2024-2025
BENEFITS OVERVIEW GUIDE

CONTENTS

Welcome to Your Charles County Government (CCG) Benefits

We are pleased to present this year's Benefits Guide with refreshed benefits that increase choice and flexibility. Please take this opportunity to review all your benefits. More than ever, it's important to make sure that your choices provide the coverage you need for your family's financial security and peace of mind.

2024 Open Enrollment

Open Enrollment is Thursday, May 16 through Thursday, May 30, 2024.

All employees are encouraged to meet face-to-face with Decision Support Specialists (DSSs) from Bolton, during Open Enrollment. Appointments are available from May 16 - May 30. Employees can schedule an appointment to meet with a DSS online at **https://go.oncehub.com/CharlesCountyGovt**. More details on page 4.

What's New This Year

Dental Enhancements from CareFirst and Delta Dental: Fluoride treatments now available for adults at preventative care visits.

Cover Photo: Marshall Hall
Table of Contents Photo: Mount Aventine
Above Photo: Aerial View of the County

CCG continues to evaluate ways to improve the quality of your health care and keep our health plans competitively priced, while controlling costs for you and CCG. Be sure to participate in Employee Wellness programs and activities, and partner with your physician to get appropriate preventative screenings. Also, consider programs like mail order pharmacy and generic prescriptions to lower your copays and overall plan costs.

Enrollment Assistance

Need help with any of your benefits this year? Want enrollment assistance? An expert opinion?

CCG is offering employees an opportunity to meet with a Decision Support Specialist (DSS). The specialists are from Bolton, our benefits consulting firm, and will be available at many locations throughout the county. Each DSS can help you with information and assistance to make your best benefit choices.

Anyone who logs into the bswift site or schedules an appointment with a DSS will have their name entered in a raffle for a chance to win one of ten (10) $25 gift cards from local small Charles County businesses. A winner will be drawn each weekday from May 16 to May 30 (excluding Memorial Day, May 27), so the earlier you schedule your appointment, the more opportunities you will have to win.

There are two ways to meet with a DSS:

In-Person Appointment

Appointments will be available beginning Thursday, May 16 to Thursday, May 30. Times vary across locations. A comprehensive appointment lasts about 30 minutes in person.

Please have your beneficiary information and your login credentials available as outlined on Page 5.

To schedule an **in-person** appointment with a DSS:
https://go.oncehub.com/CharlesCountyGovt

Phone Appointment

Appointments will be available beginning Thursday, May 16 to Thursday, May 30. All calls will be scheduled for 30 minutes. You will be contacted at the appointed time based on the number you provide.

At the beginning of the call, you will need to provide your username and password as outlined on Page 5 to verify your identity.

To schedule a **phone** appointment with a DSS:
https://go.oncehub.com/BoltonCallCenter

Benefits Fair

Thursday, May 23 – 1:00pm – 4:00pm
HR Training Room

Learn about benefit options offered to Charles County Government employees

- Meet-and-greet opportunities with benefit vendors
- Door prizes
- Vendor and wellness breakout sessions
- Healthy snacks

How to Enroll

All benefit elections/changes must be submitted online through **bswift**.

Online Enrollment Instructions

bswift allows you to access your benefits information and enroll online.

Go to **https://CharlesCounty.bswift.com** to start your enrollment.

Step 1: Sign in to bswift

Username: Your username is first initial of first name + full last name + year of birth. For example: If your name is Jane Anderson and you were born in 1970, your username would be janderson1970.

Password: All passwords have been reset to the last four numbers of your Social Security Number (SSN). You will be required to reset your password upon your initial login: all passwords must have a minimum of eight characters, one of which must be a number and one a letter.

Step 2: Your Info — Employee and Family Information

Under **Employee Information**, review your Demographics and Address to ensure accuracy. If there is anything incorrect that you cannot update, contact HR. Make sure you indicate whether you are a tobacco user on this page (tobacco means electronic cigarettes and any tobacco product including cigarettes, cigars, chewing tobacco, snuff, and pipe tobacco used four or more times a week within the past six months).

Next you will review your **Family Information**. Eligible dependents can be added on this page.

You must agree that both your Personal and Family Information is correct before you can proceed, then click **Continue**.

Scan below to go to bswift:

Step 3: Begin Your Enrollment and Enroll

Click on **Begin Your Enrollment** to get started. On the benefits page, you will see available options for this year's enrollment. To view the options for a benefit, select **View Plan Options**. Next, you can select what dependents will be covered under the benefit. Review the options, then click **Select** or **Waive**. Continue making any desired elections.

Your elections from FY24 have been copied to FY25 except for your Flexible Spending Account plan elections. The total benefit cost, per pay period, will appear on the right side of the enrollment screen.

Step 4: Confirm Enrollment Selections

Once you have finished your enrollment, on the right side under **Your Cost**, click **Continue** for the checkout process.

Next, you will be brought to the Beneficiary screen. Once you have added your beneficiaries, click **Continue** to proceed to the next page where you will review your elections. Scroll down to read the agreement, check the **I Agree** box and click **Complete Enrollment** to finish the process.

Changes will NOT be submitted unless you click Complete Enrollment. You will have the option to generate a confirmation statement once your enrollment is complete. Remember, you can return at any time through the end of the enrollment period to review or make additional changes.

Enrollment Reminders

- Note: Flexible Spending Account plans require annual enrollment.
- If you have a question or need your password reset, or are having technical issues, please send an email to **service@boltonusa.com** outlining your request and the Service team will assist you.

Benefits Eligibility

Employee Eligibility

A full-time employee must be customarily scheduled to work 37.5 hours or more per week and at least 1,950 hours per calendar year. A full-time reduced-hours employee (CCSO and States' Attorney Office only) starts at 25 hours per week and at 1,300 hours per calendar year.

