage!! Dependents may not be enrolled as both an employee/retiree in their own coverage and also as a dependent on another coverage.
- A child cannot be covered on two policies
- We do perform routine audits of this scenario, and will remove dependents who have duplicate coverage.



4 SUMMARY OF GENERAL BENEFITS JULY 2012 – JUNE 2013

Benefits Overview

WHO IS ELIGIBLE

[illegible]

Who Can be Covered

[illegible]

WHEN COVERAGE BEGINS

[illegible]

YOUR COST

[illegible]

DUPLICATE COVERAGE PROHIBITED

[illegible]

## Post Tax Benefits and Imputed Income

- IRS regulations dictate who is eligible for pre-tax coverage. Same Sex Domestic Partners, Same Sex Spouses and Children of the Same Sex Domestic Partner/Spouse (unless adopted by the employee) are NOT eligible for pre-tax benefits.
- Where these types of dependents are enrolled, there will be a pre-tax deduction for the employee and a post-tax deduction for the dependent(s).
- The amount of the State subsidy attributable to this type of dependent is considered income to the employee. The employee pays taxes on this value in each paycheck. This is known as imputed income.

MARYLAND STATE EMPLOYEES AND RETIREES 5

also applies to Satellite agency dependents (including domestic partners and their child(ren)). Two State employees and/or retirees may not be covered twice under the coverage of two employees/retirees. It is the employee/retiree's responsibility to make sure that they and their dependents do not have duplicate State coverage. This includes your children who may also be State employees. Duplicate benefits will not be paid.

**Dependent Child to Age 26**

- You can cover your eligible dependent child through the end of the month in which they turn age 26. Your dependent child does not need to be a student or disabled to be covered up to age 26. Disability certification is required to cover children beyond age 26.
  - If the child is 25 or older and not disabled, post-tax deductions and imputed income may apply to any grandchildren or legal wards that you cover under your benefit elections. Please refer to the "July 2012-June 2013 Premium Rates" document at www.dbm.maryland.gov/benefits for additional details.
- You must submit the required dependent documentation and Affidavit for Dependent Eligibility for all newly enrolled dependent children. See pages 13-14 for the required dependent documentation.
- **Disabled Eligible Dependent Child.** You are not required to provide Disability Certification until the child reaches age 26. You will then be required to provide continued certification of his/her disability status every two years in order to keep him/her on your coverage.
- Additional rules apply for covered children, see page 14.

**Important Information About Covering Your Same Sex Spouse or Same Sex Domestic Partner and Your Spouse or Partner's Child(ren)**

- **How Your Taxes May Be Affected** – Internal Revenue Service (IRS) regulations require different tax treatment for group insurance costs associated with health benefits for qualified same sex spouses and domestic partners and eligible same sex spouse and domestic partner's dependents for premium payments or enrollment in FSA coverage. In most cases, the IRS does not qualify same sex spouse and domestic partners and same sex spouse or domestic partner's dependents for tax-free payroll deductions under the tax code. Therefore, health benefits premiums for same sex spouse/domestic partners and their eligible dependents who are not qualified as dependents under the IRS tax code will be taxed as outlined below.
- **Payroll Deduction** – For each group health insurance plan where there is an employee contribution and a State subsidy in which you enroll your same sex spouse/domestic partner and your spouse/partner's eligible dependents, you will pay a:
  - Post-tax (after-tax) deduction for the coverage level attributable to the same sex spouse/domestic partner (and/or spouse/domestic partner's child); and
  - Pre-tax (before-tax) deduction for the coverage level applicable to the employee coverage level minus the amount of the post-tax deduction.
- **Imputed Income** – For each group health insurance plan where there is an employee contribution and State subsidy in which you enroll your same sex spouse/domestic partner and/or your same sex spouse/domestic partner's eligible dependents, you are subject to tax withholding on the State's contribution toward the coverage for those dependents not qualified as tax dependents under the IRS code. In other words, the State's contribution toward coverage for your same sex spouse/domestic partner and your same sex spouse/domestic partner's dependents is considered wages and is included in your taxable gross income subject to tax withholdings. This is known as imputed income. For rate information refer to the Same Sex Spouse/Domestic Partner rate pages available on the "July 2012 - June 2013 Premium Rates" documents at www.dbm.maryland.gov/benefits.

Retirees covering a same sex spouse/domestic partner will be billed quarterly for the Medicare taxes applicable to the imputed income and will receive a W-2 each January indicating the imputed income amount for the calendar year to be filed with their tax returns.

BENEFITS OVERVIEW

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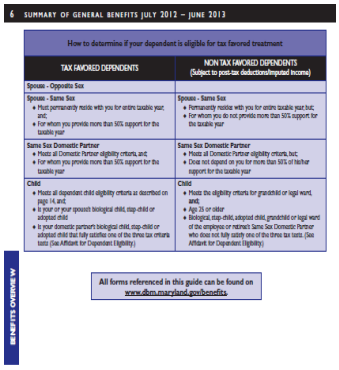
## Tax Favored vs. Non Tax Favored

- Criteria used to determine if your dependent is eligible for tax favored treatment.
- If you have questions on your dependents, pre-tax vs. post-tax deductions and imputed income, just ask us!



6 SUMMARY OF GENERAL BENEFITS JULY 2012 – JUNE 2013

How to determine if your dependent is eligible for tax favored treatment

| TAX FAVORED DEPENDENTS | NON TAX FAVORED DEPENDENTS (Subject to post-tax deductions/imputed income) |
|---|---|
| Spouse - Opposite Sex | |
| Spouse - Same Sex<br>• Must permanently reside with you for entire taxable year; and;<br>• For whom you provide more than 50% support for the taxable year | Spouse - Same Sex<br>• Permanently reside with you for entire taxable year; but;<br>• For whom you do not provide more than 50% support for the taxable year |
| Same Sex Domestic Partner<br>• Meets all Domestic Partner eligibility criteria; and;<br>• For whom you provide more than 50% support for the taxable year | Same Sex Domestic Partner<br>• Meets all Domestic Partner eligibility criteria; but;<br>• Does not depend on you for more than 50% of his/her support for the taxable year |
| Child<br>• Meets all dependent child eligibility criteria as described on page 14; and;<br>• Is your or your spouse's biological child, step-child or adopted child<br>• Is your domestic partner's biological child, step-child or adopted child that fully satisfies one of the three tax criteria tests (See Affidavit for Dependent Eligibility) | Child<br>• Meets the eligibility criteria for grandchild or legal ward; and;<br>• Age 26 or older<br>• Biological, step-child, adopted child, grandchild or legal ward of the employee or retiree's Same Sex Domestic Partner who does not fully satisfy one of the three tax tests. (See Affidavit for Dependent Eligibility) |

All forms referenced in this guide can be found on www.dbm.maryland.gov/benefits.

BENEFITS OVERVIEW

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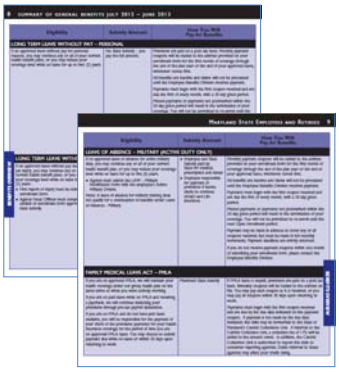
## Leave of Absence

- If you have a need for a Leave of Absence due to Military Leave, Family Medical Leave, On the Job Injury or any other reason, please speak to your Agency Benefit Coordinator for details on how this may affect your benefits.



