# Frederick County Public Schools

## 2017 – 2018 Benefits Information


**Benefits Information July 1, 2017**

**FCPS Benefits Office**
191 South East Street, 2nd Floor
T (301) 644-5080, F (301) 644-5122
Visit http://www.fcps.org/benefits for more information

# Benefits Information: July 1, 2017 – June 30, 2018

## *WHAT's NEW?*

## FCPS Plan Changes Effective July 1, 2017

### Preventive Lab Screenings

As of 7/1/16, adult preventative exams were covered at 100% when using an in-network provider and 80% after deductible when using an out-of-network provider. As of 7/1/17, preventive lab screenings will also be covered at 100% when using an in-network provider. As of 7/1/17, adult women preventive exams which require 3D mammography preventive screening will be covered at 100% when using an in-network provider.

### Physical Therapy Copay

Short-term outpatient physical therapy copay will be covered at 100% (no office visit copay). Prior authorization is required to determine that treatment is resulting in a reasonable expectation of further improvement.

### Gender Dysphoria

Gender dysphoria will be covered. The benefits will depend upon where the covered health service is provided. Prior authorization is required for certain services.

### Prescription Changes

As of 7/1/2017, Nicotine prescription for tobacco cessation will be covered with a $0 copay when using a formulary prescription. Preauthorization may be required for certain prescriptions.

### Autism Applied Behavior Analysis (ABA)

Applied Behavior Analytics for Autism Spectrum Disorders will be covered as an outpatient health benefit. Coverage for an in-network provider is 100% after a $20 copayment per session and for an out-of-network provider is 80% after deductible per session. Prior authorization is required for services.

### Vision Benefits

As of July 1, 2017, Vision Benefits will cover lens options for standard, deluxe, premium progressives and standard anti-reflective coating. (see the vision plan summary section on page 4.)

Frames and Contact lens maximums have been increased to $150 (see the vision plan summary section on page 4.)

### Real Appeal – Weight Loss Program

Real Appeal is a simple, step-by-step program that helps you lose weight without turning your life upside down. The program includes a personalized weight loss coach to customize the program to fit your needs, preferences and goals. The program includes your very own Success Kit with items such as a personal blender, food scale, pedometer, and exercise DVD's. Staying accountable has never been easier as it will include ongoing weekly analysis, feedback, goal reporting and much more. To participate you must meet specific criteria. It's free for you to enroll and participate. Watch for additional news about the program in the coming weeks.

### "Grandfathered Status"

Frederick County Public Schools (FCPS) has elected to be a "grandfathered health plan" under the Patient Protection and Affordable Care Act. As permitted by the Affordable Care Act, a "grandfathered health plan" can preserve certain basic health coverage that was already in effect when the law was enacted. As a "grandfathered health plan," FCPS is not subject to certain consumer protections of the Affordable Care Act that may apply to other plans.

### Summary of Benefits and Coverage

To comply with the Patient Protection and Affordable Care Act (the Affordable Care Act), Frederick County Public Schools provides a Summary of Benefits and Coverage ("SBC"). The SBC can be found at the school system's website, www.fcps.org/benefits and paper copies are available upon request. The SBC is intended to be educational in nature. Complete details can be found in the insurance companies' documents and the plan's legal documents, which will always govern in case of a dispute.

**NOTE:**

***The premium rates and benefits included in this material are contingent upon final contract negotiations with FCTA, FASSE, FCASA and final adoption of the Board of Education's Fiscal Year 2018 budget.***

# *JULY 1, 2017 – JUNE 30, 2018*
# FREDERICK COUNTY PUBLIC SCHOOLS
# EMPLOYEE BENEFITS AND INSURANCE SUMMARY

| ***INFORMATION ABOUT INSURANCE:*** • ***MEDICAL*** • ***PRESCRIPTION*** • ***DENTAL*** | **FY18 PAYROLL DEDUCTIONS – EACH PAY PERIOD*** | | | |
|---|---|---|---|---|
| | **HEALTH INSURANCE** UnitedHealthcare Medical, UnitedHealthcare Vision, CVS CareMark Prescription** | | | **EMPLOYER'S CONTRIBUTION (How much FCPS pays on your behalf)** |
| | **10-Month Employees** | **11-Month Employees** | **12-Month Employees** | **Employer Annual Contribution** |
| Employee Only | $20.89 | $18.99 | $17.41 | $7,886.40 |
| Employee + **One** Dependent*** | $157.36 | $143.06 | $131.14 | $14,939.60 |
| Employee + Family**** | $208.02 | $189.11 | $173.35 | $14,939.60 |
| Employees + Family**** (both parents employed by FCPS) | $42.97 | $39.06 | $35.81 | $18,240.60 |