Dependent Eligibility

You may enroll your eligible dependents in the same plans you choose for yourself. Eligible dependents include your legal spouse, dependent children and disabled adult children. Grandchildren are not eligible dependents under our plans.

When to Enroll

Open Enrollment: Open Enrollment will run from May 16 through May 30, 2024. Coverage for all benefits will be effective on July 1, 2024.

New Hire: You must enroll within 30 days of your eligibility/hire date. If you don't enroll for coverage within 30 days of your eligibility date, you won't receive health coverage during the plan year, unless you have a qualifying life event (see below for details). Coverage begins on the 1st of the month following your date of employment.

Making Changes To Your Benefits

The choices you make at Open Enrollment are in effect for the remainder of the plan year that ends on June 30. Once you enroll, you must wait until the next Open Enrollment period to change your benefits or add or remove coverage for dependents, unless you have a qualifying life event as defined by the IRS.

The following are examples of a qualifying life event:

- Marriage, divorce, legal separation, annulment or death of spouse
- Birth, adoption or placement for adoption
- Loss of health coverage
- Change in your dependent's eligibility status because of age, or any similar circumstance

Life event changes must be made within 31 days of the qualifying event.

Ex-spouses may not remain on insurance as an eligible dependent. Eligibility ends the end of the month in which the divorce decree is signed.

Lifestyle Change/Event	Documentation Required
Marriage	Marriage Certificate & Social Security cards
Divorce	Divorce Decree
Birth or Adoption	Birth Certificate or Adoption papers & Social Security cards
Change in employment status from part-time to full-time or vice versa	No documentation required—Human Resources will confirm
Your child loses eligibility for dependent coverage	No documentation required
Your spouse gains or loses coverage under another plan	Letter from spouse's employer verifying the change
You go on or return from leave of absence	No documentation required—Human Resources will confirm

Your Cost for Health Coverage

Your per PAYCHECK payroll deductions for Medical (including Pharmacy and Vision) and Dental coverage are shown in the tables below. Premiums from the tables below are deducted from 24 paychecks, respectively. Actual payroll amounts may vary slightly.

Medical, Pharmacy, and Vision Premiums (Full-time Employees)

	BlueChoice Advantage		BlueChoice Open Access	
Coverage Level	**CCG**	**Employee**	**CCG**	**Employee**
Employee	$348.97	$149.56	$244.89	$104.95
Employee + Child	$606.29	$259.84	$465.37	$199.45
Employee + Spouse	$726.19	$311.23	$563.25	$241.39
Family	$853.73	$365.88	$734.70	$314.87

Dental Premiums (Full-time Employees)

	CareFirst Dental		Delta Dental	
Coverage Level	**CCG**	**Employee**	**CCG**	**Employee**
Employee	$19.43	$8.33	$16.33	$7.00
Employee + Child	$29.67	$12.71	$25.94	$11.12
Employee + Spouse	$44.57	$19.10	$38.49	$16.49
Family	$58.29	$24.98	$50.00	$21.43

Historic Port Tobacco Courthouse

Medical Coverage (includes Pharmacy and Vision)

CCG offers two medical plan choices through CareFirst BlueCross BlueShield: BlueChoice Advantage and BlueChoice Open Access. The plans give you access to a quality network of practitioners and hospitals in Maryland, along with access to a national network. CareFirst does not require a referral, so you may receive services from any provider. However, the benefit you receive will be based upon the network status of the provider as well as the plan in which you are enrolled. Both medical plans include vision and prescription drug coverages at the same level of coverage elected for medical.

The Advantage Plan covers care provided both inside and outside the plan's provider network. This plan does require the deductible to be met if going outside of the network, before the plan contributes to most services. Preventive care is covered 100%.

With Open Access, you are required to **select a primary care provider** (PCP) who provides routine care and coordinates specialty care. When you choose an in-network provider, you'll pay the lowest out-of-pocket care costs. If you choose to receive care from an out-of-network provider, with Open Access, you will be responsible for the entire amount billed.

When reviewing your benefit, please be aware of the difference between the following terms:

- Calendar Year—runs from January 1 to December 31 and resets each January 1.
- Plan Year—CCG benefit plan year, which runs from July 1 to June 30.
- Every 12 months—a rolling 12 months that begins on the date of your most recent service.

Plan Features	BlueChoice Advantage		BlueChoice Open Access	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar Year Deductible	$0	$200/$400	$0	No Coverage
Annual Out-of-Pocket Maximum* Individual/Family	$1,000/$2,000	$1,000/$2,000	$2,000/$6,000	No Coverage
Prescription Annual Out-of-Pocket Maximum* Individual/Family	$5,600/$11,200	$5,600/$11,200	$4,600/$7,200	No Coverage
Lifetime Maximum	Unlimited	No coverage	Unlimited	No Coverage
Copayments for Certain Services				
Office Visit	$15 per visit	Deductible, then 20% of "AB"	$10 per visit	No Coverage
Specialist	$25 per visit		$20 per visit	
Hospital Facility	$35 per visit		$0	
Practitioner (at hospital)	$35 per visit		$0	
Urgent Care	$30 per visit		$25	
Emergency Room	$125 per visit waived if admitted		$100 per visit waived if admitted	
Well Care				
Adult Routine Physical Exam	$0	Deductible, then 20% of "AB"	$0	No Coverage
Routine GYN Exam				
Well Child Visits (guidelines apply)				

* Plan has a separate max for medical and drug expenses, which accumulate independently.
"AB" = Allowed Benefit