8 SUMMARY OF GENERAL BENEFITS JULY 2012 – JUNE 2013

LONG TERM LEAVE WITHOUT PAY – PERSONAL

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LEAVE OF ABSENCE – MILITARY (ACTIVE DUTY ONLY)

FAMILY MEDICAL LEAVE ACT – FMLA

BENEFITS OVERVIEW

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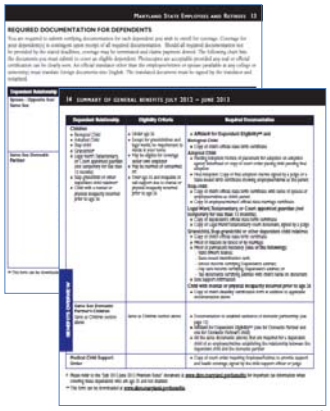
## Required Documentation for Dependents

- You must supply documentation for all dependents you add to your coverage.
- If you add a dependent during OE, we will send you a letter requesting the documentation after OE has closed.



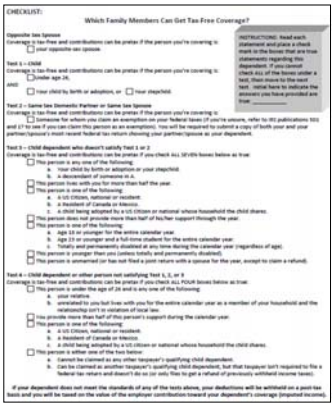



## Dependent Eligibility and Tax Status Forms

- Page 1
  - Gives you a basic overview of tax favored and non tax favored rules
  - Obtains Member and Dependent Information
  - Asks for the relationship of the dependent
  - You affirm that the information provided is true and correct.

## Dependent Eligibility and Tax Status Forms

- Page 2
  - Provides a checklist tool for you to determine if the dependent you are adding is eligible for pre-tax benefits.
  - You should check the boxes that apply (are true statements) to the dependent in question.
  - Must meet ALL boxes of at least one Test in order to have pre-tax coverage.



## New Dependent Eligibility and Tax Status Forms

- All documents needed for all eligible dependents under our plans are included on this one checklist.
- You should complete one packet for each dependent you are enrolling.
- If you are adding a new dependent during Open Enrollment, you do not have to submit this document with your enrollment – EBD will contact you following OE for you to complete this form and provide the required documentation.

DEPENDENT DOCUMENTATION CHECKLIST:

INSTRUCTIONS: In addition to completing the Checklist or Flowchart above, you must supply documentation supporting your relationship (or your spouse or domestic partner's relationship) to your dependent. Review the checklist below for the type (relationship) of dependent you are adding and supply ALL indicated documents with your enrollment. For details on the necessary documents, review the "Required Documentation for Dependents" section of your Benefit Guide

| | |
|---|---|
| **Legally married, opposite sex spouse or same sex spouse** | |
| | Copy of Official State marriage certificate (must be a certified copy and dated by the appropriate State or County official such as the Clerk of the Court) |
| **Same sex Domestic Partner** | |
| | Dually signed Affidavit of Domestic Partnership |
| | Notarized validation of signed Affidavit of Domestic Partnership |
| | Document to verify common primary residence |
| | Document to verify financial interdependence for previous 12 months |
| **Biological child of employee/retiree or domestic partner** | |
| | Copy of the child's official state birth certificate documenting lineage |
| | Newborns only: a copy of the crib card or hospital discharge papers if birth certificate is not yet available |
| **Adopted child or child placed with you for adoption** | |
| | Completed adoptions: Copy of adoption papers signed by a judge |
| | Pending adoptions: Notice of placement for adoption from adoption agency, or copy of court order placing child pending final adoption |
| | Copy of child's official state birth certificate (if available) |
| **Stepchild** | |
| | Copy of the child's official state birth certificate documenting lineage |
| | Copy of official state marriage certificate for employee/retiree and spouse |
| **Grandchild** | |
| | Copy of child's official state birth certificate documenting lineage |
| | Copy of child's parent's official state birth certificate documenting lineage |
| | Proof of permanent residency |
| **Legal Ward, Testamentary, or Court appointed Guardianship (not temporary for less than 12 months)** | |
| | Copy of child's official state birth certificate |
| | Copy of court documents signed by a judge |
| **Step-Grandchild or other dependent child relative** | |
| | Copy of child's official state birth certificate |
| | Proof of relation (marriage certificates, birth certificates of any/all related parties) |
| | Proof of permanent residency |
| **Child with a physical or mental incapacity that occurred prior to reaching age 26** | |
| | Disability certification form (in addition to documentation listed above depending on relationship) |



## Official Dependent Eligibility Documentation

- EBD will only accept official documents.
  - Copies of official documents are accepted
  - Only exception: newborns
- Documents in a language other than English must be translated and notarized.

PUTTING the PIECES TOGETHER



## Official Marriage Certificate

- Shows the License Number.
- Signed by the Deputy Clerk of the Circuit Court.

PUTTING the PIECES TOGETHER

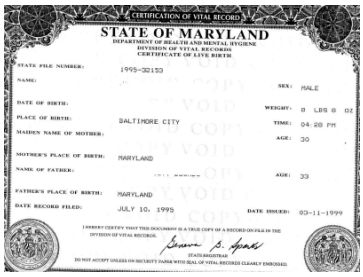
## Unacceptable Marriage Certificate

- Signed only by the minister.
- Not certified

MARYLAND



## Official Birth Certificate

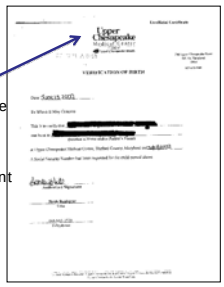


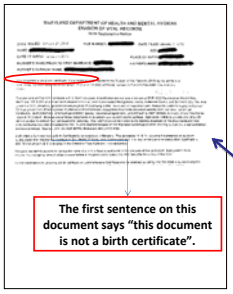

- Employee/retiree must be linked to the dependent on the birth certificate(s).
- If the employee adding the child to his/her coverage is not indicated by name on the birth certificate, we will be unable to accept it.
- Must be signed by the Registrar of Vital Records.



## Unacceptable Birth Certificates

- Document issued by hospital.
- Only acceptable to use as temporary documentation when dependent child is a newborn.



The first sentence on this document says "this document is not a birth certificate".

This document is the "Birth Registration Notice" and is not signed by the State Registrar.

PUTTING the PIECES TOGETHER

## Qualifying Life Status Changes

- The only way to make changes mid-year to elections made (or not made) during Open Enrollment, is to experience a Qualified Life Status Change.
- Changes to your benefits MUST coincide with the event necessitating the change.
  - As an example – if you get divorced mid year, you can remove your ex-spouse and that spouses' children, however you cannot remove children that are biologically yours.

Maryland State Employees and Retirees 15

**QUALIFYING STATUS CHANGES**

Regardless of how you pay for your coverage (by automatic deduction from your paycheck or retirement allowance or with payment coupons), the State uses the same rules to permit changes outside of Open Enrollment for all enrollees. IRS regulations for cafeteria plans strictly govern when and how benefits election changes can be made.