| | **DENTAL INSURANCE** *Standard* Delta Dental $1,000 Maximum Benefit Per Covered Person** | | | **DENTAL INSURANCE** *Buy Up* Delta Dental $2,000 Maximum Benefit Per Covered Person** | | |
|---|---|---|---|---|---|---|
| | **10-Month Employees** | **11-Month Employees** | **12-Month Employees** | **10-Month Employees** | **11-Month Employees** | **12-Month Employees** |
| Employee Only | **Paid 100% by FCPS ($345.84/year)** | **Paid 100% by FCPS ($345.84/year)** | **Paid 100% by FCPS ($345.84/year)** | $6.49 | $5.90 | $5.41 |
| Employee + **One** Dependent*** | $36.32 | $33.02 | $30.27 | $56.45 | $51.32 | $47.05 |
| Employee + Family**** | $42.04 | $38.21 | $35.03 | $64.30 | $58.45 | $53.58 |
| Employees + Family**** (both parents employed by FCPS) | $24.75 | $22.50 | $20.63 | $47.02 | $42.74 | $39.18 |

*Payroll deductions are contingent upon final contract negotiations with FCTA, FASSE and FCASA and final adoption of the Board of Education's Fiscal Year 2018 budget.

**Contributions for medical and dental insurance coverage are deducted from your gross earnings before taxes are calculated.

***In this context, "Employee + One Dependent" would refer to employee + spouse or employee + dependent.

****In this context, "Family" refers to two or more dependents.

This publication is intended to provide an overview of FCPS benefits; complete details can be found in the insurance companies' documents and the plans' legal documents, which will always govern in case of a dispute. The Board of Education of Frederick County, FCTA, FASSE and FCASA jointly reserve the right at any time to modify or amend, in whole or in part, any or all plan provisions.

# Summary of Benefits Plans

## UnitedHealthCare Choice Plus Medical Plan

UnitedHealthcare Choice Plus allows you to take advantage of two levels of care benefits:

- ***In-network*** — Selecting a physician or health care provider within the UnitedHealthcare's large local and national network means maximum coverage and lower out-of-pocket expenses. Copayments are charged for eligible services, and referrals are not required for specialty services.
- ***Out-of-network*** — Higher deductibles are required and you must file claims for reimbursement of 80% of eligible expenses. Employees have a $200 deductible and an annual out-of-pocket maximum of $1,250. Family coverage requires a $400 deductible and an annual out-of-pocket maximum of $2,500.

### *BENEFITS HIGHLIGHTS*

| IN NETWORK | | OUT OF NETWORK |
|---|---|---|
| ***CO-PAYMENTS:*** | | ***CO-INSURANCE:*** 20% after deductible |
| Primary Care Physician | $20.00 | ***DEDUCTIBLE:*** |
| Specialist | $30.00 | $200 per Covered Person |
| Outpatient Diagnostic Services | $20.00 | $400 for all Covered Persons in a family |
| Inpatient Hospital | $100.00 | ***MAXIMUM OUT-OF-POCKET:*** |
| Emergency Room (Non-Emergency) | $75.00 | $1,250 per Covered Person per policy year |
| ***DEDUCTIBLE:*** None | | $2,500 for all Covered Persons in a family |
| ***MAXIMUM OUT-OF-POCKET:*** No Out-of-Pocket Maximum | | Out-of-Pocket Maximum includes the Annual Deductible |

## UnitedHealthCare Vision Plan

The UnitedHealthcare Vision Plan offers vision benefits every 12 months.

I**n-Network –** Exam & Standard lenses paid in full

Covered lens options now include:

- Standard anti-reflective,
- Standard, deluxe and premium progressives
- Adult frame allowance $150.00

Child under age 19 frame allowance 100% coverage to $150, then tiered copay structure

- Elective Contact Lens Allowance for Adults is $150, Formulary contacts remain covered in full
- **Out-of-network –** Adults are reimbursed according to a fee schedule for exam, lenses and frames.
- Children under age 19 are reimbursed according to a coinsurance schedule for exam, lenses and frames.

## AxisPlus Flexible Spending Account Plan

AxisPlus offers health/dependent care spending accounts to pay for eligible expenses on a pre-tax basis.

- Participating employees will receive an AxisPlus debit card that looks like a credit card and is issued under the MasterCard system and is accepted at specific locations.
- Use the debit card to pay for copayments and other qualifying expenses, and there is no more need to file claims for reimbursement from the flexible spending accounts. **(It is very important to keep your receipts when using the debit card since you must submit receipts requested under IRS tax rules and regulations.)**
- A new card will be issued upon initial enrollment and at the expiration date shown on each card.
- Up to $500 of unused funds can be rolled over to the next plan year. (Dependent care is not eligible for roll over.)