Plan Features	BlueChoice Advantage		BlueChoice Open Access	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Type of Service				
Hospital Inpatient Pre-admission review/ approval required	$0	Deductible, then 20% of "AB"	$0	No Coverage
Outpatient Diagnostic — Lab	$15 copay	Deductible, then 20% of "AB"	$10 copay	No Coverage
Inpatient Mental Health	$0	Deductible, then 20% of "AB"	$0	No Coverage
Prescription Drugs: Retail (up to a 34-day supply)*				
Generic*	$5 copay		$5 copay	
Preferred Brand	$25 copay		$25 copay	
Non-Preferred Brand	$50 copay		$50 copay	
Prescription Drugs: (CVS Pharmacy or Mail Order)/Other Retail Stores (up to 90-day supply for maintenance medications)*				
Generic	2 copays/3 copays		2 copays/3 copays	
Preferred Brand	2 copays/3 copays		2 copays/3 copays	
Non-Preferred Brand	2 copays/3 copays		2 copays/3 copays	

"AB" = Allowed Benefit
*For all prescription drugs: Prior authorization may be required for certain drugs; No charge for preventive drugs or contraceptives; Copay applies to up to 34-day supply; 90-day supply at a CVS pharmacy or through mail order for 2 copays for maintenance drugs, 3 copays at all other retail stores
Specialty Drugs: Participating Providers: Covered when purchased through the Exclusive Specialty Pharmacy Network. Non-Participating Providers: Not covered

This is only a brief summary of the plans. For more details, including limitations and exclusions, please see bswift library for a Summary Plan Description.

Medical Coverage Features

Virtual Care: A Virtual Option for Patient Visits

Starting January 1, 2024, CareFirst Video Visit has been replaced with CloseKnit. This change does not impact our network providers' ability to offer telemedicine to their patients. CloseKnit offers the same services as CareFirst Video Visit and more, including:

- Primary care (ages 18+)
- Urgent adult/pediatric care (ages 2+)
- Behavioral and mental health therapy
- Psychiatry
- Care coordination
- Medication management
- Chronic condition prevention and management
- Lactation consulting
- Nutritional counseling

To schedule a video visit, go to **carefirstvideovisit.com**.

Post Employment Health Plan

New employees and employees hired in 2017 or after and are enrolling in health insurance will be enrolled in a Post-Employment Health Plan (PEHP). Upon retirement or separation from employment, you will be able to use the funds accumulated in this account to obtain health insurance and pay premiums and other qualified medical expenses. There is a required employee contribution of **$31.75** per pay period (taken via payroll deduction). CCG will contribute **$95.26** each pay period into this account. These contributions may be adjusted each year based on the Consumer Price Index.

You must return the completed Nationwide form to the Charles County Government Department of Human Resources in order to complete your health insurance enrollment. This form can be downloaded from the PEHP page in your New Hire Enrollment or from the bswift Library once you complete your enrollment.

You may reach out to our Nationwide Representative, Scott Wambolt - if you have any questions regarding investment options: **r.s.wamboldt@nationwide.com** or **410-274-9568**; or call Nationwide Customer Service at **877-677-3678**.

Healthy Vision (included with your Medical Coverage)

BlueVision Plus includes routine eye examinations, eyeglasses, and contact lenses offered by CareFirst BlueCross BlueShield, through the Davis Vision, Inc. national network of providers.

Plan Features	BlueVision Plus	
	In-Network	Out-of-Network
	You pay:	Plan reimburses you:
Exam every 12 months	$0	Up to $45
Frames every 12 months	$0*	Up to $45
Lenses every 12 months		
Single Vision	$0	Up to $52
Lined Bifocal	$0	$82
Lined Trifocal	$0	$101
Contact lenses every 12 months (in lieu of lenses and frames)		
Medically Necessary	No copay**	Up to $285
Elective	Single: $97 allowance Bifocal: $127 allowance Davis Vision Contacts: $0 copay***	Single: up to $97 Bifocal: up to $127

*Davis Vision Collection frames only; all other frames: $45 allowance, you pay balance
**With prior approval
***With evaluation if Davis Vision Collection lenses are dispensed

Finding an In-Network Provider

To find an in-network provider, search online at **www.carefirst.com** and click Find a Doctor or call Davis Vision at **800-783-5602**. Be sure to ask your provider if they participate in the Davis Vision network.

Mail Order Replacement Contact Lenses

DavisVisionContacts.com offers members the flexibility to shop for replacement contact lenses online after benefits are spent. This website offers a wide array of contact lenses; easy, convenient purchasing online; and quick shipping direct to your door.

Pharmacy Coverage (included with your Medical Coverage)

CCG offers Pharmacy coverage through CareFirst providing you with a safe, convenient and cost-effective prescription drug plan that offers:

- A nationwide network of 69,000 pharmacies
- Access to thousands of covered prescription drugs
- Mail Service Pharmacy, a convenient and fast option to refill your prescriptions through home delivery
- Coordinated medical and pharmacy programs to help improve your overall health and reduce costs
- Personalized notices and phone calls from CVS Caremark, our pharmacy benefit manager, detailing cost savings opportunities, safety alerts and drug education

Our Formulary (Drug List) Structure

A formulary is a list of covered prescription drugs. Our formulary list can be found under the Library tab on bswift. Our drug list is reviewed and approved by an independent national committee comprised of physicians, pharmacists and other health care professionals who make sure the drugs on the formulary are safe and clinically effective. The tiers that are included in your plan:

- Tier 1: Generic Drugs
- Tier 2: Preferred Brand Drugs
- Tier 3: Non-Preferred Brand Drugs

Dental Coverage

Good dental hygiene is important for your overall health. This year, fluoride treatments for adults at preventive exam and cleaning appointments has been added to our benefit. Search for a provider at www.deltadentalins.com or www.carefirst.com.