You are only permitted to make changes to your coverage during the Open Enrollment period each year. The coverage you elect during Open Enrollment will be in place July 1 to June 30. However, there are some changes in status that permit you to make limited changes during the plan year. Examples of qualifying changes in status include:

- Birth or adoption/placement for adoption of a child;
- Death of a dependent;
- Marriage or divorce;
- Dissolution of a domestic partnership;
- You or your dependent child's loss of SCHIP Medicaid/Medical Assistance coverage;
- You or your dependent gain access to a SCHIP/ Medicaid subsidy based on your residence in another state;
- Loss of other coverage, such as if coverage under your spouse's employment ends or your child ceases to be eligible;
- Gaining eligibility for Medicare (for retirees); or
- Changes in your other coverage which has a different plan year.

You have 60 days from the date of the qualifying change in status to submit an enrollment form and supporting documentation making changes to your benefits. Any changes submitted after 60 days of the qualifying change in status cannot be accepted, and you will have to wait until the next Open Enrollment period to make the desired change.

NOTE: Documentation supporting a qualifying event must be submitted with the enrollment form. For example, requesting to cancel benefits due to obtaining other coverage requires a letter from the employer or insurance provider on company letterhead. The letter must identify all benefits (i.e. medical, dental, life insurance, etc.) for which the person is enrolled, the nature of dependents covered and the effective date of the new coverage.

If you decline to enroll yourself or a dependent because of other coverage, you may be able to enroll in the future if you or your dependent(s) lose that other coverage.

**REMOVING DEPENDENTS WHO LOSE ELIGIBILITY**

It is your responsibility to submit an enrollment form to remove any dependent as soon as he/she loses eligibility. If you fail to remove the ineligible dependent within 60 days from the date of ineligibility, you will be required to pay the full insurance premium including the State subsidy from the date he/she became ineligible until the date removed. You may face disciplinary action, termination of employment, and/or criminal prosecution for continuing to cover dependents who no longer meet the definition of an eligible dependent noted on pages 13 and 14. In most cases, dependents who lose eligibility are entitled to COBRA/Continuation Coverage for a limited time, which is not subsidized by the State. Please see the COBRA/Continuation of Coverage section for more information.

*Ex-Spouse*

If you are obligated to continue coverage for a former spouse by terms of the divorce, that coverage can be provided for a **limited time** under COBRA and Maryland law. If COBRA is selected, the ex-spouse will have his/her own account and will be responsible for paying premiums directly. COBRA coverage is not subsidized by the State.

**FOR MORE INFORMATION** about enrollment and changes outside of Open Enrollment, contact:
- **Your Agency Benefits Coordinator, if you are an active, Satellite or Direct Pay employee;**
- **The Employee Benefits Division, if you are a retiree or Direct Pay employee.**
- **For additional information regarding qualifying events, go to www.dbm.state.md.us.**

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## Removing Dependents and Mid-Year Change Instructions

- It is your responsibility to remove dependents who lose eligibility within 60 days of the life status change that results in loss of eligibility.
- Divorced spouses are not eligible to remain on our plan. If you are divorced and responsible for your spouse's insurance coverage, you have to elect COBRA continuation coverage.

16 Summary of General Benefits July 2012 – June 2013

**To Remove an Eligible Dependent outside of Open Enrollment***

| Dependent Relationship | Required Documentation |
|---|---|
| Spouse – Opposite Sex/Same Sex | • Final limited divorce decree (must be signed by a judge) or<br>• Final divorce decree (must be signed by a judge) |
| Same Sex Domestic Partner | • An affidavit signed by the employee/retiree attesting to the permanent dissolution of the domestic partner relationship<br>• Proof of the termination of financial common primary residence; and<br>• Proof of the termination of financial interdependence |
| Children | • Documents to establish the loss of eligibility of the dependent child such as marriage certificate, proof of other coverage, etc. |
| Same Sex Domestic Partner's Children | • Documents listed above to remove a domestic partner if partnership is ending; and<br>• Documents to establish the loss of eligibility of the dependent child of your domestic partner such as marriage certificate, proof of other coverage, etc. |

*The documentation is required when removing a dependent from coverage during Open Enrollment.

**INSTRUCTIONS ON HOW TO MAKE MID-YEAR CHANGES**

| If You... | Then... |
|---|---|
| Are rehired or transferred to another agency within 30 days following termination from previous agency | You will automatically be enrolled into the same elections you had previously upon rehire or transfer. |
| Are an active State employee enrolling for the first time | You must submit an enrollment form and dependent verification documentation within 60 days of your hire date. Enrollment forms will not be accepted after 60 days. The Agency Benefits Coordinator must sign the enrollment form and check the accuracy of the dependent verification documentation before forwarding to the Employee Benefits Division. If you want coverage to begin on your date of hire, you must contact your Agency Benefits Coordinator to make sure the payroll office has your enrollment form, so your benefits can repeat a retroactive adjustment and pay your portion of the back premiums on a pro-rata basis. |
| Are enrolling as a new retiree | You must submit an enrollment form within 60 days of your retirement date. (If your retirement date is retroactive, you must submit an enrollment form within 60 days of receiving your first retirement allowance.) Submit the enrollment form and the required documentation to the Employee Benefits Division. You will receive a retroactive adjustment letter from the Employee Benefits Division regarding how to pay any missed premiums between your retirement date and the period covered by your first retiree premium deduction. |
| Are an active employee or retiree making a mid-year change in coverage | You must submit an enrollment form and applicable documentation verifying the qualifying change in status within 60 days of the event. Active employees must submit their enrollment form to their Agency Benefits Coordinator. Retirees must submit their form to the Employee Benefits Division. Active employees must submit their form to the Employee Benefits Division, along with the required documentation. |
| Experience a qualifying event | In order for your qualifying event to be effective on the earliest effective date following the date of qualifying event, you must request a retroactive adjustment. A newborn's effective date may go back to the date of birth. Even if the qualifying event does not change your coverage level, a zero balance retroactive adjustment is still required. Active employees must submit the enrollment form to their Agency Benefits Coordinator. Retirees must submit their form to the Employee Benefits Division, along with the required documentation. |
| Have a newborn child that you want to add to your health benefits | You must notify the Employee Benefits Division in writing through an enrollment form signed by your Agency Benefits Coordinator. (Retirees must notify the Employee Benefits Division directly.) You must include documentation with your notification. If you do not receive an ineligible dependent within 60 days of the loss of eligibility, you must remove the dependent from your coverage. Failure to remove an ineligible dependent may result in disciplinary action, termination of employment, and/or criminal prosecution. Satellite agency employees must notify their Agency Benefits Coordinator. |

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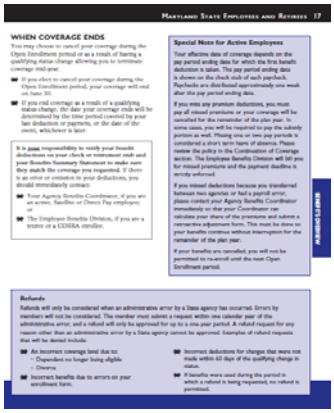
## Verifying Payroll Deductions and Refunds

- It is your responsibility to ensure your payroll deductions and/or payment coupons are correct. If any inaccuracies are noted, EBD should be contacted so we can research and correct if necessary.
- Refunds will only be considered when an error by a State agency has occurred, if the error is brought to our attention within one year of the occurrence, and no more than one year (12 calendar months) of a refund will be granted.



Maryland State Employees and Retirees 17

**WHEN COVERAGE ENDS**

You may choose to cancel your coverage during the Open Enrollment period or as a result of having a qualifying status change allowing you to terminate coverage mid-year.

