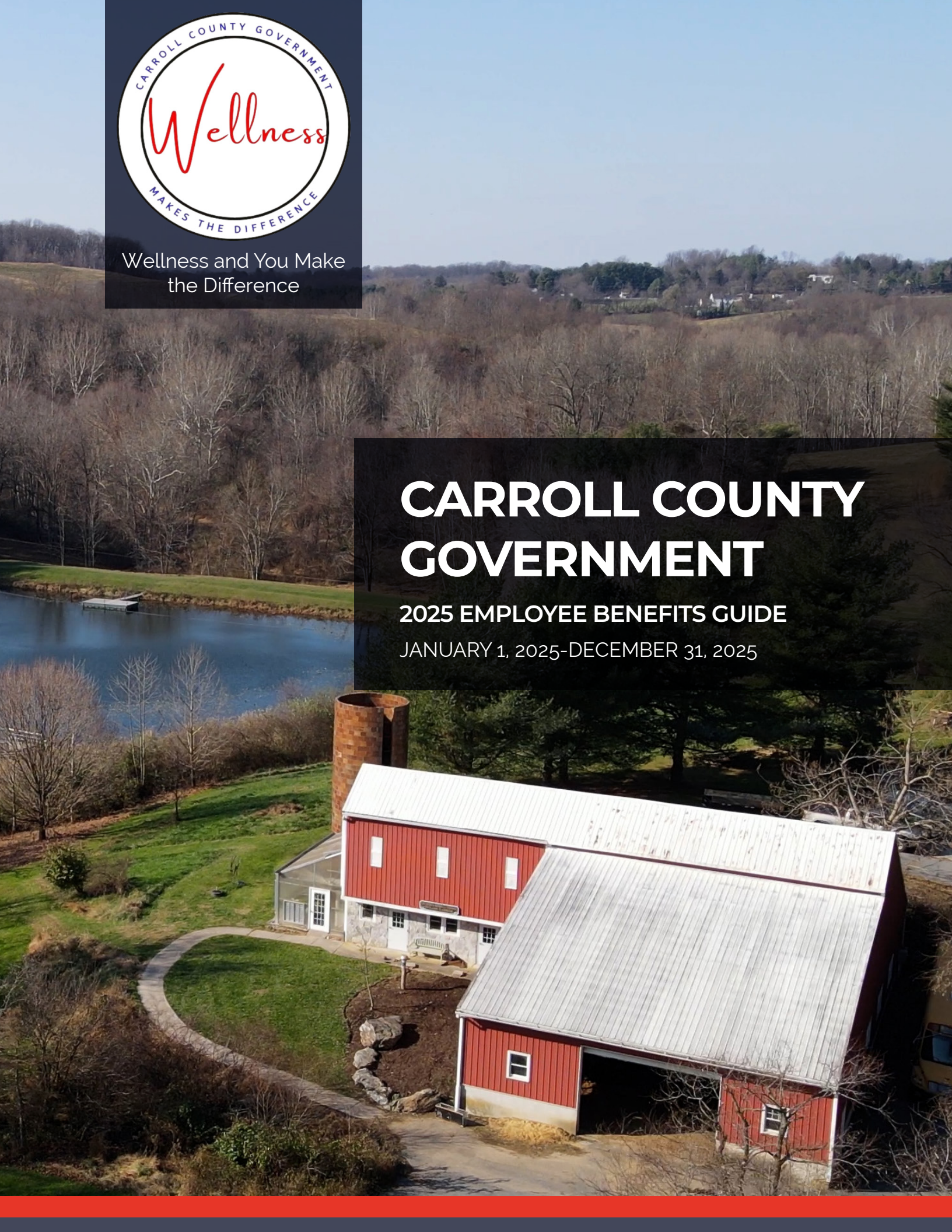

Wellness and You Make the Difference

CARROLL COUNTY GOVERNMENT

2025 EMPLOYEE BENEFITS GUIDE

JANUARY 1, 2025-DECEMBER 31, 2025

PICK THE BEST BENEFITS FOR YOU AND YOUR FAMILY.

Carroll County Government strives to provide you and your family with a comprehensive and valuable benefits package. We want to make sure you're getting the most out of our benefits—that's why we've put together this Benefits Guide.

This guide is a starting point for learning about the benefit plans available to you in 2025 and how to enroll or make changes to existing coverage. Every effort has been made to ensure the information in this guide is accurate; however, if there are any discrepancies the actual summary plan documents and contract for each plan will govern.

Open Enrollment is your annual opportunity to reassess which benefit plans you and your family will need in the new year. We encourage you to participate in this year's Open Enrollment period: October 11 - November 15, 2024.

Elections you make during Open Enrollment will become effective on January 1, 2025. Please review the information in the guide carefully. You cannot make changes to your benefit elections until the next annual Open Enrollment period. The exception to this rule is if you experience a qualifying life event, including marriage, divorce, birth or adoption of child, change in dependent status or a gain or loss of coverage.