Plan Features	CareFirst Dental	Delta Dental
	In-Network & Out-of-Network	In-Network & Out-of-Network
Benefit Year Deductible (waived for Preventive Services)	$25 individual $75 family	$25 individual $75 family
Calendar Year Maximum	$2,000 per member	$2,000 per member
Diagnostic and Preventive Services (e.g., X-rays, cleanings, exams)	100% of "AB"	100% of "AB"
Basic and Restorative Services Fillings, simple extractions Root canals and Periodontal	 100% of "AB" 80% of "AB"	 100% of "AB" 80% of "AB"
Major Services (e.g., dentures, crowns, occlusal guards)	50% of "AB"	50% of "AB"
Orthodontia (Adults and dependent children)	50% of "AB"	50% of "AB"
Orthodontia Lifetime Maximum	$2,000 per member	$2,000 per member

*__Note__: Non-participating providers may bill you the difference between the insurer's allowed benefit and the provider's total charge.
"AB" = Allowed Benefit

Accident Insurance

Accident Insurance pays cash benefits directly to you for covered injuries and treatments.

Accidents happen all the time. Working around the house or driving your car… your child on their bike or at soccer practice. Accidents can be painful, and costly. Even with major medical insurance, there may be out-of-pocket expenses that you'll have to pay. Wouldn't it be nice to have money to offset those unexpected bills?

Did you know that:

- The accident plan pays cash directly to you to be used however you choose.
- This is a 24-hour policy, covers on- and off-the-job injuries.
- You can cover yourself, your spouse, and your children.
- This policy pays an additional 25% benefit if your child (ages 18 and under) is injured while playing organized sports.
- Line of Duty Benefit provides additional benefits for public safety officers.
- Includes a $50 Health Maintenance Screening benefit.
- Exclusions for hazardous activities, self-inflicted injuries, etc.

Benefits are payable for:

- Fractures, dislocations, cuts, and burns
- Emergency, Urgent, and Follow-up Care
- Accidental Death and Dismemberment
- X-rays, MRI, CAT scans, and other tests
- Concussions, Eye Injuries, and Tendon, Ligament, and Disc Repair

How it works:

Lacrosse Match

It was going so well! Then, two girls collided. It didn't look too serious, but Olivia was limping badly and simply couldn't finish the game. A trip to Urgent Care and bad news — a torn ACL meant surgery and rehab. Her season was cut short, but they would have plenty of help with the costs of treatment and recovery.

Benefit example:

Urgent Care	$60
MRI	$300
ACL Repair	$1,000
Surgical Facility (outpatient)	$500
Therapy (four visits)	$200
Subtotal	$2,060
25% Youth Organized Sports Benefit	$515
Benefits Paid	$2,575

Affordable rates per pay:

Deductions are taken post-tax

Employee	Employee & Spouse	Employee & Child(ren)	Family
$7.41	$10.26	$13.60	$16.45

Click here to watch a short video on how Accident Insurance benefits you and your family.

See Certificate of Insurance under the Library tab on the bswift website.

Hospital Indemnity Insurance

Hospital Indemnity Insurance pays cash benefits directly to you for covered hospital stays.

Some trips to the hospital are planned, like having a baby or a scheduled procedure, but sometimes they are totally unexpected. And hospital stays are expensive: The average cost of a 3-day hospital stay is around $30,000. Hospital Indemnity coverage could help to pay for expenses of a hospitalization as brief as 20 hours.

Did you know that:

- Hospital Indemnity provides coverage for injuries and illnesses, including pregnancy
- No pre-existing condition limitations
- Coverage is guaranteed, no medical questions asked.
- Hospital Indemnity rates are not based on age or smoker status.
- Includes a $100 Health Maintenance Screening benefit per insured

How it works:

Ellen was ready to deliver boy number three and just that fast, two surprises. A healthy girl, and a C-section baby at that. The admission benefit was $1,500 and four days in the hospital added an extra $400. The money meant that her spouse could take time off for their growing family. And they would have money left over for newborn expenses.

Benefit example:

Policy Benefits	
Hospital Admission	$1,500/year
Daily Hospital Confinement	$100/day
CCU* Admission	$500/year
Daily CCU Confinement	$100/day
Health Maintenance Screening per insured	$100/year

*Critical Care Unit

Keep in mind:

- Critical Care Unit Benefits are paid in addition to Hospital Benefits.
- Coverage is portable at the same rates.
- There is no termination age for employees or spouses.
- Admitted or Admission means: A stay at a hospital or Critical Care Unit for at least 20 consecutive hours for examination by a Physician for diagnosis or treatment of a loss.

Affordable rates per pay:

Deductions are taken post-tax

Employee	Employee & Spouse	Employee & Child(ren)	Family
$7.99	$13.82	$11.21	$19.98

Click here to watch a short video on how Hospital Indemnity Insurance benefits you and your family.

See Certificate of Insurance under the Library tab on the bswift website.

Critical Illness Insurance

Critical Illness Insurance pays benefits directly to you for covered illnesses and treatments.

You may have medical insurance, but that doesn't mean you're covered for all of the expenses resulting from a serious illness that you probably haven't budgeted for — things like copays, loss of income, childcare, and travel expenses. Do you have enough in savings to cover the expenses from a Critical Illness?

Do you know:

- The policy pays you a lump sum benefit upon diagnosis.
- You can cover yourself and your spouse with no health questions to enroll.
- You can elect up to $30,000 of coverage (rates are based on your age and tobacco status).
- Your children under age 26 are automatically covered at 50% of your benefit amount.
- Includes a $100 Health Maintenance Screening benefit

Here's how it works:

Robin learned that she had breast cancer, and upon her diagnosis, the policy paid a lump sum benefit of $10,000. Relieved of the financial worry, she could focus on getting well. The extra money would come in handy, and Robin could decide how she wanted to spend it. Medical expenses, alternative treatments, or that trip that she always dreamed of.