# Summary of Benefits Plans – continued

## CVS Caremark Prescription Plan

Copayments for generic, preferred and non-preferred brand prescription drugs, per the following schedule:

| | 30-Day Supply – Retail *(Any Retail Pharmacy)* | 90-Day Mail Order or *90-Day CVS/Pharmacy (only)* |
|---|---|---|
| **Generics** | **$13** | **$21** |
| **Preferred brand prescription drugs** | **$25** | **$45** |
| **Non-preferred brand prescription drugs** | **$40** | **$65** |

- Maintenance Choice Program – plan participants who take maintenance medications have the choice to purchase their 90-day supply from the mail order program or purchase from a CVS/Pharmacy store and pay the same mail order copayment.
- Mandatory generics when available as well as mandatory specialty pharmacy program for specialty prescription drugs.
- Diabetic Meter Program – plan participants with diabetes may qualify for a free blood glucose meter when diabetic testing supplies are ordered through the mail order program.

## Delta Dental Plan

Dental coverage will be offered solely through Delta Dental, at three levels:

***Delta PPO —*** You receive in-network benefits with no deductible, no forms to file and lower copayments.
***Delta Premier —*** You are responsible for copayments and a deductible.
***Out-of-network —*** You have a deductible to satisfy and need to file claims for reimbursement.

Standard Plan: $1,000 maximum benefit per covered person
Buy Up Plan: $2,000 maximum benefit per covered person

To see the complete summary plan highlights and find additional plan information, go to http://www.fcps.org/staff/Benefits-Links-and-Forms1.cfm

# How to Update Your Benefits by Using Employee Self Service

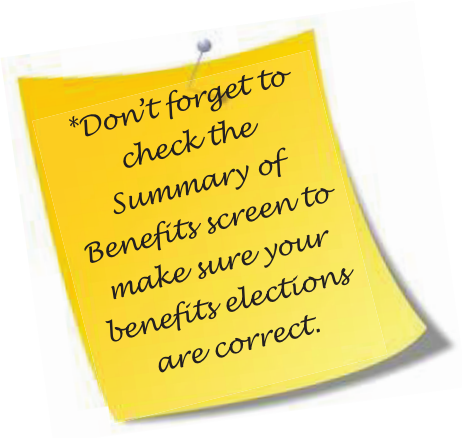
Open enrollment is fast and easy. Go to www.fcps.org and click on ***For Staff*** **>** ***Employee Portal.*** Select ***Employee Self-Service*** then follow the directions below:

1. Log into ***Employee Self-Service.*** You will need to do this twice.
2. Click on ***Main Menu*** **>** ***FCPS Menu*** **>** ***Employee Self Service*** **>** ***Benefit Information*** **>** ***Medical/Dental Enrollment***
3. Under **Medical Coverage,** the button for coverage change will be selected.
4. Select your level of **Employee Coverage.**
5. To add dependents, click on **Add a Dependent** towards the bottom of the page.
6. Read the **"Attestation for Dependent Eligibility",** click **I Agree,** and click **OK** (be advised that we preform periodical audits to verify dependent eligibility and you may be required to provide documentation as follows: marriage certificate, 1040, or birth certificates as necessary).
7. Enter all of your dependent information and then click on **Save** at the bottom of the page.
8. Click **OK** on the confirmation page.
9. Click **Return** at the bottom of the page to return to the enrollment screen.
10. Repeat steps 5 – 9 until all of your dependents have been added.
11. View your dependents and under the **Medical Coverage** select their **Coverage Election.**
12. Under **Dental Coverage,** the button for coverage change will be selected.
13. There is an option to enroll in the **Dental Buy Up** plan. Check this box if you would like to enroll.
14. Select you **Employee Coverage.**
15. View your dependents and under the **Dental Coverage** select their **Coverage Election.**
16. Scroll down to the bottom of the page, click the box next to **Date Signed** and click **Save.**
17. Click **OK** on the confirmation page.
18. When your change request has been received, a confirmation email will be sent to your FCPS email account from **Benefits.Systems@fcps.org.**
19. Remember to securely exit by clicking **Sign Out** in the upper right-hand corner of your screen or click on the door icon.