- If you elect to cancel your coverage during the Open Enrollment period, your coverage will end on June 30.
- If you end coverage as a result of a qualifying status change, the date your coverage ends will be determined by the time period covered by your last deduction or payment, or the date of the event, whichever is later.

It is **your** responsibility to verify your benefit deductions on your check or retirement stub and your Benefits Summary Statement to make sure they match the coverage you requested. If there is an error or omission in your deductions, you should immediately contact:

- Your Agency Benefits Coordinator, if you are an active, Satellite or Direct Pay employee; or
- The Employee Benefits Division, if you are a retiree or a COBRA enrollee.

**Special Note for Active Employees**

Your effective date of coverage depends on the pay period ending date for which the first benefit deduction is taken. The pay period ending date is shown on the check stub of each paycheck. Paychecks are distributed approximately one week after the pay period ending date.

If you miss any premium deductions, you must pay all missed premiums or your coverage will be cancelled for the remainder of the plan year. In some cases, you will be required to pay the subsidy portion as well. Missing one or two pay periods is considered a short term leave of absence. Please review the policy in the Continuation of Coverage section. The Employee Benefits Division will bill you for missed premiums and the payment deadline is strictly enforced.

If you missed deductions because you transferred between two agencies or had a payroll error, please contact your Agency Benefits Coordinator immediately so that your Coordinator can calculate your share of the premiums and submit a retroactive adjustment form. This must be done so your benefits continue without interruption for the remainder of the plan year.

If your benefits are cancelled, you will not be permitted to re-enroll until the next Open Enrollment period.

**Refunds**

Refunds will only be considered when an administrative error by a State agency has occurred. Errors by members will not be considered. The member must submit a request within one calendar year of the administrative error, and a refund will only be approved for up to a one-year period. A refund request for any reason other than an administrative error by a State agency cannot be approved. Examples of refund requests that will be denied include:

- An incorrect coverage level due to:
  - Dependent no longer being eligible
  - Divorce
- Incorrect benefits due to errors on your enrollment form.
- Incorrect deductions for changes that were not made within 60 days of the qualifying change in status.
- If benefits were used during the period in which a refund is being requested, no refund is permitted.

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## Medical Benefits Overview

- Choosing a medical plan can be a daunting task. All the options, the treatments, the payments out of your pocket at time of service, the associated payroll deductions.
- It is extremely important to be an informed consumer when selecting a plan that best suits the needs of yourself and your family.

SUMMARY OF GENERAL BENEFITS JULY 2012 – JUNE 2013

Medical Benefits (includes routine vision and behavioral health coverage)

NOT SURE WHICH PLAN TO CHOOSE?

YOUR CHOICES

HOW THE PLANS WORK

Allowed Amount

Standard Benefits for Medical Plans

Coordination of Benefits

If Your Provider Terminates from Your Plan Network

NOTE: Outpatient prescription drug benefits are not included under the medical benefits plan and require a separate enrollment election. Please refer to page 19 for details.

MEDICAL BENEFITS

- There are no pre-existing condition limitations for any of the medical plans, but there are other exclusions. Please contact the medical plans for further information on coverage exclusions, limitations, determination of medical necessity, preauthorization requirements, etc.
- For a list of participating plan providers, please access carrier websites located on the inside cover of the guide.

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## What's New for 2013?

- Flu shots are covered by the medical plan at 100%
  - In network only, pharmacists are not generally considered in-network providers
- Rabies vaccinations and allergy serum are now covered under Medical.

## Choosing a Medical Plan: What is the Same?

- The services that are covered
  - except vision care - this benefit varies by plan
- The copays and coinsurance levels at which services are covered

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## Choosing a Medical Plan: What are the Differences?

- The network of available physicians and hospitals
- The "allowed benefit" for Out-of-Network reimbursement levels
- Which services require pre-authorization
- Vision benefits
- Web & Mobile Technology

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## Definitions You'll Need to Know

| Benefit | PPO In-Network | PPO Out-of-Network | POS In-Network | POS Out-of-Network | EPO In-Network Only |
|---|---|---|---|---|---|
| Plan Year Deductible | | | | | |
| Individual | None | $250 | None | $250 | None |
| Family | None | $500 | None | $500 | None |
| Out-of-Pocket Coinsurance Maximum | | | | | |
| Individual | $1,000 | $3,000 | $1,000 | $3,000 | None |
| Family | $2,000 | $6,000 | $2,000 | $6,000 | None |
| Any charges above the plan's Allowed Amount are not counted toward the out-of-pocket maximum. | | | | | |

- PPO (Preferred Provider Organization) – A PPO is a health insurance plan that utilizes a network of physicians and facilities contracted by the insurance carrier to provide services within negotiated price boundaries. PPO members have the option to use physicians and facilities that are not part of the network, but their out of pocket costs will be significantly higher.

- POS (Point of Service) – A POS plan is like a hybrid between a PPO and an HMO. Members use a network of physicians and facilities to seek care, but also have the ability to see providers outside of the network.

- EPO (Exclusive Provider Organization) – An EPO is a type of managed care plan. The EPO uses a network made up of providers from which a member must choose. EPO members are restricted to using In-Network providers only.



## Definitions You'll Need to Know

| Benefit | PPO In-Network | PPO Out-of-Network | POS In-Network | POS Out-of-Network | EPO In-Network Only |
|---|---|---|---|---|---|
| Plan Year Deductible | | | | | |
| Individual | None | $250 | None | $250 | None |
| Family | None | $500 | None | $500 | None |
| Out-of-Pocket Coinsurance Maximum | | | | | |
| Individual | $1,000 | $3,000 | $1,000 | $3,000 | None |
| Family | $2,000 | $6,000 | $2,000 | $6,000 | None |
| Any charges above the plan's Allowed Amount are not counted toward the out-of-pocket maximum. | | | | | |

- In-Network – Services provided by a Participating Provider or facility

- Out-of-Network – Services received from providers outside of the plan's network. Such services are subject to up-front deductibles and coinsurance

- Deductible – The amount a member is required to pay before payment for services are paid for out-of-network treatment

- Out-of-Pocket Maximum – This is the most a member will pay out of his or her pocket in coinsurance charges. The deductible is included in the OOP max. Copays are excluded from the Out of Pocket maximum



## Definitions You'll Need to Know

| | | | | | |
|---|---|---|---|---|---|
| Primary Care Physician's Office Visit | $15 copay | 70% of allowed benefit after deductible | $15 copay | 70% of allowed benefit after deductible | $15 copay |
| Specialist Office Visit | $30 copay | 70% of allowed benefit after deductible | $30 copay | 70% of allowed benefit after deductible | $30 copay |
| Adult Physical Exams & associated lab work | 100% of allowed benefit | 70% of allowed benefit after deductible | 100% of allowed benefit | Not covered | 100% of allowed benefit |
| One exam per plan year for all members and their dependents age 22 and older. | | | | | |
| Well Baby/Child Visits | 100% of allowed benefit | 70% of allowed benefit after deductible per visit | 100% of allowed benefit | Not covered | 100% of allowed benefit |
| Inpatient Care/ Hospitalization (requires preauthorization) | 90% of allowed benefit | 70% of allowed benefit after deductible; 90% of the allowed benefit after emergency admission | 90% of allowed benefit | 70% of allowed benefit after deductible; 90% of the allowed benefit after emergency admission | 100% of allowed benefit |

- Allowed Benefit – The maximum fee a health plan will pay for a covered service or treatment. Allowed benefit is determined by each health plan.