Rates for a $10,000 non-tobacco policy:

Age Range at Issue	Rates per Pay
18-29	$1.95
30-39	$2.90
40-49	$4.80
50-59	$7.55
60-69	$12.25
70-99	$20.65

Keep in Mind:

- Covered Conditions
  - Heart attack, Stroke, Cancer, Paralysis, Advanced MS, ALS
  - Major organ failure, End-stage renal failure, Coma
  - Advanced Alzheimer's, Bone Marrow transplant, more
- 21 additional covered children's diseases
- Pays a 100% additional occurrence benefit if you are diagnosed with another covered condition after the first one
- Pays a 50% re-occurrence benefit if you have the same diagnosis at least 6 months after the initial diagnosis and have been treatment free
- Future purchases are based on your age when you buy your first Critical Illness policy — consider a starter policy to lock in your rate this year
- Deductions are taken post-tax

Click here to watch a short video on how Critical Illness Insurance benefits you and your family.

See Certificate of Insurance under the Library tab on the bswift website.

Flexible Spending Accounts (FSAs)

Flexible Spending Accounts (FSAs) allow you to set aside pre-tax dollars for healthcare and/or dependent child daycare expenses. You must enroll each year in order to participate in an FSA.

FSA Contributions

When you elect an FSA, you contribute a portion of your salary to pay for healthcare or dependent child day care expenses that you will have to pay for "out-of-pocket." The amount you defer to an FSA will automatically be deducted from your pre-tax earnings per paycheck. FSAs allow you to save money as your contributions reduce your taxable income.

Healthcare Flexible Spending Account (HC FSA)

FSA funds may only be used to pay for "out-of-pocket" medical, dental, vision, and prescription drug expenses at any time without federal tax liability or penalty. **For the 2024-2025 plan year, you may contribute a minimum of $120 or up to a maximum of $3,200 (annually) to your HC FSA.**

Dependent Care Flexible Spending Account (DC FSA)

The Dependent Care Flexible Spending Account can be used to pay day care expenses for your eligible dependents. Your eligible dependents are any individuals under age 13 and those not able to care for themselves because of a physical or mental disability that you claim as dependents on your federal income tax return.

Dependent care expenses must be incurred to enable you (and your spouse if married) to work or look for work. Work may include actively looking for work but does not include unpaid volunteer work, or volunteer work for a nominal salary. Your spouse is considered to have worked if he or she is a full-time student for at least five calendar months during the tax year, or if he or she is physically or mentally incapable of self-care.

Expenses you pay for dependent care while you are off work due to illness are not eligible for reimbursement.

DC FSAs cannot be used to pay for care provided by your spouse or anyone claimed by you as a dependent. Care providers must be licensed.

The maximum annual amount that you may contribute to the DC FSA is:

$5,000 if single, or married, filing jointly
$2,500 if married, filing separately

Click here to watch a short video on understanding Flexible Spending Account Benefits

Mallows Bay

Life and AD&D Coverage—Prepare for the Unthinkable

Basic Term Life and Accidental Death & Dismemberment (AD&D) Insurance

CCG provides The Hartford Basic Term Life insurance and Accidental Death & Dismemberment (AD&D) insurance to all benefit eligible employees. The coverage is automatic and the premiums are 100% employer paid.

	Full-Time Employees
Benefit Schedule	**1.5x Annual Earnings rounded to the nearest $1,000**
Maximum Benefit	$250,000
Guarantee Issue	Full Benefit
AD&D Benefit	Matches Life Benefit
Employer Contribution	100%

Supplemental Employee Term Life Insurance

You can purchase Supplemental Term Life Insurance coverage for yourself and your family. Consider the cost of funeral expenses, legal expenses, and general living expenses for your surviving family members when choosing an appropriate amount of additional coverage.

Insurance coverage over $400,000 requires Evidence of Insurability.

	Employee	Spouse	Child
Benefit Schedule	1x, 2x, 3x Annual Earnings	Flat $20,000	Flat $10,000
Maximum Benefit	$500,000	n/a	n/a
Minimum Benefit	$10,000	n/a	n/a
Age Reduction Schedule	To 65% at age 70 To 50% at age 75	None	n/a
Employer Contribution	0%	0%	0%

Unum Whole Life Insurance with Long-Term Care

An innovative plan that provides Life Insurance with built-in Long-Term Care benefits.

Just starting out? Growing your family? Thinking about retirement? This policy can be an important part of your overall financial wellness. It provides a life insurance benefit and could be used to pay for long-term care expenses. It eliminates the possibility of paying for coverage you may never use. That's why these hybrid policies have become so popular.

Did you know that:

- Most people outlive their employer-paid life insurance and need coverage for retirement.
- You can lock in rates that will not increase with age.
- Coverage for yourself, your spouse, or both of you is affordable.
- Inexpensive coverage for kids is available too!

Here's how it works:

- You can choose the benefit amount that you want: as little as $10,000, up to $200,000. This is referred to as the face amount or death benefit.
- If you leave employment or retire, you can take the policy with you — the cost will not increase and the benefits will not decrease, guaranteed.
- There is a second part of the policy, the Cash Value, that builds over time. It gives you many options that your group term benefit does not provide.
- Because of the Cash Value, you have three options whether you have the policy as an employee or you decide to keep the policy if you leave employment and pay Unum directly (at the same rates):
    - Keep the policy. As long as you pay the premiums, and the policy is in force, your beneficiary will receive the death benefit.
    - Cancel your life insurance and receive a check for the Cash Value.
    - Choose a Reduced Paid-Up policy (payments stop, but the policy doesn't). Simply notify Unum to do this. Unum will use your Cash Value to buy a new policy for a smaller death benefit, but there will be no more premiums due (because it is "Paid Up").

Click here To see a video that explains the difference between this policy and the CCG group term plan.

See Certificate of Insurance under the Library tab on the bswift website.

Please schedule an appointment with a Decision Support Specialist or send an email to service@boltonusa.com if you have additional questions on the Whole Life Insurance plan or need assistance enrolling.