## Eligibility for Dependents:

- The eligible employee's legal married spouse;
- Children from birth through the end of the month in which they attain the age of twenty six (26) including:
  - ❖ Biological children
  - ❖ Adopted children or children placed for adoption or Stepchildren
  - ❖ Legal ward children
  - ❖ Disabled dependent children over the age of twenty-six (26) (Proof of disability must be provided)

**Please note:** *The Plan performs random audits and reserves the right to request at any time documentation that substantiates the eligibility of an enrolled spouse and/or dependent child(ren). These documents include birth certificates, marriage certificates and 1040 tax records.*



## INSURANCE COMPANY CONTACT INFORMATION

| Plan/Contact | Address | | Phone & Website |
|---|---|---|---|
| **Health/Vision Insurance** | | | |
| UnitedHealthCare | Main Contact:<br>UnitedHealthcare<br>800 Oak Street<br>Frederick, MD 21703 | Claims Office:<br>P.O. Box 740800<br>Atlanta, GA 30374-0800 | Phone: 1-877-702-5116<br>www.myuhc.com |
| UnitedHealthCare Vision | P.O. Box 30978<br>Salt Lake City, UT 84130 | | Customer Service: 1-800-638-3120<br>Provider Locator: 1-800-839-3242<br>www.myuhcvision.com |
| **Dental Insurance** | | | |
| Delta Dental | One Delta Drive<br>Mechanicsburg, PA 17055 | | Phone: 1-800-932-0783<br>www.deltadentalins.com |
| **Flexible Spending Accounts** | | | |
| AxisPlus | 860 East 9085 South<br>Sandy, UT 84094 | | Phone: 1-877-872-2125<br>www.myaxisplus.com |
| **Prescription Plan** | | | |
| CVS/CareMark Claims Office | P.O. Box 52010<br>Phoenix, AZ 85072-2010 | | Phone: 1-866-260-4646<br>www.caremark.com |
| CVS/CareMark Mail Order | P.O. Box 94467<br>Palatine, IL 60094-4467 | | Fax: 1-800-323-0161 |

## FCPS BENEFITS OFFICE CONTACT INFORMATION

| Contact | Email | Phone Number |
|---|---|---|
| Benefits Office | benefits.office@fcps.org | 301-644-5080 |
| Penny Opalka | penny.opalka@fcps.org | 301-644-5112 |
| Phoebe Barreto | phoebe.barreto@fcps.org | 301-644-5085 |
| Molly Bentz | molly.bentz@fcps.org | 301-644-5093 |
| Doris Toms | doris.toms@fcps.org | 301-644-5052 |

**FOR BENEFITS INFORMATION AND FORMS YOU MAY USE THE FCPS WEBSITE**
*http://www.fcps.org/benefits*

**UNITEDHEALTHCARE SUMMARY PLAN DESCRIPTION and DELTA DENTAL INFORMATION SHEETS CAN BE FOUND AT**
*insidefcps*

The HIPAA Privacy Rules require health plans to provide a Notice of Privacy Practices to persons covered under the health plan. Eligible employees may obtain a copy of the Notice of Privacy Practices by visiting the school system's website: www.fcps.org. Go to Departments, Human Resources, Benefits Links & Forms, HIPAA Privacy Statement. Employees may also contact the school system's Benefits Office for a copy of the privacy practice notice.

Questions concerning the HIPAA Privacy Rules may be directed to: Frederick County Public Schools
Penny Opalka, Senior Manager, Benefits
191 South East Street, Frederick, MD 21701

# FCPS Cafeteria Plan At a Glance

AXISPLUS BENEFITS

One of the many benefits of being employed with Frederick County Public Schools (FCPS) is that you have access to a Cafeteria Plan established by FCPS. A Cafeteria Plan allows you to pay for out-of-pocket medical expenses. The major advantage of FCPS's Cafeteria Plan is that, by participating, you save money by paying for benefits you would normally pay for but you avoid having to pay Federal Income and Social Security taxes. If you do participate in the Cafeteria Plan you would not be eligible for a Federal income tax credit on your next tax return.

## FCPS's Plan Information

| | |
|---|---|
| **Plan Name:** | Frederick County Public Schools |
| **Address:** | 191 South East St. Frederick, MD 21701 |
| **Telephone:** | (301) 644-5112 |
| **Plan Number:** | 125 |
| **Plan Year Begin:** | July 1 |
| **Amended:** | N/A |
| **Plan Year End:** | June 30 |
| **Maximum Health FSA Limit:** | $2600 |
| **Maximum Dependent Care Limit:** | $5000 |
| **Annual Rollover Maximum:** | $500 |
| **Grace Period:** | No |
| **Run-out Period for Active Employees:** | 90 days Plan year ends (last day to submit claims is Sep. 28th) |
| **Run-out Period for Terminated Employees:** | 90 days after your termination date |
| **Plan Administrator:** | FCPS |
| **Service Provider:** | AxisPlus Benefits |
| **Service Provider Contact:** | Laura Fernelius |

### Elections

It is important for you to decide what benefits you will need for each Plan year. Your decision should be carefully made based on your expected health expenses for the coming year.

Unless a qualifying "change in status" event occurs, you will not be able to change your elections after the first month of the Plan year. To see a list of the qualifying "change in status" events please see your Summary Plan Description.