- Coinsurance – Cost sharing between you and the plan for certain services. Expressed in terms of a percentage. Percentage shown is the insurance carrier's payment amount.

- Copayment – The flat dollar amount a member pays at the time service is rendered. Copays vary by type of service.

## Details - Medical Plan Changes

**PPO and POS**
**In-Network Changes**

Beginning 7/1/12

- No deductibles (no change)
- Plans pay 90% for all in-patient and out-patient hospitalization
- $1,000 out of pocket max per individual/ $2,000 per family

**PPO and POS**
**Out-of-Network Changes**

Beginning 7/1/12

- 70% of allowed benefit after deductible
- $250 deductible per individual / $500 per family
- $3,000 out of pocket max per individual / $6,000 per family

**These changes are not applicable to the EPO plans**



## Details - Medical Plan Changes

**PPO, POS and EPO Copay Changes**

Beginning 7/1/12

- Specialist office visit: $30 copay
- Urgent care: $30 copay
- Emergency room: $75 facility copay PLUS $75 physician copay

**No Changes to the Following Benefits**

- In-network primary care provider office visit copay remains $15
- In-network preventive care still covered at 100% with no copay
  - routine GYN exams/mammograms
  - adult/child physicals
  - immunizations and vaccines



## When Will I Pay Coinsurance?

**In-Network Examples – This List is NOT All Inclusive**

- Inpatient Hospitalization & Services
- Inpatient Surgery
- Outpatient Surgery
- Anesthesia
- Diagnostic Lab & X-Ray
- Ambulance Services
- Durable Medical Equipment
- Home Healthcare
- Maternity Hospitalization
- Hospice Care

## Doing the Math – Coinsurance

(example assumes individual coverage)

**In-Network**

$10,000 surgery
-but-
$8,000 is the allowed benefit
x 10% (patient coinsurance)
$800 (patient responsibility)

$1,000 is the Out-of-Pocket Max
- $800 patient responsibility 1st surgery
$200 maximum coinsurance charge for any other service to which coinsurance applies through the end of the plan year.
Your coinsurance responsibility (10%) will never exceed $1,000.

**Out-of-Network**

$10,000 surgery
-but-
$8,000 is the allowed benefit
- $250 deductible (patient responsibility)
$7,750
x 30% patient coinsurance
$2,325 patient responsibility (coinsurance)
+ $250 patient responsibility (deductible)
$ 2,575 total patient responsibility

$3,000 is the Out-of-Pocket Max
-$2,575 paid toward coinsurance & deductible
$425 maximum coinsurance charge for any other service to which coinsurance applies through the end of the plan year.



## A Note About Out-of-Network Providers

**Example From Previous Page**

$10,000 surgery
-but-
$8,000 is the allowed benefit
- $250 deductible (patient responsibility)
$7,750
x 30% patient coinsurance
$2,325 patient responsibility (coinsurance)
+ $250 patient responsibility (deductible)
$ 2,575 total patient responsibility

$3,000 is the Out-of-Pocket Max
-$2,575 paid toward coinsurance & deductible
$ 425 maximum coinsurance charge for any other service to which coinsurance applies through the end of the plan year.

**Beware of Balance Billing**

- The $10,000 surgery had a maximum allowed benefit of $8,000.
- This leaves the provider with a difference in his charge and the amount he collects from the insurance company of $2,000.
- This provider can "Balance Bill" you for this difference.
- This would make total cost to you $4,575!!

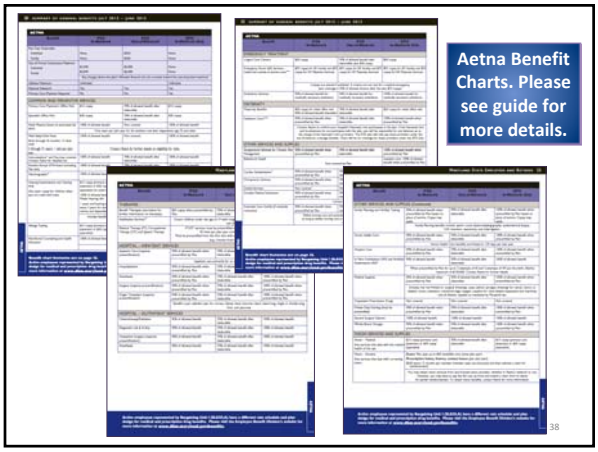
**We cannot stress enough how important it is to use In-Network providers in order to receive the best care at the lowest out-of-pocket cost!!**



## A Final Word About Out-of-Pocket Expenses

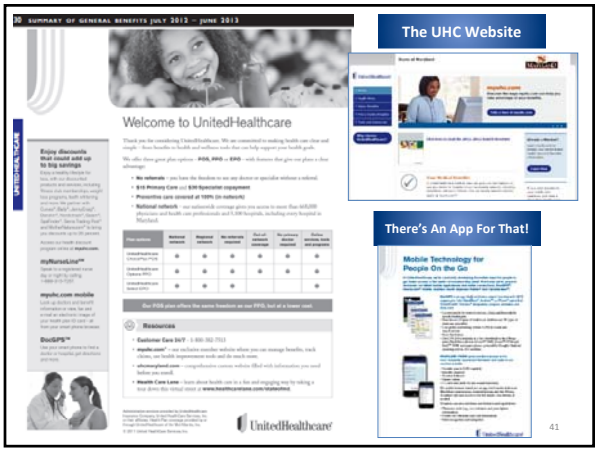
- Every July 1st, your deductible and out-of-pocket maximum resets to $0.
- You have to meet these costs every plan year.

The Aetna Website
There's An App For That!
HEALTH INFO
TO GO.
aetna


Aetna Benefit Charts. Please see guide for more details.

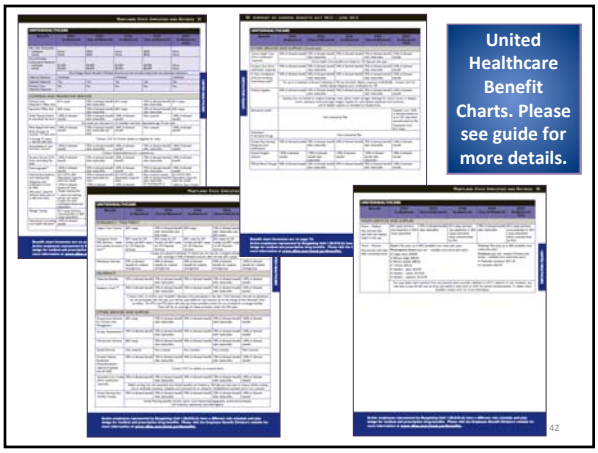
The CareFirst Website
Welcome to a healthy relationship.
One where everyone is committed to keeping you healthy.
There's An App For That!
symptom checker

CareFirst Benefit Charts. Please see guide for more details.




The UHC Website

There's An App For That!




United Healthcare Benefit Charts. Please see guide for more details.

## Medical Wrap Up

- What is an emergency?

The sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that in the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in:

- Placing the patient's health in serious jeopardy;
- Serious impairment of bodily functions;
- Serious dysfunction of any bodily organ or part.