Continue reading on the next page to learn about the Long-Term Care benefits.

Educate Yourself About the Need for Long-Term Care

If you are like most people, you know a relative, neighbor, or friend who needed Long-Term Care (LTC). LTC is for people who are challenged to take care of themselves: eating, dressing, bathing… Studies show that seven in ten Americans over the age of 65 will need it at some point.[1] That's why the Unum plan automatically includes LTC benefits.

An Example:

Carol worked in the county for 30 years. After several years of retirement her health declined — so she entered an Assisted Living facility. It was not inexpensive, $3,000 a month, but she had planned ahead. The Unum policy would cover $1,800 of the cost — not the entire expense, but a good portion. And after the policy paid $30,000 of her LTC expenses, since she had elected the Restoration Rider* at enrollment, she still had the initial benefit to cover final expenses, and a little more.	$1,800 LTC Benefit paid for 16.67 months	$30,000
	Face Amount of Life Insurance Remaining	$30,000
	Total Value of Whole Life Policy Benefits	$60,000

*The Restoration Rider is an option available at the time of policy purchase. The rider replaces up to 100% of the face amount if the policy is used for LTC benefits. This rider is only available for issue ages of 15 to 60.

Please note:

- LTC benefits are available with the loss of two or more "activities of daily living" (ADLs).
- The ADLs are bathing, dressing, eating, continence, toileting, transferring, and severe cognitive impairment.
- LTC benefits are payable after receiving 90 days of qualifying care.
- The monthly benefits:
  - 4% for Home Health Care and Adult Day Care (25 months)
  - 6% for LTC and Assisted Living facilities (16.67 months)
- If you take a loan against your policy, any debt will be deducted:
  - From the Death Benefit otherwise payable at death
  - Upon payment or application of the Surrender Value

See Certificate of Insurance under the Library tab on the bswift website.

Gilbert Run Park

[1] Long Term Care Planning - What is Long Term Care?, LTC Insurance Consultants (2021)

Long-Term Disability Insurance

CCG recognizes an injury or illness could strike at any time and leave you unable to work. To protect you and your family financially in the event of an injury or illness, CCG offers Long-Term Disability coverage through The Hartford Insurance Company. The coverage is automatic and the premiums are 100% employer paid.

Benefit Amount

This coverage pays a benefit in the event that you cannot work because of injury or illness. This benefit replaces a portion of your monthly income, providing funds directly to you. The monthly benefit is 60% of your insured pre-disability earnings, reduced by deductible income from other sources, and not to exceed a maximum monthly benefit of $5,000.

Pre-existing limitation provisions do apply to the Long-Term Disability plan. A pre-existing condition is defined as a mental or physical condition whether or not diagnosed or misdiagnosed:

- For which you've done or for which a reasonably prudent person would've done any of the following:
  - Consulted a physician or other licensed medical professional;
  - Received medical treatment, services, or advice;
  - Undergone diagnostic procedures, including self-administered procedures; and/or taken prescribed drugs or medications.
- Which, as a result of any medical examination, including routine examination, was discovered or suspected at any time during the 90-day period just before your insurance becomes effective.

You are not covered for a disability caused or contributed to by a pre-existing condition or medical or surgical treatment of a pre-existing condition unless, on the date you become disabled, you:

- Have been continuously insured under the Group Policy for 12 months; and
- Have been Actively at Work for at least one full day after the end of that 12 months.

Legal Services

Legal Resources is an employee benefit that provides high-quality legal services to its members, helping to lead lives free of major legal expenses. It provides you and your family with the peace of mind of knowing legal assistance is always just a call, click, or tap away. Members choose their own law firm from an experienced Law Firm and Attorney Network and contact them directly with unlimited usage when a legal need arises. The Legal Plan provides coverage for a wide range of personal legal matters, including:

- General Advice and Consultation
  - unlimited in-person or telephone advice and consultation for fully covered services
  - any legal matter where the attorney fees are not fully covered, you will receive an hour of consultation free and a 25% discount.
- Family Law
- Elder Law
- Criminal Matters
- Wills and Estate Planning
- Traffic Violations
- Civil Accidents
- Preparation and Review of Routine Legal Documents
- Real Estate
- Consumer Relations and Credit Protection
- Identity Theft

You Pay Per Paycheck: $8.00

24 post-tax times per year

Click here to see a video how Legal Resources benefit you and your family.

Additional Benefits–Because You Deserve More

2024-2025 Fiscal Year

Worker's Compensation

All employees are covered by Worker's Compensation under the Employee's Worker's Compensation Guidelines for injuries occurring while performing normal work duties. Central Services Division administers this program.

CareFirst Options Discount Program

Your CareFirst ID card entitles you to discounts on alternative therapies and health and wellness programs such as chiropractic, acupuncture, massage, yoga, Pilates, tai chi, qi gong, guided imagery, nutritional counseling, and fitness centers. Additionally, the program offers discounts on Weight Watchers® Online, Jenny Craig®, mail order contacts, laser vision correction, hearing aids, and eldercare referrals. Since this program is in addition to your medical plan, rather than a benefit, there are no claim forms, referrals, or paperwork to complete. We see this as a way for our members to tap into health and wellness practitioners at discounted rates. To find out more, visit **www.carefirst.com/options**. Additional discounts are also available through BlueCross BlueShield at **www.blue365deals.com**.

Retirement Plans

When is the best time to start saving for retirement? *Now.*
The sooner you begin planning for your retirement, the better!

Pension Plans
Charles County Pension Plan — 401(a)

The Charles County Pension Plan (the "Plan") is a defined benefit plan sponsored by the County Commissioners of Charles County.

Participation is mandatory for an employee hired on or after July 1, 1991.