If you have questions about any of the benefits mentioned in this guide, please don't hesitate to reach out to Human Resources at 410-386-2129 or email **benefits@carrollcountymd.gov.**

WHAT'S INSIDE

What's New for 2025

Wellness and You Make the Difference

As of January 1, 2025, Carroll County Government has made a few changes and improvements to your benefits:

1. Preventive Care under both Medical Plan options will now be covered in-network at 100%, no cost to you. This includes annual physicals, immunizations, screenings and more. Refer to the UHC plan booklet for a complete list of eligible preventive services.
2. There are some changes to copays under the Medical and Rx plans. These changes help manage plan costs and keep premium increases low.
3. Prior Authorization will be required for GLP-1 weight loss drugs.
4. A new UHC Rewards program will be implemented 1/1/25. UHC Rewards is an integrated engagement platform that rewards healthy behaviors. You can earn up to $100 a year– see page 5 for more details.
5. The annual opt-out credit for employees that have other health insurance coverage will be a flat amount of $1,200. You must have other qualifying health coverage to be eligible for the opt-out credit. All employees that are eligible for the opt-out and submit the required paperwork will receive this amount.
6. VSP Vision coverage and rates will no longer be packaged with the Medical/Rx coverage. Therefore, you are not required to have Medical/Rx coverage to enroll in the VSP vision plan and have the option to elect Vision coverage only at a separate rate. If you currently have Medical/Rx/Vision, you will be automatically enrolled in the VSP vision plan at the Vision rates on page 9 unless you elect to waive Vision coverage on your Benefit Selections Form.

Eligibility and Enrollment

Who is Eligible for benefits?

If you're a full-time employee working 30 or more hours a week you're eligible to enroll in the benefits outlined in this guide. Full-time employees are eligible for family coverage for health, dental and vision as well as life insurance. Part-time employees working 24 hours or more per week are eligible for employee only health, dental and vision coverage. Eligible dependents are defined below.

- Spouse: a person to whom you are legally married
- Dependent Children: your biological, adopted, or legal dependents up to age 26 regardless of student, financial, and marital status.

To enroll a dependent in the plan you must provide a copy of their social security card, marriage certificate (spouse), birth certificate (child), legal documents (if applicable) and complete the 2025 Carroll County Government Benefit Selections Form.

Coverage Effective Date

When newly hired into a benefit eligible position you will have 30 days from your hire date to choose your plans for the remainder of the calendar year in which you were hired. If you are hired on the 1st through the 15th of the calendar month, benefits are effective on the first day of the following month. If you are hired on the 16th through the last day of the calendar month, benefits are effective on the first day of the second calendar month.

Example: Hired May 5th - benefits begin June 1st; Hired May 18th - benefits begin July 1st.

Eligibility for health benefits coverage will terminate at the end of the month in which eligibility ends, except for adult children who turn age 26 during the plan year. Their coverage will end on December 31 of the year they turn 26.

When to Enroll

Open Enrollment

New Hires: Review the benefits guide and make your benefit selections within 30 days of your date of hire!

The first step is to review your current benefits. Once you have reviewed your current benefits, it's time to make your benefit elections. Open enrollment begins October 11 and runs through November 15, 2024. The benefits you choose during Open Enrollment will be effective on January 1, 2025. Remember, if you have not returned a Benefit Selections Form by November 15, all current 2024 benefit selections will be automatically renewed for calendar year 2025 EXCEPT your Health and Dependent Care Flexible Spending Account (FSA). The Flexible Spending Accounts administered by FBA must be renewed each year you wish to participate (see page 12).

Making Changes

The benefit plan year runs January 1- December 31. You will not be allowed to make changes to your elections during the plan year unless you experience a life-changing qualifying event. Qualifying events include things like:

- Marriage, divorce, or legal separation
- Birth or adoption of a child
- Change in child's dependent status
- Death of a spouse, child, or other qualified dependent
- Change in employment status or a change in coverage under another employer-sponsored plan

You must notify the Human Resources Department within 30 days of the change-in-status event in order to make a change to your benefit elections. Documentation supporting the change will be required. **If you wish to change any of your benefit selections for 2025, you must complete all parts of the 2025 benefit selection form – front and back!**

Opt-Out Credit

Carroll County Government provides an opt-out credit in the form of a taxable payment to full-time employees who waive health coverage. The annual Opt-Out Credit amount for 2025 will be $1,200. The Opt-out credit is paid out over each pay period. New-hires that elect the opt-out receive a pro-rated amount based on hire date.

To receive the Medical Opt-Out Credit you must certify you have other qualifying health care coverage by completing the Medical Insurance Opt-Out Credit Form (Waiver Agreement) and elect to waive Medical insurance on your Benefit Selections Form. The forms must be submitted by the open enrollment deadline every year when requesting the Medical Opt-Out Credit. Contact HR at benefits@carrollcountymd.gov or 410-386-2129 to request for these forms.

Medical/Rx Insurance - UnitedHealthcare and OptumRx

Carroll County Government offers you a choice of two medical plans through UnitedHealthcare (UHC) with OptumRx. The UHC Choice Plan provides coverage for In-Network providers only and the UHC Choice Plus Plan provides coverage for both In and Out-of-Network providers.

Preventive Services

Both medical plan options now cover eligible in-network Preventive Services at 100%, no cost to you. Preventive services include annual routine examinations, well-childcare visits, immunizations, routine OB/GYN visits, mammograms, PAP tests, prostate screenings, birth control, and other services as required by the Affordable Care Act. These preventive services are covered in full when you visit a participating, in-network provider.

