PRINCE GEORGE'S COUNTY GOVERNMENT

BENEFITS AT-A-GLANCE 2019

1400 McCormick Drive, Suite 245, Largo, Maryland 20774
Main: (301) 883-6380 ***Fax: (301) 883-6192***

GENERAL PLAN INFORMATION

- The Prince George's County Government (County) benefits plan year is from January 1st to December 31st.

- A spouse (to include a same sex spouse) can be added to the health benefit plans. A marriage certificate and social security number is required to add a spouse.

- Children under the age of 26 are eligible for coverage under the health benefit plans. This includes stepchildren and children of the same-sex spouse. A birth certificate(s) and social security number(s) is required to add a child(ren). If you are only adding the stepchildren or child(ren) of a same-sex spouse, you will need to submit a marriage certificate. You will also need to submit the birth certificate of the child(ren) and your spouse must be listed as a parent.

- The premiums for the health benefit plans (Medical, Dental, Prescription and Vision) are deducted on a pre-tax basis.

- The premiums for the Long-Term Disability, Extra Life Insurance and Voluntary Benefits (Group Accident, Group Critical Illness, Whole Life, Individual Short-Term Disability, Supplemental Dental and Legal Plans) are deducted on a post-tax basis.

- New employees must enroll in the health benefit plans within thirty **(30)** days of their hire date.

- The effective date of the health benefit plans is the first of the month following an employee's date of hire.

- After enrolling in the health benefit plans, employees may only make changes to the plans either during the open enrollment period, which occurs annually (usually each October), and/or during the year, due to a family status change (i.e., marriage, birth, divorce and adoption). Employees must complete an Enrollment Form and provide necessary documents within thirty **(30)** days of any family status change. For a birth of a child, please do **NOT** wait until you receive the birth certificate and/or social security number to enroll the child.

- Upon receipt of the previously stated documents, you can bring or mail them to the **Benefits Administration Division** (Division). The Division is located at **1400 McCormick Drive, Suite 245, Largo, MD, 20774.**

NOTE

Medical, Dental, Prescription and Vision are separate health benefit plans. The plans are administered by different insurance plan carriers.

MEDICAL PLAN COVERAGE

***Health Maintenance Organization (HMO) Plans*:**

- The two (2) HMO plans that are offered **Cigna Open Access Plus In-Network (OAPN) HMO**, and **Kaiser Permanente**. These plans offer preventive health care services through a network of providers (Cigna) and health care centers (Kaiser).

- The HMO plans do **not** include coverage for prescription, dental and vision benefits. It **only** covers medical health benefits.

- The Cigna plan is an open access network medical plan and there is no requirement to select a Primary Care Physician (PCP) or obtain a referral to a specialist.

- The Kaiser Permanente HMO plan requires their members to see doctors who are located in the various Medical Centers throughout the Washington Metropolitan area. There are no deductibles and claim forms under the Kaiser Permanente HMO plan.

- The Cigna plan has a $50 individual annual deductible for *certain* in-network services that must be met each calendar year prior to any plan coverage. **Please see the Summary of Benefits for the services that are subject to the annual deductible**.

- The co-payments for office visits, laboratory services and x-rays and other services range from $0 to $35 for Cigna and Kaiser Permanente. Please see the Summary of Benefits to determine the applicable co-payments for services.

- The Kaiser Permanente co-pay for emergency room services is $50 and $100 co-pay for each *in-patient hospital* admission.

- The Cigna plan co-pay for emergency room services is $150 and it is a $50 co-pay for urgent care services. Additionally, the Cigna plan co-pay for *out-patient* hospital is $100 and $250 co-pay for each *in-patient* hospital admission.

- Medical services are also available through the Convenience Care Clinics (Minute Clinics) under the Cigna plan for certain medical conditions. The co-pay to use the clinic is $30. **Please contact Cigna for a list of Convenience Care Clinics.**

- Any non-emergency in/outpatient procedure requires precertification that must be authorized by your health plan.