Current participants may obtain additional information pertaining to your pension benefit online or via phone:

- Call Empower Retirement's toll-free telephone service at **877-778-2100**, to access your account 24 hours a day, 7 days a week.
- Visit **www.empowermyretirement.com**.

Sheriff's Office Retirement Plan — 401(a)

The Charles County Sheriff's Office Retirement Plan (the "Plan") is a defined benefits plan which is sponsored by the County Commissioners of Charles County. The Plan was established on July 1, 1973, to provide a measure of financial security for you and your family during retirement. Participation in the Plan is mandatory for all Sheriff's Office employees.

Current participants may obtain additional information and pertaining to your pension benefit at the following link:

- Charles County Sheriff's Office Retirement Plan: **www.mypensionbenefit.com/Default.aspx?co=charlespol**
- Contact HR **301-645-0585** for password assistance

Deferred Compensation

457(b) Retirement Plan

The 457(b) retirement plan is available to employees and can serve as a supplement to a traditional pension plan or other retirement plans. You determine the pre-tax/post-tax amount you want to contribute (up to the IRS maximum) and how it is to be invested.

How a 457(b) Works

Employees may enroll in the 457(b) plan through approved vendors. Contributions are made by payroll deduction on a pre-tax/post-tax basis. Contributions are called elective deferrals and may be excluded from the employee's taxable income. Personal contributions grow tax-deferred until retirement, when withdrawals are taxed as ordinary income. To participate in the 457(b) plan, please contact one of our approved vendors on the Contacts page.

Employee Assistance Program

We recognize you may experience issues that affect the quality of life at home or at work. The Employee Assistance Program (EAP) is available to you and your household family members 24 hours a day, seven days a week by calling **888-993-7650**. All calls are completely confidential and there is no cost to you for using the service. The professionals at the EAP will help by assessing, advising, and recommending options to help you or your family members deal with problems. In addition to unlimited phone counseling, you're eligible for six free face-to-face counseling sessions per incident per year.

The EAP Can Help with Many Issues Including:

- Conflicts at work
- Financial or legal problems
- Depression, grief, stress, or anxiety
- Marital or family concerns
- Eldercare
- Drug and alcohol dependency
- And more!

Program Benefits Include:

- Up to 6 FREE counseling sessions with an EAP professional for you and your household members
- FREE financial consultation & referrals
- FREE legal consultation & referrals
- FREE child care resources & referrals
- FREE eldercare resources & referrals
- FREE online Resource Library, with thousands of resources

For information about the EAP services, contact Deer Oaks EAP Services or see a Central Services Division Safety Officer.

Click here to see an overview on the Employer Assistance Program.

Questions?

Your Benefits Contacts

Benefit Plans	Contact	Phone	Website or email
bswift Online Enrollment	Bolton	240-232-8875	service@boltonusa.com
Medical, Vision and Dental	CareFirst	877-691-5856	www.carefirst.com
Dental	Delta Dental	800-932-0783	www.deltadental.com
The Standard Accident, Hospital Indemnity and Critical Illness	Bolton	240-232-8875	service@boltonusa.com
Basic & Supplemental Term Life Insurance	The Hartford	800-523-2233	bswift Library https://CharlesCounty.bswift.com
Flexible Spending Account	Benefit Resource	800-473-9595	www.benefitresource.com/
Unum Whole Life Changes	Unum	800-635-5597	www.unum.com/employees/benefits/life-insurance
Unum Whole Life Questions	Bolton	240-232-8875	service@boltonusa.com
Long-Term Disability	The Hartford	800-523-2233	bswift Library https://CharlesCounty.bswift.com
Legal Plan	Legal Resources	800-728-5768	lrm@legalresources.com
Pension SORP	Human Resources	301-645-0585	DHR@charlescountymd.gov
Pension	Empower for Non Public Safety, Paramedics and EMTs	877-778-2100	www.empowermyretirement.com
Deferred Compensation Plan	Empower	301-262-2919	bob.r@widmannfinancial.com
Deferred Compensation Plan	MetLife	540-429-4705	gmarsh@financialguide.com
Deferred Compensation Plan	Nationwide	410-274-9568	r.s.wamboldt@nationwide.com OR directly schedule at outlook.office365.com/owa/calendar/CharlesCountyMD@onyourside.onmicrosoft.com/bookings/
EAP	Deer Oaks	888-993-7650	members.deeroakseap.com Username/Password: ccg Registration code: 226038

Your Benefits Contacts

Nancy Bowling
BowlingN@charlescountymd.gov
301-885-2764

Kim Pelczar
pelczark@charlescountymd.gov
301-645-0563

Taneesha Swann
swannta@charlescountymd.gov
240-776-6705

Annual Notices

Charles County Government is required by applicable law to provide you with certain notices each year that inform you of your rights and our responsibilities with respect to the City's health plan (the "Plan"). Please carefully review the information contained below and share it with your covered dependents. We suggest you keep this information for future reference.

Medicare Part D–Creditable Coverage

Important Notice from CCG About Your Prescription Drug Coverage and Medicare

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

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

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

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

When Can You Join a Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current coverage will be affected. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will not be eligible to receive all of your current health and prescription drug benefits. If you drop your current coverage with CCG and enroll in Medicare prescription drug coverage, you may enroll back into the CCG Health Plan during the Open Enrollment period or if you experience a qualifying event. If you do decide to join a Medicare drug plan and drop your current CCG Health Plan coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with CCG and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

For further information contact the Human Resources Department.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through CCG changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program for personalized help
- Call **1-800-MEDICARE** (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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

HIPAA Notice of Availability of Privacy Practices

The CCG Health Plan (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. The Notice describes the legal obligations of the CCG group health plan (the "Plan") and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Among other things, the Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Human Resources.