Telehealth - Quality Care Done Virtually (Included in both Medical Plan Options)

With virtual care through your United Healthcare plan, you can get care any time. Whether you need to see a primary care provider or get urgent care on the same day, you can do it all from your phone, tablet, or computer. Simply use your smartphone or any connected device to access virtual primary, specialist, behavioral and urgent care. To schedule a virtual primary care appointment or access urgent care through 24/7 Virtual Visits, just download the United Healthcare® app or visit myuhc.com/virtual care.

What kind of virtual care might be right for you?...

24/7 Virtual Visits:

- Non-emergency care for common health issues like the flu, fevers, sore throats, etc.
- Non-emergency care for sudden health issues like pinkeye, migraines, back pain, even allergies and anxiety
- Prescription refills, if needed
- Cost aligns with 24/7 Telehealth benefit

Virtual Primary Care:

- Annual wellness visits
- Regular follow-ups for conditions like asthma, diabetes, etc.
- Lab testings and preventative screenings
- Referrals to quality network specialists
- Medication review and prescriptions, if needed
- Cost aligns with PCP benefit

Virtual Specialist Care:

- Quality virtual specialists to help create a personalized care plan
- Eliminate the inconvenience of travel and waiting rooms
- Care for conditions such as back and joint pain, dermatology, Migraine care, sleep conditions, and speech therapy
- Cost aligns with Specialist benefit

Virtual Behavior Care*:

- Virtual therapy offers confidential counseling services
- Private video sessions at the time and place that works for you
- Virtual therapist can provide a diagnosis, treatment and medication if needed
- Cost aligns with Mental Health Services benefit

For non-emergent, same-day care, connect with a certified care provider through 24/7 Virtual Visits. Care is available at all hours, every day – and medications, if needed, may be prescribed.*
* Certain prescriptions may not be available, and other restrictions may apply

Access 24/7 Virtual Visits on myuhc.com or the UnitedHealthcare app. Click on the provider group you would like to choose -AmWell, (download their app), Doctor on Demand (download their app) or Teladoc (integrated on myuhc.com - no need to download their app) and schedule or begin a visit.

Scan the QR code to access your virtual care options.

Members can contact the provider groups via these toll-free numbers if they have issues connecting:

Doctor on Demand	AmWell	Teladoc
800-997-6196	855-635-1393	800-835-2362

You can also access Specialists or Behavioral Health Providers at myuhc.com/virtual care.

UHC Rewards

UnitedHealthcare Rewards is included in your health plan at no additional cost.

With UHC Rewards, a variety of actions — including things you may already be doing, like tracking your steps or sleep — lead to rewards. You can earn up to $100 a year! The activities you choose are up to you, and your earnings can be put onto a digital Visa® gift card.

Here are just a few of the ways you can earn:
- Connect a tracker
- Take a health survey
- Get an annual checkup
- Get a biometric screening

Start earning on January 1, 2025. Just download the UnitedHealthcare® app,
- Sign in or register.
- Select UHC Rewards
- Activate UHC Rewards and start earning

Medical/Rx Plan Highlights

The chart below highlights your costs and copays for some of the features of your medical plan options. Remember, if you enroll in the Choice Plus plan and choose to seek care from an out-of-network provider, you may be subject to higher out-of-pocket expenses and balance billing by that provider. You are not required to select a Primary Care Physician (PCP) or obtain a referral for specialist care under either plan. For full plan details, please refer to your UHC plan summaries.

Plan Name	UHC Choice Plan	UHC Choice Plus Plan	
Provider Network	**EPO**	**PPO**	
In-Network / Out-of-Network	**IN**	**IN**	**OUT**
Annual Deductible			
Individual	None	None	$200
Family	None	None	$400
Annual Out-of-Pocket Maximum			
Individual	$1,500	$1,500	$2,000
Family	$3,000	$3,000	$4,000
Coinsurance (Member Pays)	-	-	20%
Office Visits	**Copay**	**Copay**	**Coinsurance**
Preventive Care	No Charge	No Charge	20%
Primary Care Physician (PCP)	$15	$25	20%
Specialist (SPC)	$25	$35	20%
Virtual Care (Telehealth)	$15	$25	20%
Diagnostic Tests (Lab & X-rays)	No Charge	No Charge	20%
Imaging (MRI, CAT, PET)	No Charge	No Charge	20%
Hospital Services	**Copay**	**Copay**	**Coinsurance**
Outpatient	No Charge	No Charge	20%
Inpatient	No Charge	No Charge	20%
Emergency Room	$100	$100	
Urgent Care	$25	$35	
Prescription Drug			
Retail (30-day supply)			
Tier 1	$10	$10	
Tier 2	$20	$20	
Tier 3	$30	$30	
Mail Order (90-day supply)			
Tier 1	$20	$20	
Tier 2	$40	$40	
Tier 3	$60	$60	
Specialty Drugs (30-day supply)			
Tier 1	$50	$50	
Tier 2	$75	$75	
Tier 3	$100	$100	

Deductible is the amount you pay before your insurance starts covering costs.

Out-of-pocket maximum is the maximum amount you pay for covered services in a year, including deductibles, copays, and coinsurance. Once you reach your out-of-pocket maximum, your insurance pays 100% of covered services.

OptumRx our plan's pharmacy services manager is committed to helping you find cost-effective ways to get your medication(s). Generic medications usually have a lower co-pay than brand name. Ask your doctor if there is a generic alternative available. You may also search for lower-cost alternatives by logging in to **myuhc.com**. According to the FDA, a generic medication is the same as a brand-name in dosage, safety, strength, quality, the way it works, the way it is taken, and the way it should be used.