### Eligibility

Open enrollment will take place each year prior to the start of the Plan year. After the Plan year begins enrollment is limited to newly hired employees or those with special circumstances (see Summary Plan Document). For mid-year enrollments, participation will begin on the 1st of the month following hire date.

### Beginning and Ending of Coverage

The coverage will begin the first day of the Plan Year for those who enroll during the open enrollment period. For mid-year enrollments the coverage date will begin as set forth by FCPS (see eligibility). The coverage will end at the end of the month of the termination date, or at the end of any applicable run-out/carryover period. This plan is subject to COBRA (see the Summary Plan Description for more details).

### Benefits Available

The FCPS Cafeteria Plan offers the following benefits:

***Health Flexible Spending Account***

A Health Flexible Spending Account (FSA) allows you to get reimbursed for qualified medical expenses with pre-tax funds (see Section 213D and Section 105 of the Internal Revenue Code for list of eligible expenses. You cannot use your FSA for expenses that have been paid by your medical insurance plan.) The maximum annual election amount is $2600.

***Dependent Care Flexible Spending Account***

The Dependent Care Flexible Spending Account (DCAP) allows you to be reimbursed for qualified dependent day-care expenses with pre-tax funds. The maximum annual election amount is $5000 (married filing jointly or head of household) or $2500 (married filing separately). To be eligible for reimbursement you will need to provide a statement from the service provider with the following information: name, address, taxpayer identification number (in most cases), and incurred expense amount.

Please see the Summary Plan Description for dependent eligibility requirements.

### Reimbursement

Throughout the Plan year you can submit for reimbursement for qualified medical and dependent care expenses in the following ways: fax (forms available at myaxisplus. com), email, online, or mobile application. Employees may also pay for their qualified medical expenses directly from their FSA with the AxisPlus debit card. See the SPD for further details.

Expenses are "incurred" when the service has been provided. The reimbursement requirements will be listed on the reimbursement claim forms.

For Health FSA and DCAP accounts reimbursement claims must be submitted no later than 90 days after the end of the Plan Year. Any Health FSA funds exceeding $500 left over after the 90 day run-out period will be forfeited. See "Rollover" section below for additional details.

### Non Discrimination

Per compliance with the various rules and regulations of the Internal Revenue Code the election amounts of "highly compensated employees" and "key employees" (officers, shareholders or highly paid employees) may be limited due to non-discrimination regulations. For more information please see the Summary Plan Description.

### Family and Medical Leave Act (FMLA)

If you go on a qualifying FMLA Leave this plan will comply with the rules and regulations set forth in the proposed Regulation 1.125-3 as well as any additional policies established by FCPS. Please see the Summary Plan Description for more details.

### Rollover

Under the new IRS regulations, employees will be able to rollover up to $500 of their Health FSA funds from one Plan year to the next. The rollover funds will be available to employees for one additional year. Any amount rolled over will not affect the election amount for the new Plan year. Any funds above $500 left over after the 90 day run- out period will be forfeited.

## Flexible Spending Frequently Asked Questions

### What is a Flexible Spending Account (FSA)?

Flexible Spending is an employer sponsored program that allows you to set aside money pre-tax to use for certain IRS eligible expenses. The Medical FSA covers not only medical expenses, but also dental and vision services.

### How does an FSA work?

During the open enrollment period with your employer, you will make an election for the amount you want contributed to your FSA. That annual amount will be divided equally over your yearly pay schedule, and deductions will be made pre- tax from each pay check and deposited to that account. As you incur expenses, you will submit for reimbursement from your account, either with a paper claim or with the AXISPlus debit card.

### What are the advantages to having an FSA?

When you participate in the Flexible Spending program, your eligible expenses are paid for with tax-free money. Also, as the contributions are withheld from your paycheck pre-tax, it lowers your taxable income, meaning you pay less in taxes, and take more money home.

### What are considered eligible expenses?

There are 3 things to consider as you determine whether an expense is eligible for reimbursement from your Medical FSA – services, service dates, and eligible dependents.

**Services-** Eligible medical expense are defined by IRS Code §213(d) and must not be excluded by the plan documents. In order to qualify for reimbursement, the expense must diagnose, cure, mitigate, treat, or prevent disease, or affect a structure or function of the body. Expenses aimed at maintaining general health or improving a person's appearance (cosmetic procedures), are not considered eligible expenses.

**Service Dates-** In order to be eligible for reimbursement, services must be provided/incurred during the time that you are covered and active under the plan. The IRS is concerned with the actual date of service, not the date of payment.

**Eligible Dependents-** Coverage for a Medical FSA is extended to the employee, the employee's spouse, and the employee's child who is under age 26 or someone else who is a qualified tax dependent of the employee.