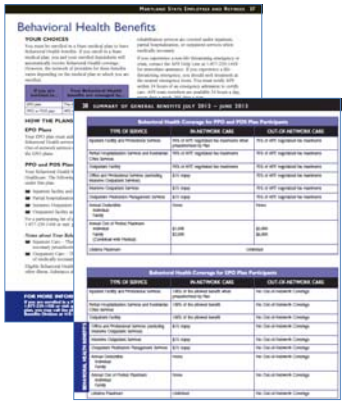
36 SUMMARY OF GENERAL BENEFITS JULY 2012 – JUNE 2013

BENEFIT CHART FOOTNOTES



## Behavioral Health Benefits

- Members in the EPO health plan have behavioral health benefits through their medical plan.
- Members in the PPO and POS plans have their behavioral health benefits through APS.
- Coverage for behavioral health benefits is the same as for any other illness.


Behavioral Health Benefits

YOUR CHOICES

HOW THE PLANS

EPO Plans

PPO and POS Plans

38 SUMMARY OF GENERAL BENEFITS JULY 2012 – JUNE 2013

Behavioral Health Coverage for PPO and POS Plan Participants

| TYPE OF SERVICE | IN-NETWORK CARE | OUT-OF-NETWORK CARE |
|---|---|---|
| Hospital Facility and Professional Services | 75% or 90% registered for maximum after prepayment by Plan | 75% or 90% registered for maximum |
| Partial Hospitalization Services and Residential Care Services | 75% or 90% registered for maximum | 75% or 90% registered for maximum |
| Outpatient Facility | 75% or 90% registered for maximum | 75% or 90% registered for maximum |
| Office and Professional Services (including Intensive Outpatient Services) | $15 copay | 75% or 90% registered for maximum |
| Intensive Outpatient Services | $15 copay | 75% or 90% registered for maximum |
| Outpatient Medication Management Services | $15 copay | 75% or 90% registered for maximum |
| Inpatient Detoxification Services | Unlimited | Unlimited |
| Annual Cost of Partial Hospitalization | $2,000 | $2,000 |
| Annual Cost of Residential Care (Combined with Partial) | $2,000 | $2,000 |
| Lifetime Maximum | Unlimited | |

Behavioral Health Coverage for EPO Plan Participants

| TYPE OF SERVICE | IN-NETWORK CARE | OUT-OF-NETWORK CARE |
|---|---|---|
| Hospital Facility and Professional Services | 100% of the allowed benefit after prepayment by Plan | No Out-of-Network Coverage |
| Partial Hospitalization Services and Residential Care Services | 100% of the allowed benefit | No Out-of-Network Coverage |
| Outpatient Facility | 100% of the allowed benefit | No Out-of-Network Coverage |
| Office and Professional Services (including Intensive Outpatient Services) | $15 copay | No Out-of-Network Coverage |
| Intensive Outpatient Services | $15 copay | No Out-of-Network Coverage |
| Outpatient Medication Management Services | $15 copay | No Out-of-Network Coverage |
| Inpatient Detoxification Services | Unlimited | No Out-of-Network Coverage |
| Annual Cost of Partial Hospitalization | Unlimited | No Out-of-Network Coverage |
| Annual Cost of Residential Care | Unlimited | No Out-of-Network Coverage |
| Lifetime Maximum | Unlimited | No Out-of-Network Coverage |



## The APS Website

APS Healthcare

877-259-1458

My Benefits Parenting Aging Balancing Thriving Working Living Intersections

Practicing Listening Skills

Learn more about... Practicing Listening Skills

C.O.N.N.E.C.T.

Conflict Resolution in a Relationship

Listening to Clients, Prices, and Patients

News For You

Claims and Eligibility

State of Maryland members now have the option to review Claims and Eligibility information. Access Claims and Eligibility information by clicking the link below.

Access Claims and Eligibility

Click Here to download the State of Maryland claim submission form.

Site Search

Search

Locate an EAP Counselor

Online Provider Locator

Locate Work Life Resources

Make a Selection

Insurance Information

Savings Center

Learning Center

Relocation Center

The APS website is filled with articles, assessments, audio casts, online seminars and "skill builders" on many of life's milestones and challenges.

## Prescription Drugs through Express Scripts

- Express Scripts (ESI) is the new Pharmacy Benefits Manager for the State of Maryland effective May 16, 2012. We have worked with ESI to develop a comprehensive communications plan to ensure all members receive clear and concise information on how to utilize their new prescription drug benefits.
- The Plan – the coverage, copays, etc. –has not changed from the prior year.

MARYLAND STATE EMPLOYEES AND RETIREES 39

Prescription Drug Benefits

HOW THE PLAN WORKS

Brand Name Versus Generic Medications

YOUR COST AT RETAIL PHARMACIES

Active employees represented by Bargaining Unit 1 (SLEOLA) have a different rate schedule and plan design for medical and prescription drug benefits. Please visit the Employee Benefit Division's website for more information at www.dbm.maryland.gov/benefits.

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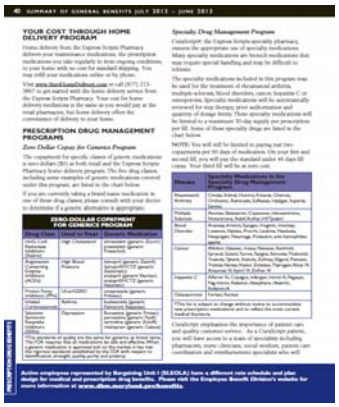
## Home Delivery, Zero Copay Generics, and Specialty Drugs

- The Home Delivery and Specialty Drug programs are changing. Current medications under these programs will be transferred from old PBM to ESI.
- Targeted communications will be sent directly to the members affected by these changes, notifying them of the new provider, and making them aware of new claims procedures for future claims.
- The Zero Dollar Generic program will continue for generic drugs in the therapeutic classes of high cholesterol, high blood pressure, Ulcer/GERD, Asthma and Depression.



40 SUMMARY OF GENERAL BENEFITS JULY 2012 – JUNE 2013

YOUR COST THROUGH HOME DELIVERY PROGRAM

PRESCRIPTION DRUG MANAGEMENT PROGRAMS

Zero Dollar Copay for Generics Program

ZERO-DOLLAR COPAYMENT FOR GENERICS PROGRAM

Specialty Drug Management Program

Active employees represented by Bargaining Unit 1 (SLEOLA) have a different rate schedule and plan design for medical and prescription drug benefits. Please visit the Employee Benefit Division's website for more information at www.dbm.maryland.gov/benefits.

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## Prior Authorizations and Step Therapy

- Prior Authorization is used for medications that have a tendency for misuse, and requires that a physician provide diagnosis information to ESI prior to ESI approving the medication to be paid through the plan.
- Step Therapy is in place for medications that have equally therapeutic alternatives at a lower cost to the member and the plan. Before using a high cost medication, some members are required to try at least one lower cost, equally therapeutic medication.
- When a medication requires step therapy or prior authorization, the pharmacist will notify you when you fill the prescription.

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Prior Authorization Medications

Medications with Quantity Limits

Step Therapy

Active employees represented by Bargaining Unit 1 (SLEOLA) have a different rate schedule and plan design for medical and prescription drug benefits. Please visit the Employee Benefit Division's website for more information at www.dbm.maryland.gov/benefits.

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## Drug Exclusions and Direct Member Reimbursements

- Some medications are not covered under our plan either because the State of Maryland has specifically excluded them, or because they are not on ESI's formulary.
- Review the formulary for your medications. If a medication you currently take is not on the ESI formulary, please ESI Customer Service for assistance.