Additional Information Regarding Prescription Coverage

A prior authorization (PA) requires your doctor to tell OptumRx why you are taking a medication to determine if it will be covered under your pharmacy benefit. Some medications must be reviewed because they may:

- Only be approved or effective for safely treating specific conditions.
- Cost more than other medications used to treat the same or similar conditions.

On January 1st, your health plan will include prior authorization for glucagon-like peptide-1 (GLP-1) drugs that are prescribed for weight loss. The prior authorization is a process that will be used to ensure that patients are receiving the correct medication, that the medication is being used appropriately and to monitor side effects. To obtain prior authorization for GLP-1 drugs, patients should ensure that their request is submitted in accordance with our plan's guidelines and that they meet all requirements. After the request is submitted, UHC/OptumRx will review it and either approve or deny it.

STEP THERAPY requires you to try Step 1 drugs before Step 2 drugs can be covered. Step 1 drugs usually cost less and can be used to treat the same conditions as Step 2 drugs. If you already tried a Step 1 drug and it didn't meet your needs, or your doctor wants you to keep taking your Step 2 drug(s), your doctor will need to ask for a prior authorization (PA). If the PA is approved, you may continue to fill your prescription(s) as usual. If the PA is not approved, you will have to pay the full cost of the drug(s). In some situations, coverage for your original medication may be extended if you need extra time to review your options with your doctor. We encourage you to discuss your treatment and medication options with your doctor.

Home Delivery from OptumRx is safe, reliable and offers the following advantages:

- Cost savings. You may pay less for your medication with a 90-day supply through OptumRx for twice the retail copay.
- Convenience. Get free standard shipping.
- 24/7 access and reminders. Speak to a pharmacist any time, any day. Set up medication reminders.

If you need your medication right away, ask your doctor for a 1-month prescription to fill at a local pharmacy and a 3-month prescription you can use to set up home delivery. Choose home delivery by going online at myuhc.com and following the simple step-by-step instructions. You may also call the member phone number on the back of your plan ID card. It's helpful to have your plan ID card and medication bottle available. Your doctor can also send an electronic prescription to OptumRx by ePrescribe.

UnitedHealthcare						
	Choice			Choice Plus		
	2024 Per Pay	**2025 Per Pay**	**2025 Annual Cost**	2024 Per Pay	**2025 Per Pay**	**2025 Annual Cost**
Employee	$39.43	**$40.02**	**$1,040.52**	$60.72	**$64.88**	**$1,686.88**
Employee/ Child	$69.01	**$70.03**	**$1,820.78**	$106.24	**$113.54**	**$2,952.04**
Employee/ Spouse	$78.86	**$80.04**	**$2,081.04**	$121.44	**$129.76**	**$3,373.76**
Family	$108.44	**$110.05**	**$2,861.30**	$166.95	**$178.42**	**$4,638.92**

All costs shown are employee costs for Medical/Rx coverage.

Dental Insurance - Delta Dental

The County offers you a choice of two Dental Preferred Provider (PPO) plans through Delta Dental. A Basic Dental Plan and an Enhanced Dental Plan. The following chart outlines the Basic and the Enhanced dental plan options. The Delta Dental PPO program allows you the freedom to visit any licensed dentist, including a dentist from our Delta Dental Premier network. **However, you will pay the lowest amount for services when you visit a Delta Dental PPO dentist.**

DELTA DENTAL PPO PLANS	BASIC	ENHANCED
DIAGNOSTIC & PREVENTIVE (D&P) * Exams, cleanings, x-rays, and sealants. Two per calendar year.	100% **	100% **
BASIC SERVICES* Fillings, simple extractions, root canals, gum treatment, oral surgery	80% **	80% **
MAJOR SERVICES* Crowns, inlays, onlays, cast restorations, bridges, dentures, and implants.	50% **	50% **
DEDUCTIBLE per calendar year (Waived for Diagnostic & Preventive Services)	$50 per person $150 per family	$25 per person $75 per family
MAXIMUM per calendar year Diagnostic & Preventive (D&P) services are excluded from annual maximum when using a PPO/Premier dentist.	$1,500/person per calendar year	$2,000/person per calendar year
ORTHODONTIC BENEFITS	50% ** Dependent children to age 19	50% ** Adults and dependent children
ORTHODONTIC MAXIMUMS	$1,500 Lifetime	$3,000 Lifetime

*Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

**Reimbursement is based on PPO contracted fees for PPO dentist. Premier contracted fees for Premier dentist and Premier contracted fees for non-Delta Dental PPO dentist.

	BASIC PPO PLAN			ENHANCED PPO PLAN		
	2024 Per Pay	**2025 Per Pay**	**2025 Annual Cost**	2024 Per Pay	**2025 Per Pay**	**2025 Annual Cost**
Employee	$5.12	**$5.46**	**$141.96**	$8.82	**$9.39**	**$244.14**
Employee/ Child	$10.52	**$11.21**	**$291.46**	$18.68	**$19.91**	**$517.66**
Employee/ Spouse	$10.52	**$11.21**	**$291.46**	$18.68	**$19.91**	**$517.66**
Family	$15.98	**$17.03**	**$442.78**	$28.27	**$30.13**	**$783.38**

All costs shown are employee costs for Dental coverage.