MEDICAL PLAN COVERAGE (cont'd)

Open Access Plus (OAP) Preferred Provider Organization (PPO):

- The PPO plan is administered by **Cigna.** This plan offers the convenience and cost savings of **HMO**-type **(in-plan) benefits** along with the freedom and flexibility of out-of-plan benefits.
- Please see previous section on HMO plan features for information on the in-plan benefits.
- The ***out-of-plan benefits*** enable you to access specialists or hospitals of your choice. This plan allows employees to use non-participating providers; however, a deductible, coinsurance and any amounts over the usual and customary fee will apply.
- The ***out-of-plan benefit*** has a $300 deductible per individual/$550 per family that must be met each calendar year. Once the deductible has been met, the plan will pay 80% of the usual and customary fee. The employee is responsible for the remaining 20% co-pay, which is the coinsurance, and any amount charged over the usual and customary fee.
- The out-of-pocket maximums are $2,000 for Single and $4,000 for Family.
- Non-emergency in/outpatient procedures require precertification. In-plan (HMO) providers are responsible for pre-certifying procedures. A procedure scheduled by out-of-plan providers requires the member and/or the doctor to obtain precertification.

Medical Plan Opt - Out Provision:

- The County offers employees who have medical plan coverage through an external medical plan or coverage under the County plans as a result of marriage to another County employee or retiree to receive a credit each pay day. The medical opt-out credit is $15.38 per payday or $400 annually. **Proof of other coverage (a copy of your medical card) must be provided.**

NOTE

The member has the ultimate responsibility to obtain precertification for procedures performed by out-of-plan providers.

PRESCRIPTION PLAN COVERAGE

- Express Scripts is the County's administrator for the prescription plan.
- Coverage is available at participating retail pharmacies.
- The prescription plan has an annual deductible of $50 per individual. This must be satisfied prior to any plan coverage.
- The plan has a mandatory generic requirement in which it provides coverage of generic only for brand medications that have a generic alternative.
- A plan participant can still opt to receive a brand medication; however, the prescription plan will only provide coverage that equates to the amount of the generic alternative. The plan participant will be responsible for the co-payment for a generic plus the cost difference between the brand and generic medication.
- The retail pharmacy provides a 30-day supply of your prescription. The following co-payments apply: Generic is $10; Formulary is $20 or 20% of the cost of prescription, whichever is greater, up to a maximum of $50. Non-formulary is $40 or 30% of the cost of the prescription; whichever is greater, up to a maximum of $50. ***(*See Express Scripts *Preferred Prescription Guide for a list of the Formulary/Non-Formulary drugs).***
- There is a Mandatory Mail Order requirement on all maintenance medication(s). See the information outlined below for details on Mandatory Mail Order.
- Diabetic supplies (needles, syringes, lancets and test strips) are covered with $10 co-pay. Glucose monitors must be obtained through your medical plan provider.
- The prescription plan includes a Preferred Drug Step Therapy (PDST) program. The PDST program targets certain drugs in specified categories that are interchangeable with good generic alternatives.
- The prescription plan has a Review Appeals program for coverage of a medication in which the prescription plan has certain administrative rules that must be satisfied in order to receive consideration for coverage under the plan.
- The prescription plan has a Prior Authorization program in place that requires a physician review to ensure that requested medications are being used appropriately for certain drug categories. (You may contact Express Scripts at the above stated telephone number to find out if your medication falls under this Program).

Prescription Plan Opt-Out Provision:

- The County offers employees who elect not to have prescription coverage, enrolled in an outside plan or covered by the County as a result of marriage to another County employee or retiree the opportunity to earn a credit. The prescription opt-out credit is $7.69 per payday or $200 annually.
- ***Proof of coverage is not required***.

MAIL ORDER SERVICE (Express Scripts by Mail)

- The mail order service provides you the only mechanism to receive a 90-day supply of prescriptions that are needed for long-term use ("maintenance drugs").

- The 90-day prescription co-payments for Express Scripts by Mail are: Generic $20; Formulary $40 or 20% of the cost, whichever is greater, up to a maximum of $100; and Non-Formulary $80 or 30% of the cost, whichever is greater, up to a maximum of $100. **(See Express Scripts Preferred Prescription Guide.)**

- **The prescription plan has a mandatory mail order requirement on all maintenance medication(s)**. The requirement will allow you to get two (2) fills for a maintenance medication at the retail pharmacy for the retail co-payments. After the second fill, the prescription plan will provide no coverage for the maintenance medication at the retail pharmacy and you will have to submit your prescription(s) to Express Scripts-by-Mail for coverage of the medication and the mail order co-payments will apply.

NOTE

The $50 annual deductible must be satisfied prior to any plan coverage.