DRUG EXCLUSIONS

DIRECT MEMBER REIMBURSEMENT



## The Express Scripts Website

## There's an App For That!

## Express Scripts – Communication Plan

**Targeted Mailings**

- Communications to members who may have to make some changes under the new ESI plan.
- Early April
  - Members who have to choose a new pharmacy
  - Members who currently have preferred brand drugs that will be moving to the non-preferred brand tier
  - Members who have refills remaining in Catalyst mail order drug to get them transferred to ESI mail order
  - Members taking specialty drugs

**Welcome to ESI Packets**

- Sent to all members enrolled in pharmacy benefits
- Late April
  - Welcome Booklet with info on ESIs programs
  - Formulary Listing
  - Benefits of Generic Drugs Booklet

**ESI ID Card Packets**

- Early May
  - Welcome Letter
  - Packet with ID Card

## Dental Benefits - UCCI

- The DPPO plan allows you to see any dentist, whether in network or out – just remember that you will always pay more to an out of network dentist.
- Predetermination of Benefits (also known as Pre-treatment Estimates) are always a good idea to obtain. Your dentist submits to UCCI the plan of treatment, and UCCI returns an estimate to the dentist for what they will pay and what will be your out of pocket cost.

Dental Benefits

YOUR CHOICES

HOW THE PLANS WORK

The DPPO Plan

PREDETERMINATION OF BENEFITS

What's Covered – DPPO Plan

FOR MORE INFORMATION

52

## How the DHMO Plan Works

- DHMO is Regional!! Do not pick the DHMO if you do not live within the region, or if your children attend college outside of the region.
- Your dentist leaving the UCCI network is not a qualifying reason to change plans if there is still another dentist in the network within 50 miles of your home or work address.

The DHMO Plan

What's Covered – DHMO Plan

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UCCI DHMO Benefit Charts. Please see guide for more details.

The UCCI Website

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## ConnectYourCare Flexible Spending Accounts

- Flexible Spending Accounts are a great way to save money on taxes!
- This plan year, with the increase to the coinsurance and some copays, you may have more out of pocket expenses that are eligible for reimbursement through a Healthcare FSA.
- Beginning in 2013, the maximum you can contribute under a Healthcare FSA is $2,500 per year.

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## Healthcare vs. Dependent Care

- Only Active State and Satellite employees are eligible to participate in the Flexible Spending Accounts.
- Retirees and Direct Pay members are not eligible to participate.
- **Remember** – The FSA is Use it or Lost it! Be conservative in your contribution to be sure you do not over-contribute.

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## Submitting Claims

- Getting reimbursed is easy, and there are many options for submitting claims:
  - Online through your CYC account
  - Using a paper claim form and faxing or mailing it to CYC
  - Using CYC's mobile app

  -or-
  - Skip the need to file for reimbursement by using your FSA Debit card!
- Reimbursements can be directly deposited to your bank account – the form is available on the DBM website.

Important information to note regarding the availability of FSA funds for reimbursement

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## Eligible Expenses and the FSA Debit Card

- A full list of eligible Healthcare FSA expenses is available from the IRS website. Go to www.irs.gov, and in the search bar, type "Publication 502".
- For the same detailed information regarding the Dependent Care FSA, search for "Publication 503".

- The Debit card makes using the Healthcare FSA easy.
- **YOU STILL NEED TO SAVE ALL OF YOUR RECEIPTS!!**
- The same card is used year after year, so save your card.

52 SUMMARY OF GENERAL BENEFITS JULY 2013 – JUNE 2014

HEALTHCARE ACCOUNT – ELIGIBLE EXPENSES

HEALTHCARE ACCOUNT – WHAT IS NOT COVERED

DEPENDENT DAY CARE ACCOUNT – ELIGIBLE EXPENSES

DEPENDENT DAY CARE ACCOUNT – WHAT IS NOT COVERED

HEALTHCARE PAYMENT CARD FREQUENTLY ASKED QUESTIONS



## Deadlines for Claims Submission

- Eligible expenses for Healthcare must be incurred between the first day of the plan year and September 15th of the following year.
- Eligible expenses for Dependent Care must be incurred between the first day of the plan year and the last day of the plan year.
- Claims must be submitted for reimbursement by October 15th, 2013 for both FSA accounts.
- If you terminate your employment prior to the end of the plan year, you have 90 days following your date of termination to submit all claims.

MARYLAND STATE EMPLOYEES AND RETIREES 53

Direct Deposit

Timeline for Using Account Funds

Deadline for Eligible Expenses

Deadline for Submitting Reimbursement Requests

UPDATED IRS GUIDANCE ON THE USE OF HEALTHCARE PAYMENT CARDS FOR OTC MEDICINES



## The ConnectYourCare Website

## There's an App For That!

## MetLife – Term Life Insurance

- Please remember – no duplication of benefits.
- Employees exiting state service have the option of converting their life insurance benefit to an individual policy. This must be done within 31 days of termination.
- Will Preparation, Power of Attorney and Living Will preparation services are offered to all participants in the plan at no additional charge through MetLife's partner Hyatt Legal Plans.

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Term Life Insurance

FOR MORE INFORMATION

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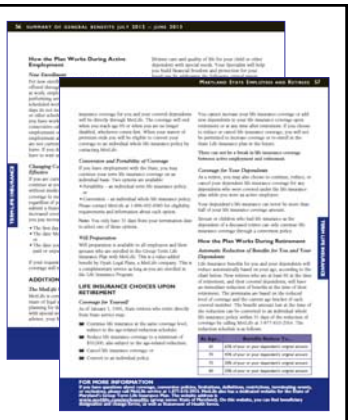
## MetLife – Term Life Insurance

- Any increase to coverage amount or new election of coverage usually requires medical Evidence of Insurability (also called a Statement of Health). Your newly elected amount will not be in place until you submit the Evidence of Insurability form to MetLife, and they approve the increase or new election.
- Coverage is now available for your child(ren) through age 26!



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## Accidental Death and Dismemberment

- AD&D has several value-added services, including Travel Assistance and Identity Theft Solutions.

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Accidental Death and Dismemberment

FOR MORE INFORMATION

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## Long Term Care
## The Prudential

- For this year's Open Enrollment, the plan is open for ALL eligible employees to enroll, without the requirement of medical evidence of insurability!!
- Plan improvements:
  - Expanded eligibility – now your siblings and their spouses can enroll in coverage. (ANY family members that enroll MUST submit evidence of insurability).
  - Increased daily and lifetime maximum payouts.

Long Term Care Insurance



## Optional Features & Additional Benefits

- This plan is still a separate enrollment – not done through the IVR during Open Enrollment, nor on a form for new hires.
- Information on how to enroll included in benefit guide.

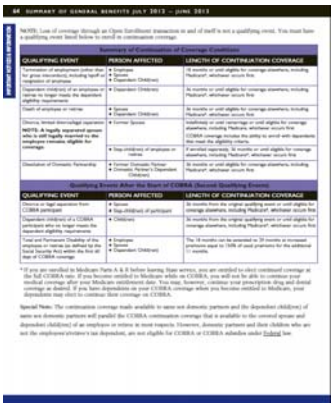
## Important Notices

- Employee Fraud will not be tolerated! We routinely audit our plans – looking for duplicate coverage and recertifying certain dependent relationships as needed.

- Social Security numbers are required for all enrolled dependents in order for our plan to comply with Federal regulations regarding coordination of Medicare benefits. We will be performing an audit and requesting SSNs for those we are missing.

## COBRA Qualifying Events

- Explains the various COBRA qualifying events, the people affected, and the length of continuation coverage offered.
- Removing a dependent during Open Enrollment is not a COBRA qualifying event. If you remove a dependent during OE, that dependent will not be offered continuation coverage.