Vision Insurance - VSP

The County offers vision coverage through VSP. As a Vision Service Plan (VSP) member, you'll get access to savings and personalized vision care from a VSP network doctor for you and your family. An annual eye exam not only helps you see well, but helps a doctor detect signs of eye conditions and health conditions, like diabetes and high blood pressure.

The following chart outlines the coverage available under the County Vision plan when you use a VSP provider:

VSP Choice		
Benefit	**Description Coverage with VSP Provider – VSP CHOICE**	**Copay**
WellVision Exam	Focuses on your eyes and overall wellness. Frequency - Every 12 months	**$10**
Essential Medical Eye Care	Retinal Screening for members with diabetes.	**$0**
	Additional exams & services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. (Coordination with your medical coverage may apply. Ask your VSP doctor for details.)	**$20 per exam**
Prescription Glasses		**$10**
Frame	$150 frame allowance $170 featured frame brands allowance 20% savings on the amount over your allowance $150 Walmart/Sam's Club frame allowance $80 Costco frame allowance Frequency - Every 12 months	**Included in Prescription Glasses copay**
Lenses	Single vision, lined bifocal, and lined trifocal lenses Impact-resistant lenses for dependent children Frequency – Every 12 months	**Included in Prescription Glasses copay**
Lens Enhancements	Standard progressive lenses Premium progressive lenses Custom progressive lenses Average savings of 30% on other lens enhancements	**$0** **$95-$105** **$150-$175**
Contacts (Instead of glasses)	$130 allowance for contacts; copay does not apply Contact lens exam (fitting and evaluation) Frequency - Every 12 months	**Up to $60**
EXTRA SAVINGS	**Routine Retinal Screening** - No more than a $39 copay as an enhancement to a WellVision Exam. **Laser Vision Correction** - Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities.	

VSP Vision Plan Costs	2025 Per Pay	2025 Annual Cost
Employee	$0.53	$13.78
Employee/Child	$0.93	$24.18
Employee/Spouse	$1.06	$27.56
Family	$1.46	$37.96

All costs shown are employee costs for Vision coverage.

Life, AD&D, and LTD Insurance - The Standard

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

Life insurance helps protect your family from financial risk and sudden loss of income in the event of your death. Accidental Death and Dismemberment (AD&D) insurance provides an additional benefit if you lose your life, sight, hearing, speech, or limbs in an accident. Life and AD&D Insurance is provided through The Standard.

Carroll County Government provides full-time employees with Basic Group Term Life insurance equal to one times annual earnings to a maximum of $250,000. The Basic life insurance plan automatically includes AD&D coverage, which provides protection and additional benefits in the event of your death or dismemberment due to a covered accident. If you die as a result of an accident, the AD&D benefit will be equal to your basic life benefit amount. For other covered losses, a percentage of the AD&D benefit will be payable. Under the policy, insurance coverage reduces by 35% at age 65, 50% at age 70, and 75% at age 75.

Carroll County Government pays 100% of the premium for Basic Life and Accidental Death and Dismemberment insurance.

Additional Life Insurance

You may purchase additional life insurance for yourself, your spouse, and/or your dependent children through The Standard. Participation is voluntary, and premiums are paid by you. Consider whether the Basic Life insurance benefit would be enough to help your family meet daily expenses, maintain their standard of living, pay off debt and fund your children's education. If not, you may want to apply for additional coverage now. To enroll your spouse or children for additional life insurance they must not be full-time member(s) of the armed forces, insured by more than one employee or insured as an individual and a dependent under this Carroll County Government policy.

With additional life insurance, you are responsible for paying the full cost of coverage through bi-weekly payroll deductions. You can purchase coverage for yourself in increments of one, two, or three times your annual salary up to $500,000. Spouse coverage is available in increments of $5,000 to a maximum of $50,000, but not to exceed 50% of your combined Basic and Additional life coverage. Under this policy, insurance coverage reduces by 35% at age 65, 50% at age 70, and 75% at age 75. Coverage will be subject to medical underwriting approval. The chart below outlines the monthly costs of purchasing additional coverage for yourself and your dependents.

Monthly Rate per $1,000 of Employee and Spouse Life Insurance Coverage												
Age	<30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80+
Rate/$1,000	$0.06	$0.08	$0.09	$0.10	$0.15	$0.24	$0.45	$0.69	$1.33	$2.16	$3.51	$6.16
Children	$5,000 in coverage for an annual cost of $2.40, no matter how many children you cover. Eligible children are unmarried, not a member of the armed forces and are covered until the end of the year they turn 26.											

Please refer to the Benefits Selection form for help with calculating your Annual Additional Life Insurance benefit cost.

Death Benefit

The beneficiary of any employee with at least one year of full-time County service will receive prompt payment of one month's salary upon the death of the employee, to assist in the payment of immediate expenses related to death.

Long-Term Disability (LTD)

The County provides eligible full-time employees a Long-Term Disability (LTD) plan. The County pays 100% of the premium. Long-Term Disability is meant to provide protection for more significant disabilities that cause you to be out of work for longer than 180 days. The Plan pays a benefit of 60 % of monthly pay up to a maximum monthly benefit of $7,500. Benefits are paid monthly. The benefit duration is based on your age at the time of disability. Refer to The Standard Booklet Certificate for complete plan provisions, limitations and exclusions.