### When can I enroll?

You may enroll in the plan during your employer's open enrollment period prior to the start of the plan year. You may also enroll mid-year if you are a newly hired employee, or if you have a qualified Status Change Event as outlined in the Summary Plan Description.

### Can I make changes to my account mid-year?

Once you make your election during the enrollment period, it cannot be changed or cancelled during the plan year, it is irrevocable. Exceptions to the irrevocability rule are allowed mid-year with a qualified Status Change Event such as a marriage, divorce, birth, adoption, death, etc. The election changes must be consistent with the status change.

### What if my spouse has a Health Savings Account?

If your spouse is participating in a Health Savings Account (HSA), participation in this FSA may disqualify them from further contributions to that HSA.

### What happens to money left in the account at the end of the plan year?

Under new IRS regulations, employees are now able to rollover up to $500 of their Health FSA funds from one plan year into the next. This will allow participants an additional 12 months to spend the remaining balance. Funds that are rolled over will not affect election amounts for the new plan year. A Run-out period will still be applicable, allowing you time to submit reimbursement claims for expenses incurred prior to the end of the plan year. Rollover does not apply to the Dependent Care FSA.

### Do I have to wait for the money to be deposited before requesting reimbursement?

With a Medical FSA, you do not have to wait for the deposits to be made before requesting reimbursement. Your full annual election amount is available to you on the first day of the plan year.

### What information do I need for reimbursement?

In order to verify the eligibility of an expense, we need a third party statement indicating the provider's name and contact information, the patient, the date of service (not the date of payment), a description of services rendered, and your portion of the expense. You should also retain a copy of the statement for your records.

### How do I submit a reimbursement claim and when can I expect payment?

Reimbursement claims may be submitted electronically with the "Online Claims Entry" option on your account through www.myaxisplus.com. Reimbursements may also be submitted with a printed reimbursement claim form and sent to our office via email, fax or postal service. Reimbursement claims will be processed daily.

### Where can I find out my account information and balance?

As a participant, you will have access to a secure online account through www.myaxisplus.com. Here you will be able to view your account history and balance, submit reimbursement claims electronically, view eligible expenses lists, print various forms and documents, and much more. You will be provided the online registration information after enrollment.

## AXISPlus Debit Card

### What is the AXISPlus debit card?

The AXISPlus debit card is a MasterCard® debit card that offers you direct access to your FSA funds.

### How does it work?

You may swipe your AXISPlus card as you would any other debit card at a qualified medical merchant. The merchant must accept MasterCard® as a form of payment. The funds will be debited from your Flexible Spending Account and paid directly to the service provider.

### Where can I use it?

The use of the AXISPlus card is limited to providers with a qualified medical Merchant Category Code (MCC). These include doctor's offices, hospitals, pharmacies, dental offices, and vision clinics. The card will not be accepted at an ATM or for cash back on a purchase.

### What if I lose my card?

From your account on www.myaxisplus.com you have the capabilities to report your AXISPlus debit card as lost or stolen and to order a replacement card.

### Can I have additional cards?

All enrollees will automatically be issued one debit card at the start of participation in flexible spending. Any additional or replacement cards may be ordered through AxisPlus Benefits.

### Will I need to send in any paper work?

Under the IRS regulations, we are required to verify the eligibility of every expense, whether paid with a reimbursement claim or the AXISPlus debit card. There are various check-point systems in place to greatly reduce the amount of documentation you will be required to submit to our office as you use the debit card, but it does not eliminate the need for paper work entirely. The information requested will be the same as that of a reimbursement claim (see What information do I need for reimbursement? above).

For each card swipe, you will receive automatic email notifications. These notifications will inform you of the status of the transaction, and whether or not additional information/documentation is being requested.

### What happens if a card payment is ineligible?

If all or a portion of your AXISPlus debit card transaction is deemed ineligible, you will be required to pay back the ineligible amount to your Flex account. This can be done in a variety of ways and our staff will help you find the option best suited for you. Please be aware that while there is money due on your account, your debit card will be temporarily suspended until all transactions are either paid back or resolved.

# Legal Notices

## HIPAA Notice of Special Enrollment Rights

### LOSS OF OTHER COVERAGE

If you are declining enrollment for yourself and/or your dependents (including your spouse) because of other health insurance coverage or group health plan coverage, you may be able to enroll yourself and/or your dependents in this plan in the future, if you or your dependents lose eligibility for that other coverage or if the employer stops contributing towards your or your dependent's coverage. To be eligible for this special enrollment opportunity, you must request enrollment within 31 calendar days after your other coverage ends or after the employer stops contributing towards the other coverage.