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IMPORTANT NOTICES REGARDING

NOTE: Loss of coverage through an Open Enrollment transaction or end of itself is not a qualifying event. You must have a qualifying event listed below to enroll in continuation coverage.

Summary of Continuation of Coverage Conditions

| QUALIFYING EVENT | PERSON AFFECTED | LENGTH OF CONTINUATION COVERAGE |
|---|---|---|
| Termination of employment (other than for gross misconduct), including layoff or resignation of employee | • Employee<br>• Spouse<br>• Dependent Child(ren) | 18 months or until eligible for coverage elsewhere, including Medicare*, whichever occurs first. |
| Dependent child(ren) of an employee or retiree ceases the dependent eligibility requirements | • Dependent Child(ren) | As months or until eligible for coverage elsewhere, including Medicare*, whichever occurs first. |
| Death of employee or retiree | • Spouse<br>• Dependent Child(ren) | As months or until eligible for coverage elsewhere, including Medicare*, whichever occurs first. |
| Divorce, legal dissolution/legal separation<br>**NOTE: A legally separated spouse who is still legally married to the employee remains eligible for coverage.** | • Former Spouse | Indefinitely or until remarriage or until eligible for coverage elsewhere, including Medicare, whichever occurs first.<br>COBRA coverage includes the ability to enroll with dependents that meet the eligibility criteria. |
| | • Dep.-child(ren) of employee or retiree | If enrolled separately, 36 months or until eligible for coverage elsewhere, including Medicare*, whichever occurs first. |
| Dissolution of Domestic Partnership | • Former Domestic Partner<br>• Domestic Partner's Dependent Child(ren) | As months or until eligible for coverage elsewhere, including Medicare*, whichever occurs first. |

Qualifying Events After Any Part of COBRA Elected Qualifying Events

| QUALIFYING EVENT | PERSON AFFECTED | LENGTH OF CONTINUATION COVERAGE |
|---|---|---|
| Divorce or legal separation from COBRA participant | • Spouse<br>• Dep.-child(ren) of participant | 36 months from the original qualifying event or until eligible for coverage elsewhere, including Medicare*, whichever occurs first. |
| Dependent child(ren) of a COBRA participant who no longer meets the dependent eligibility requirements | • Child(ren) | 36 months from the original qualifying event or until eligible for coverage elsewhere, including Medicare*, whichever occurs first. |
| Total and Permanent Disability of the employee or retiree (as defined by the Social Security Act) within the first 60 days of COBRA coverage. | • Employee<br>• Spouse<br>• Dependent Child(ren) | The 18 months can be extended to 29 months at increased premiums equal to 150% of usual premiums for the additional 11 months. |

* If you are enrolled in Medicare Parts A & B before leaving State service, you are entitled to elect continued coverage at the full COBRA rate. If you become entitled to Medicare while on COBRA, you will not be able to continue your medical coverage after your Medicare entitlement date. You may, however, continue your prescription drug and dental coverage as desired. If you have dependents on your COBRA coverage when you become entitled to Medicare, your dependents may elect to continue their coverage on COBRA.

**Special Note:** The continuation coverage made available to same sex domestic partners and the dependent child(ren) of same sex domestic partners will parallel the COBRA continuation coverage that is available to the covered spouse and dependent child(ren) of an employee or retiree in most respects. However, domestic partners and their children who are not the employee/retiree's tax dependent, are not eligible for COBRA or COBRA subsidies under Federal law.



## Medicare – A Few Notes

- Coordination of Benefits
  - For Active employees with Medicare, the State plan is primary.
  - For Retiree participants with Medicare, the State plan is secondary.
- When Medicare is primary and the State plan is secondary, Medicare pays roughly 80% of claims, then the State pays per our plan document the remaining 20% that is usually the Member's full responsibility had the State plan not paid secondary.
- For the PPO and POS plans, when the new coinsurance begins on 07/01, that 20% will continue to be paid per our plan document, but at the new coinsurance rates. So, if a member goes to an In-Network hospital for a surgery, we will pay 90% of the 20% leftover by Medicare – the member will be responsible for the 10% coinsurance. This does not apply to the EPOs.



## Benefits Appeal Process

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BENEFITS APPEAL PROCESS

**BENEFITS APPEAL PROCESS**

*Important Information about Your Health Benefits Claims Review and Appeal Rights*

**Under the Patient Protection and Affordable Care Act (PPACA) of 2010, the claims appeals process has changed. Effective July 1, 2011, the following process is in place. Please read this notice carefully.**

**Internal Appeals:** If a healthcare claim you will be incurring or have incurred has been denied, you may contact your insurance carrier using the contact information on your Explanation of Benefits (EOB) form or on the back of your insurance identification card for information on filing an internal appeal. This must be done within 180 days (six months) from the date that you received the EOB. If the insurance carrier upheld the denial, you have the right to request an external review. You must appeal the denial of the claim to the insurance carrier before requesting an external review.

**External Appeals:** For a claim denied because the service was considered not medically necessary, medically inappropriate or is considered experimental or investigational, you, your representative or a healthcare provider acting on your behalf, may be entitled to request an independent, external review within 120 days (four months) from the date the claim was denied. If you request an external review, the Maryland Insurance Administration (MIA) will review and provide a final, written determination. If MIA decides to overturn the insurance carrier's decision, we will contact you to arrange for the prompt provide coverage or payment for your healthcare item or service. For questions on your rights to external review contact:

Maryland Insurance Administration
Attn: Appeals and Grievance Unit
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202
Telephone: (410) 468-2090
Toll-free: 1-800-492-6116
Facsimile: (410) 468-2270
TTY: 1-800-735-2258

If a claim is denied because the service was not a covered service and is not eligible for an independent, external review, but you still disagree with the denial, you may contact the Employee Benefits Division for additional review at the following:

Employee Benefits Division
Attn: Adverse Determination
301 West Preston Street, Room 510
Baltimore, MD 21201
Telephone: (410) 767-4775
Toll-free: 1-800-307-8285
Facsimile: (410) 333-7166

**Urgent Care Request:** If your situation meets the definition of urgent care under the law, a review of your claim will be conducted as expeditiously as possible. An urgent care situation is one in which your health may be in serious jeopardy or in the opinion of a physician with knowledge of your medical condition, would subjectively cause you severe pain. You will receive a decision on the external review of your claim. If you believe your situation is urgent, you may request an expedited review process by contacting your plan at the phone number listed on the back of your insurance identification card, or you may contact the Maryland Insurance Administration (see above).

**Assistance resources:** For questions about your rights or for assistance in filing an appeal, you can contact:

Office of Health Insurance Consumer Assistance
Maryland Office of Attorney General
Health Education and Advocacy Unit
200 St Paul Place, 16th Floor
Baltimore, MD 21202
Telephone: (877) 261-8807
http://www.oag.state.md.us/Consumer/HEAU.htm
healthoag.state.md.us

OR

Employee Benefits Security Administration
1-800-444-3272

## The DBM – EBD Website

Improvements to site organization and quality of information provided are coming! Check back often for updates and improvements.

## Thank You For Reading!

MARYLAND
DEPARTMENT OF BUDGET & MANAGEMENT
Employee Benefits Division
301 West Preston Street
Room 510
Baltimore, MD 21201

Local: 410-767-4775
Toll-Free: 1-800-30-STATE

PUTTING the PIECES TOGETHER