Short-Term Disability (STD)

Short Term Disability (STD) coverage provides partial salary replacement (approximately 75%) to eligible employees who are unable to work due to a non-work-related accident, injury, or illness. Benefits begin after a 7-day waiting period from the date determined as the date of disability, and after all accrued leave has been exhausted. Employees will accrue weekly benefit eligibility but cannot receive STD benefits until after the first six months of employment.

Flexible Spending Accounts - Flexible Benefits Administrators (FBA)

Flexible Spending Accounts (FSAs) allow you to reduce your taxable income by setting aside pre-tax dollars from each paycheck to pay for eligible out-of-pocket health care and dependent care expenses for you and your family. There are two types of FSAs: Health Care FSA and Dependent Care FSA. You can elect one or both of these accounts. The FSAs are administered by Flexible Benefit Administrators (FBA).

All employees who participate in a Flexible Spending Account will receive a Debit Card they can use to pay for qualified expenses. You may also pay up front for expenses and get reimbursed at **fba.wealthcareportal.com**. Remember to keep your receipts, as you may need to verify your debit card purchases for the IRS.

IMPORTANT! You must re-enroll if you want to participate in the FSAs for 2025. Once you have enrolled, you cannot change your election during the plan year, unless you have a qualifying life event.

Health Care FSA

With this account, you can pay for your out-of-pocket healthcare expenses for yourself, your spouse and all your tax dependents for healthcare services that are incurred during the 2025 Plan Year and while an active participant. Eligible expenses are those incurred for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for affecting any structure or function of the body.

The Healthcare account is a pre-funded account. This means you can submit a claim for medical expenses on the first day of the Plan Year and you will be reimbursed your total claim amount up to your annual election. The funds that you are pre-funded will be recovered as deductions taken from your paycheck on a pre-tax basis.

- **Contribution Limits:** The maximum you may place in this account for the 2025 Plan Year is $3,200.

- **Forfeiting Funds:** Plan carefully! Unused funds will be forfeited as governed by the IRS's "use-it-or-lose-it" rule. The County has elected to continue the $640 roll-over provision to the Healthcare FSA.

- **Benefits Card:** Your benefits debit card gives you access to the funds in the tax-advantaged benefits accounts by swiping the card at the point of sale. The card can be used at any qualified service provider that accepts Mastercard. Funds are automatically transferred from the benefit account directly to the qualified providers with no out-of-pocket cost and no need to file a claim for reimbursement.

Dependent Care FSA

Dependent Care Reimbursement. This account allows you to pay for day care expenses for your dependents with tax-free dollars. The Dependent Care FSA is NOT a Pre-Funded Account! This means that you will only be reimbursed up to your account balance at the time you submit your claim. If your claim is for more than your account balance, the unreimbursed portion of your claim will be tracked by Flexible Benefit Administrators, Inc. You will be automatically reimbursed as additional deductions are deposited into your account.

- **Contribution Limits:** The annual maximum contribution may not exceed: $5,000 ($2,500 if married filing separately).

- **Eligible Dependents** are defined as:
  - A child under age 13 who qualifies as a dependent on your Federal Income Taxes
  - Any other dependents, including a disabled spouse, disabled children over age 13 and elderly parents, who depend on you for financial support, qualify as dependents for tax purposes, and are incapable of self-care

- **Forfeiting Funds:** Plan carefully! Unused funds will be forfeited as governed by the IRS's "use-it-or-lose-it" rule. There is not a rollover provision to the Dependent Care FSA.

How to Enroll in Our FSA Plan:

1. Carefully estimate your eligible Healthcare and Day Care/Aged Adult Care expenses for the upcoming Plan Year. Then use our online FSA Educational Tools located at **https://fba.wealthcareportal.com/** to help you determine your total expenses for the Plan Year.

2. Complete your enrollment on the benefit selection form during the enrollment period, which instructs payroll to deduct a certain amount of money for your expenses. This amount will be contributed on a pre-tax basis from your paychecks to your FSA. Remember the amount you elect will be set aside before any Federal, State, and FICA taxes are calculated.

Employee Assistance Program (EAP) - BHS

To support a healthy and productive workplace, Carroll County Government offers an integrated employee assistance program that connects you to solutions designed to improve your life, boost your productivity, and transform your work-life experience. Carroll County Government's EAP services through BHS provides free, confidential, in-the-moment support to help with personal or professional problems that may interfere with work or family responsibilities. Employees and their household members have unlimited telephonic access to EAP and work-life services and up to six face-to-face (or virtual) EAP counseling sessions per person, per issue, per year. An EAP session or visit is defined as a 45-50 minute, in-person counseling (individual/couple or family) session.

Call 800-327-2251 for direct, 24/7 access to a BHS Care Coordinator, who will confidentially answer your call, understand your need, assist with any emergencies, and connect you to the appropriate resources. They will then follow up with you to ensure your satisfaction and progress.

Text 800-327-2251 to ask a question about the program, get in-the-moment support (routine needs only) or initiate services. All texts will be answered within one (1) business day*. To start a conversation, simply send a text and use one of the following hashtags: #BEBETTER to connect with a master's level Care Coordinator #WORKLIFE to connect with a Work-Life Resources specialist

*Text users must be 18 or older. Not available for CA residents. Text Services are not intended for emergencies or urgent issues – please call 9-1-1 or 800-327-2251 for immediate help.