### NEW DEPENDENT AS A RESULT OF MARRIAGE, BIRTH, ADOPTION OR PLACEMENT FOR ADOPTION

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/or your dependent(s). To be eligible for this special enrollment opportunity, you must request enrollment within 31 calendar days after the marriage and within 31 days after the birth, adoption or placement for adoption.

### TERMINATION OF MEDICAID OR SCHIP COVERAGE OR ELIGIBILITY FOR PREMIUM ASSISTANCE UNDER MEDICAID OR SCHIP

If you or your dependent is eligible, but not enrolled for coverage, you may be able to enroll yourself and/or your dependent if either of the following events occur:

- You or your dependent is covered under a Medicaid plan or under a State Child Health Insurance Plan (SCHIP) and coverage under the plan is terminated as a result of loss of eligibility; or
- You or your dependent become eligible for premium assistance under Medicaid or SCHIP. To be eligible for this special enrollment opportunity, you must request enrollment within 60 calendar days after the date you or your dependent become eligible for premium assistance or you or your dependent's Medicaid or SCHIP coverage ends.

## The Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act became effective January 1, 2010. The act prohibits health coverage discrimination and employment discrimination against employees based on their (or their family members') genetic information.

### GENETIC INFORMATION INCLUDES:

- Genetic tests;
- The request for, or receipt of, genetic counseling or other genetic services; and,
- The manifestation of a disease or disorder in an individual's family member.

The availability of genetic testing and results of any genetic testing you undergo will be treated as confidential, as required by HIPAA and GINA. Likewise, genetic information collected about family history – such as through a Health Risk Assessment (HRA) – will be treated as confidential, as required by HIPAA and GINA.

## Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother from discharging the mother or her newborn earlier than the 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization for the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

## Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act requires group health plans that provide coverage for mastectomies to cover reconstructive surgery and prostheses following mastectomies. All medical plans provide this coverage.

If you receive benefits for a medically necessary mastectomy, and if you elect breast reconstruction after the mastectomy, you will also be covered for:

- 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 all stages of mastectomy including lymphedema.

## Medicare Part D 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 through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription 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. FCPS has determined that the prescription drug coverage offered by the FCPS Plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

You can enroll in a Medicare prescription drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. Beneficiaries leaving employer coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. If you do decide to enroll in a Medicare prescription drug plan and drop your FCPS prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. Please contact Us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

*If you continue your coverage through the FCPS Retiree healthcare Plan Option, you will have prescription coverage included in your FCPS health plan that meets creditable coverage.*

You should also know that if you drop or lose your coverage with FCPS and do not enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later. If you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without coverage, your premium will always be at least 19% higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

## FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE:

Contact your Medicare Division office for further information. You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through FCPS changes. You may also request a copy.

## FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE:

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

## FOR MORE INFORMATION ABOUT MEDICARE PRESCRIPTION DRUG PLANS:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227) TTY 1-877-486-2048. For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at **www.socialsecurity.gov,** or you can call them at **1-800-772-1213 (TTY 1-800-325-0778).**

# FCPS Comprehensive Group Health Plan Benefit Communications

## Discrimination is Against the Law

FCPS complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Frederick County Public Schools does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

## Frederick County Public Schools

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact ***Penny Opalka, Senior Benefit Manager.***

If you believe that Frederick County Public Schools has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Senior Benefit Manager:

Penny Opalka, Senior Benefit Manager
191 S. East Street
Frederick, MD 21701
Phone: 301-644-5112
Fax: 301-644-5122
Email: penny.opalka@fcps.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Penny Opalka is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1–800–868–1019, 800–537–7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-301-644-5112.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-301-644-5112

# 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).**

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**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 January 31, 2016. Contact your State for more information on eligibility –**