HIPAA Notice of Special Enrollment

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Also, you may be entitled to special enrollment rights pursuant to the Children's Health Insurance Program Reauthorization Act of 2009 (the Act) if you or your dependents:

1. Lose coverage under a Medicaid or State Plan; or
2. Become eligible for group health premium assistance under a Medicaid plan or State Plan.

If a special enrollment right is provided pursuant to the Act, you may change your election consistent with such special enrollment right within 60 days as long as the election is made consistent with the special enrollment.

Waiver of Coverage

If you elect to waive coverage for yourself or your dependents (including your spouse), you acknowledge that you and your spouse and/or dependent child(ren) can only enroll later during an annual Open Enrollment period. An exception to this is if you and your spouse and/or dependent child(ren) are entitled to enroll in accordance with the "Special Enrollment Rights" described above.

To request special enrollment or obtain more information, contact Human Resources.

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

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

If you or your dependents are already enrolled in Medicaid or CHIP your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP, to see if your state has a premium assistance program, or for more information on special enrollment rights, contact the U.S. Department of Labor or the U.S. Department of Health and Human Services or the Employee Benefits Security Administration Centers for Medicare & Medicaid Services at **1-866-444-EBSA (3272), 1-877-267-2323,** Menu Option 4, Ext. 61565.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW (543-7669)** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

Women's Health & Cancer Rights Act (WHCRA)

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Contact Human Resources for more information.

Model Wellness Program Disclosure

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact HR and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

General Glossary of Terms

AD&D	Accidental Death & Dismemberment (AD&D) Insurance pays a benefit if you suffer certain types of injuries, such as the loss of a hand, foot, or eye as a result of an accident, or if you die as a result of an accident. AD&D coverage is automatically provided as part of your Basic Life Insurance.
Allowed Benefit	The fee an insurance company has negotiated with a provider to charge for covered services. Payment for covered services is based on this negotiated amount.
Annual Benefits Election Period	A period during the year when your employer allows you to elect new benefits or make changes to your current benefits. Also referred to as Open Enrollment.
Basic Life Insurance	The group term life insurance provided at no cost to full-time and part-time employees working at least 25 hours per week.
Beneficiary	A person(s) or an entity (such as an association or organization) that you name to receive your life and AD&D insurance benefits if you die while covered; or to receive your vested account balances in your Retirement and Savings Program if you should die.
Coordination of Benefits (COB)	A provision of the insurance industry, which limits benefits if you are covered under multiple insurance plans. Benefits are limited to 100% of covered expenses. The order in which insurance companies are paid is also designated by this provision.
Calendar Year	The period spanning from January 1 to December 31 of each year.
Coinsurance	A fixed percentage of medical or dental costs that you are required to pay for covered services under your insurance policy. This applies if you use out-of-network providers. Coinsurance is not the same as, and does not include, copay.
Co-payment (Copay)	The amount you pay when you use in-network providers or purchase prescription drugs.
Covered Expenses	Charges that are paid in part, or in full, by the plan.
Deductible	The amount you must pay in covered health care expenses before the plan begins to pay a percentage of your costs. Applies only when using out-of-network providers with the Advantage plan.
Dependent	The definition of a "dependent" will vary according to each plan. Dependents under the medical, dental, vision, or health flexible spending plan are: 1) an employee's lawful spouse; or 2) an employee's child who a) has not yet reached age 26, b) in the case of a minor, is a member of the employee's household unless the employee has been court or administratively ordered to provide insurance coverage. Dependent requirements are different for life insurance, the dependent flexible spending plan, and health savings account. Please contact Human Resources for details.
Flexible Spending Account	A Flexible Spending Account (FSA) allows you to set aside pre-tax dollars for unreimbursed medical, prescription, vision, and dental expenses, and dependent care costs.
Generic Drug	A drug that may be sold under more than one name, by more than one company.
Guaranteed Issue	A provision that allows you to purchase insurance coverage regardless of the health of you and/or your spouse.
In-Network Benefits	Benefits that are paid at a higher level when you use network participating providers.

Medical Evidence of Insurability	If you do not purchase life insurance, long-term disability insurance, or long-term care insurance when it is first offered, or within 30 days of your date of eligibility, you may need to complete a health questionnaire in order to be approved for the plan, thus providing evidence that you are insurable. The insurance company will review your health information and determine whether or not they will provide coverage to you.
Non-Reimbursed Expenses	Services you have paid for, and that are not reimbursable by your insurance company; for example, copays, deductibles, charges in excess of the reasonable and customary or the allowed benefit, or other charges not covered by your insurance company.
Open Enrollment	See "Annual Benefits Election Period."
Out-of-Network Benefits	Benefits that are paid at a lower level when you use out-of-network providers.
Plan Year	The period spanning from the beginning of the benefit plan year to the end of the benefit plan year. Currently for CCG this is from July 1 to June 30 of the following year.
Preferred Provider	A provider who has contracted with your insurance company to be paid directly for covered services, and who will accept the allowed benefit as a payment in full. Also referred to as a participating provider, or an in-network provider.
Prescription Drugs	Allergy serums, biologicals, prescription drugs, and injectable insulin that are approved by your insurance company, or that by law must be dispensed with a prescription.
Primary Care Provider (PCP)	In an HMO plan, you must choose a network provider from a directory of providers, as your Primary Care Provider (PCP).
Provider	A person or facility who provides medical or dental services to you or your dependents. This can include doctors, nurse practitioners, physician's assistants, hospitals, labs, and other ancillary services, and health care providers.
Qualifying Event	An occurrence that entitles a person to select or change benefits outside of a defined "Open Enrollment" period. Events could include but are not limited to termination of employment, death of a covered person, marriage, divorce, birth, adoption, Medicare eligibility, a dependent child's loss of dependent status, or commencement of or return from an unpaid leave of absence.

Human Resources
301-645-0585
200 Baltimore St.
La Plata, MD 20646