Online Portal: BHSonline.com Username: CARROLL
The MyBHS Portal provides access to services, contains information about your program and offers unlimited access to more than 500,000 tools, resources & trainings on a variety of well-being and skill-building topics. Live Chat connects you with an available BHS Care Coordinator to answer questions, provide in-the-moment support or to initiate services. Or, fill out the Service Request Form and a BHS Care Coordinator will respond within one (1) business day.

What Types of Issues Does an EAP Address?

- **Relationships:** Spouse/Children; Customers, Boss/Co-worker; Friends
- **Transitions:** Marriage/Divorce; Promotions/Retirement; Birth/Death; Health/Illness
- **Risks:** Depression/Anxiety; Burnout/Anger; Suicidal Thoughts; Substance Abuse
- **Challenges:** Stress/Conflict; Parenting/Balance; Financial/Legal; Daily Responsibilities

Work-Life Solutions

Childcare: BHS provides up-to-date, carefully screened, national resources and referrals for a range of childcare needs including Adoption & Special Needs; Before and After School Programs; Family Daycare and Group Homes; Nanny and Au Pair Services; Nurseries and Preschools; Summer Camps.

Eldercare: BHS provides up-to-date, national resources and referrals for a range of eldercare needs including Home-Based Services: Nutrition, Meals on Wheels, Cleaning & Repair; Housing: Retirement Communities, Subsidized Housing; In-Home Care: Medical & Nursing Rehabilitation Services. Inpatient Services: Nursing Homes, Intermediate Care Facilities, Respite Care & Assisted Living Facilities; Older Adult Services

Legal: When faced with a legal matter, simply contact BHS and you will be connected to an attorney with expertise specific to your needs. Legal benefits under the program include Free 30-minute consultations; In office or telephonic with local plan providers; Each consultation must be over a new legal topic; 25% off the attorney's hourly rate when an hourly rate is quoted for services beyond consultation.

Financial: You and your household members can access unlimited telephonic financial counseling, information, and education from BHS' team of highly-training financial counselors. Typical financial matter includes Budgeting; College Funding; Credit Counseling; Debt Management & Consolidation; Retirement funding.

Resources

Coverage	Contact	Phone Number	Website/Email
Medical/Rx	United HealthCare	1-866-844-4864	myuhc.com or UnitedHealthcare app
Telehealth	United HealthCare Virtual Care	1-866-844-4864	myuhc.com/virtualcare or UnitedHealthcare app
Dental	Delta Dental	1-800-932-0783	www.deltadentalins.com
Vision	Vision Service Plan (VSP)	1-800-877-7195	www.vsp.com
Flexible Spending Accounts (FSAs)	Flexible Benefit Administrators (FBA)	1-800-437-3539	fba.wealthcareportal.com
Life/AD&D	The Standard	1-800-628-8600	www.standard.com
Long-Term Disability (LTD)	The Standard	1-800-368-1135	www.standard.com
Short-Term Disability (STD)	Department of Human Resources	410-386-2129	benefits@carrollcountymd.gov
Employee Assistance Program (EAP)	BHS	1-800-327-2251	portal.BHSonline.com
Benefits Office	Department of Human Resources	410-386-2129	benefits@carrollcountymd.gov

Frequently Asked Questions (FAQ)

Q: When will I receive my insurance cards?
A:

- Your United Healthcare/OptumRx card will arrive 7-10 business days after your effective date. You may access an electronic version of your card on your effective date by creating an online account at **www.myuhc.com.**
- You do not receive a card for your vision benefit, simply indicate to your provider that VSP is your insurance carrier. You may create an online account at **www.vsp.com** using your personal information to find a provider.
- Delta Dental doesn't send cards to our employees. To access a paper card, you will need to create an online account at www.deltadentalins.com. Your member number is your social security number, our group number is 3283, and our coverage is with Delta Dental of Pennsylvania.

Q: Can I add my domestic partner as a dependent?
A: No, the only type of partner that can be accepted is your legal spouse.

Q: My child is turning 26 this month, do I need to remove them?
A: Dependent Children may stay on your insurance plan through the end of the year in which they turn 26. (December 31st). They will receive a COBRA letter notifying them of their upcoming loss of coverage.

Q: Can I opt out of the medical insurance but still purchase dental and/or vision?
A: Yes!

Q: How can I see who is in-network?
A:

- For medical providers, go to **myuhc.com**
- For dental providers, go to **deltadentalins.com**
- For vision providers, go to **vsp.com**

Q: Is this a Whole life or Term life insurance policy?
A: Term. Your life insurance will terminate the day you terminate from employment with Carroll County Government. If you leave employment or retire you may be able to keep the life insurance by purchasing through Standard directly, but it will cost more than what you pay while you are employed.

Q: How can I update my beneficiaries?
A: Email the benefits team at **benefits@carrollcountymd.gov** for blank beneficiary forms & a copy of who you currently have designated.

Required Important Notices
Women's Health And Cancer Rights Act Of 1998

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator at 410-386-2129.

Medicare Part D

Important Notice from Carroll County Government 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 Carroll County Government and about your options under Medicare's prescription drug coverage. This information can help you decide whether 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. Carroll County Government has determined that the prescription drug coverage offered by the Carroll County Government is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When can you join a Medicare drug plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What happens to your current coverage if you decide to join a Medicare drug plan?