| | |
|---|---|
| **ALABAMA –** Medicaid<br>Website: www.myalhipp.com<br>Phone: 1-855-692-5447 | **NEW JERSEY –** Medicaid and CHIP<br>Medicaid Website:<br>http://www.state.nj.us/humanservices/dmahs/clients/medicaid/<br>Medicaid Phone: 609-631-2392<br>CHIP Website: http://www.njfamilycare.org/index.html<br>CHIP Phone: 1-800-701-0710 |
| **ALASKA –** Medicaid<br>Website: http://health.hss.state.ak.us/dpa/programs/medicaid/<br>Phone (Outside of Anchorage): 1-888-318-8890<br>Phone (Anchorage): 907-269-6529 | **NEW YORK –** Medicaid<br>Website: http://www.nyhealth.gov/health_care/medicaid/<br>Phone: 1-800-541-2831 |
| **COLORADO –** Medicaid<br>Medicaid Website: http://www.colorado.gov/hcpf<br>Medicaid Customer Contact Center: 1-800-221-3943 | **NORTH CAROLINA –** Medicaid<br>Website: http://www.ncdhhs.gov/dma<br>Phone: 919-855-4100 |
| **FLORIDA –** Medicaid<br>Website: http://www.flmedicaidtplrecovery.com/hipp/<br>Phone: 1-877-357-3268 | **NORTH DAKOTA –** Medicaid<br>Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/<br>Phone: 1-844-854-4825 |
| **GEORGIA –** Medicaid<br>Website: http://dch.georgia.gov/medicaid<br>Click on Health Insurance Premium Payment (HIPP)<br>Phone: 404-656-4507 | **OKLAHOMA –** Medicaid and CHIP<br>Website: http://www.insureoklahoma.org<br>Phone: 1-888-365-3742 |
| **INDIANA –** Medicaid<br>Healthy Indiana Plan for low-income adults 19-64<br>Website: http://www.hip.in.gov<br>Phone: 1-877-438-4479<br>All other Medicaid<br>Website: http://www.indianamedicaid.com<br>Phone 1-800-403-0864 | **OREGON –** Medicaid<br>Website: http://www.oregonhealthykids.gov<br>http://www.hijossaludablesoregon.gov<br>Phone: 1-800-699-9075 |
| **IOWA –** Medicaid<br>Website: www.dhs.state.ia.us/hipp/<br>Phone: 1-888-346-9562 | **PENNSYLVANIA –** Medicaid<br>Website: http://www.dhs.pa.gov/hipp<br>Phone: 1-800-692-7462 |

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|---|---|
| **KANSAS –** Medicaid<br>Website: http://www.kdheks.gov/hcf/<br>Phone: 1-785-296-3512 | **RHODE ISLAND –** Medicaid<br>Website: www.eohhs.ri.gov<br>Phone: 401-462-5300 |
| **KENTUCKY –** Medicaid<br>Website: http://chfs.ky.gov/dms/default.htm<br>Phone: 1-800-635-2570 | **SOUTH CAROLINA –** Medicaid<br>Website: http://www.scdhhs.gov<br>Phone: 1-888-549-0820 |
| **LOUISIANA –** Medicaid<br>Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331<br>Phone: 1-888-695-2447 | **SOUTH DAKOTA –** Medicaid<br>Website: http://dss.sd.gov<br>Phone: 1-888-828-0059 |
| **MAINE –** Medicaid<br>Website:<br>http://www.maine.gov/dhhs/ofi/public-assistance/index.html<br>Phone: 1-800-442-6003<br>TTY: Maine relay 711 | **TEXAS –** Medicaid<br>Website: http://gethipptexas.com/<br>Phone: 1-800-440-0493 |
| **MASSACHUSETTS –** Medicaid and CHIP<br>Website: http://www.mass.gov/MassHealth<br>Phone: 1-800-462-1120 | **UTAH –** Medicaid and CHIP<br>Medicaid Website: http://health.utah.gov/medicaid<br>CHIP Website: http://health.utah.gov/chip<br>Phone: 1-877-543-7669 |
| **MINNESOTA –** Medicaid<br>Website: http://mn.gov/dhs/ma/<br>Phone: 1-800-657-3739 | **VERMONT–** Medicaid<br>Website: http://www.greenmountaincare.org/<br>Phone: 1-800-250-8427 |
| **MISSOURI –** Medicaid<br>Website:<br>http://www.dss.mo.gov/mhd/participants/pages/hipp.htm<br>Phone: 573-751-2005 | **VIRGINIA –** Medicaid and CHIP<br>Medicaid Website:<br>http://www.coverva.org/programs_premium_assistance.cfm<br>Medicaid Phone: 1-800-432-5924<br>CHIP Website:<br>http://www.coverva.org/programs_premium_assistance.cfm<br>CHIP Phone: 1-855-242-8282 |
| **MONTANA –** Medicaid<br>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP<br>Phone: 1-800-694-3084 | **WASHINGTON –** Medicaid<br>Website:<br>http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx<br>Phone: 1-800-562-3022 ext.15473 |
| **NEBRASKA –** Medicaid<br>Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx<br>Phone: 1-855-632-7633 | **WEST VIRGINIA –** Medicaid<br>Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx<br>Phone: 1-877-598-5820, HMS Third Party Liability |
| **NEVADA –** Medicaid<br>Medicaid Website: http://dwss.nv.gov/<br>Medicaid Phone: 1-800-992-0900 | **WISCONSIN –** Medicaid and CHIP<br>Website:<br>https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf<br>Phone: 1-800-362-3002 |
| **NEW HAMPSHIRE –** Medicaid<br>Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf<br>Phone: 603-271-5218 | **WYOMING –** Medicaid<br>Website: https://wyequalitycare.acs-inc.com/<br>Phone: 307-777-7531 |

To see if any other states have added a premium assistance program since January 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
**www.dol.gov/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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