If you are a Medicare-eligible active employee and decide to join a Medicare drug plan, your current coverage with Carroll County Government will not be affected. You can keep this coverage if you join a Medicare drug plan and this plan will coordinate with your Medicare drug coverage. 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 still be eligible to receive all of your current health and prescription drug benefits. If you do decide to join a Medicare drug plan and drop your medical and prescription drug coverage through Carroll County Government, be aware that you and your dependents will not be able to get this coverage back until the next open enrollment period as long as you remain an active employee.

If you are a Medicare-eligible retiree, and drop your current Carroll County Government coverage, be aware that you and your dependents will not be able to get this coverage back and will have to find coverage elsewhere.

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 Carroll County Government and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For more information about this notice or your current prescription drug coverage…

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 Carroll County Government 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 (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **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).

- Name of Entity/Sender: Carroll County Government
- Contact-Position/Office: Department of Human Resources
- Address: 225 North Center Street Westminster, MD 21157
- Phone Number: 410-386-2129

HIPAA Privacy Notice - Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of Health and Claims records:

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct Health and Claims records:

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request Confidential Communications:

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share:

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information:

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice: You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you:

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated:

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive. We can use your health information and share it with professionals who are treating you. Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization:
We can use and disclose your information to run our organization and contact you when necessary. We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans. Example: We use health information about you to develop better services for you.

Pay for your health services:
We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan:
We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues. We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do Research: We can use or share your information for health research.

Comply with the law: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director:

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests. We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Notice of Cobra Continuation Coverage Rights

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

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

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

What is cobra continuation coverage?

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

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

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

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

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

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

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

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

When is cobra continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is cobra continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.
COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

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

- Disability extension of 18-month period of COBRA continuation coverage: If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.
- Second qualifying event extension of 18-month period of continuation coverage: If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides cobra continuation coverage?

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

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

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

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

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

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit **https://www.medicare.gov/medicare-and-you**.

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

Keep your plan informed of address changes:

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

Plan Contact Information:
Lisa Huber
Health Benefits Coordinator
Carroll County Government
225 North Center Street
Westminster, Maryland 21157
(410) 386-2129

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility.

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ **Phone:** 1-855-692-5447	**The AK Health Insurance Premium Payment Program** **Website:** http://myakhipp.com/ **Phone:** 1-866-251-4861 **Email:** CustomerService@MyAKHIPP.com **Medicaid Eligibility:** https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ **Phone:** 1-855-MyARHIPP (855-692-7447)	**Health Insurance Premium Payment (HIPP) Program Website:** http://dhcs.ca.gov/hipp **Phone:** 916-445-8322; **Fax:** 916-440-5676; **Email:** hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ **Health First Colorado Member Contact Center:** 1-800-221-3943/State Relay 711 **CHP+**: https://hcpf.colorado.gov/child-health-plan-plus **CHP+ Customer Service:** 1-800-359-1991/State Relay 711 **Health Insurance Buy-In Program (HIBI):** https://www.mycohibi.com/ **HIBI Customer Service:** 1-855-692-6442	**Website:** https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html **Phone:** 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp **Phone:** 678-564-1162, Press 1 **GA CHIPRA Website:** https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra **Phone:** 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 **Website:** http://www.in.gov/fssa/hip/ **Phone:** 1-877-438-4479 All other Medicaid **Website:** https://www.in.gov/medicaid/; **Phone:** 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members; **Medicaid Phone:** 1-800-338-8366 **Hawki Website:** http://dhs.iowa.gov/Hawki; **Hawki Phone:** 1-800-257-8563 **HIPP Website:** https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp **HIPP Phone:** 1-888-346-9562	**Website:** https://www.kancare.ks.gov/ **Phone:** 1-800-792-4884 **HIPP Phone:** 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx **Phone:** 1-855-459-6328; **Email:** KIHIPP.PROGRAM@ky.gov **KCHIP Website:** https://kidshealth.ky.gov/Pages/index.aspx **Phone:** 1-877-524-4718 **Kentucky Medicaid Website:** https://chfs.ky.gov/agencies/dms	**Website:** www.medicaid.la.gov or www.ldh.la.gov/lahipp **Phone:** 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US **Phone:** 1-800-442-6003; TTY: Maine relay 711 **Private Health Insurance Premium Webpage:** https://www.maine.gov/dhhs/ofi/applications-forms **Phone:** 1-800-977-6740; TTY: Maine relay 711	**Website:** https://www.mass.gov/masshealth/pa **Phone:** 1-800-862-4840; TTY: 711 **Email:** masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp **Phone:** 1-800-657-3739	**Website:** http://www.dss.mo.gov/mhd/participants/pages/hipp.htm **Phone:** 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP **Phone:** 1-800-694-3084; **Email:** HHSHIPPProgram@mt.gov	**Website:** http://www.ACCESSNebraska.ne.gov **Phone:** 1-855-632-7633; **Lincoln**: 402-473-7000; **Omaha:** 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov **Medicaid Phone:** 1-800-992-0900	**Website:** https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program **Phone:** 603-271-5218; Toll free number for the HIPP program: 1-800-852-3345, ext. 5218

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

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

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

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

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