VISION COVERAGE

The County offers two (2) vision plan options: **Base Plan** and **Buy-up Plan**, both administered by **Vision Service Plan (VSP)**. The vision coverage is designed to protect your visual wellness. Both plans provide coverage for eye glasses, contact lenses and a comprehensive annual eye exam benefit whereby participants will pay a $10 co-payment for a routine eye examination.

Base Plan Option:

- Lenses for glasses and contact lenses are covered every year.
- Frames are covered every other year.
- There is a $150 allowance towards the purchase of contact lenses. A co-payment does not apply.
- The participant will pay a co-payment of up to $60 for the contact lens exam (fitting and evaluation).

Buy-up Plan Option:

- Lenses for glasses and contact lenses are covered every year.
- Frames are covered every year.
- There is a $200 allowance for the purchase of contact lenses. A co-payment does not apply.
- The participant will pay a co-payment of up to $60 for the contact lens exam (fitting and evaluation).

DENTAL COVERAGE

Dental Maintenance Organization (DMO):

- **Aetna** is the carrier for the County's Dental Maintenance Organization (DMO) plan. This is a pre-paid dental plan with private practice general dentists and specialists who participate with the plan.
- You must utilize a participating dentist for this plan.
- The plan requires you to pay various co-payments to receive preventive, basic and major services. The plan provides dental services such as, routine cleanings (every 6 months), x-rays, routine extractions by a general dentist and most fillings.

Preferred Provider Option (PPO):

- **Aetna** administers the County's dental Preferred Provider Organization (PPO) plan.
- The PPO plan allows employees to use a participating dentist (in-network) and provides the flexibility of utilizing a non-participating dentist (out-of-network).
- When using a ***participating dentist***, preventive and basic services are covered at 100% and major services are covered at 60%.
- When using a ***non-participating dentist***, there is a $25 deductible. Preventive and basic services are covered at 100% of the usual and customary rate and major services are covered at 50% of the usual and customary rate.

LIFE INSURANCE COVERAGE

- Basic life insurance coverage is administered through **Aetna** and is equal to two (2) times the basic annual salary, which is effective on the date of hire. This is at no cost to the employee.

- Coverage can be reduced to one (1) times the salary. The life opt-out credit will be added to the employee's paycheck as taxable income.

- Supplemental Life Insurance (SLI) is also administered through ***Aetna*** and is equal to 50 times the monthly salary. This benefit has a maximum of $300,000, which includes both basic and supplemental life insurance. **SLI applies only to police officers, firefighters, paramedics, emergency response technicians and deputy sheriffs.**

- Extra Life Insurance (XLI) can be purchased up to four (4) times the base salary, to a maximum of $600,000. However, the election of more than three (3) times the base salary and/or an election resulting in $300,000 or more requires the completion of an *Evidence of Insurability* (EOI) Form. The EOI process could result in a medical examination and the employee must utilize a provider or facility designated by Aetna for the exam. **It is the responsibility of the employee to pay the cost of the medical examination.**

- The premium rate for the XLI plan is based on salary and age category.

- The premium rate deduction for the XLI plan is taken once (1) a month (first [1st] pay period) on an after-tax basis.

- An employee's insurance amount and premium change automatically with the effective date of a salary increase and age category change.

- Internal Revenue Service (IRS) regulations limits to $50,000 the amount of group term life insurance the County can provide on a tax-free basis. Any value over $50,000 will be treated as taxable income based on an IRS imputed life chart.

- Accidental Death and Dismemberment (AD&D) benefit is administered through ***Aetna***. It is an employer paid benefit.

FLEXIBLE SPENDING ACCOUNTS

- The ***Health Care and Dependent Care Flexible Spending Accounts (FSAs) administered by ConnectYourCare,*** allow pre-tax dollars to be placed in an account during the plan year (January 1 to December 31) to pay out-of-pocket expenses relating to health or dependent care.

- A 2½-month grace period will apply to the FSAs. If monies remain at the end of the plan year, participants will have until March 15th of the next plan year to incur an expense and use the remaining monies.

- The period to file a claim is 120 days (April 30th) after the plan year ends.

- ***These accounts must be renewed each year*** during open enrollment for the following plan year. If the enrollment process is not completed***, the FSA will be cancelled.***

Health Care:

- A maximum of $2,700 may be set aside each year.

- A participant can be reimbursed for eligible out-of-pocket expenses not covered by a medical, prescription, vision or dental insurance plan for an employee and all eligible dependents.

- A participant can be reimbursed for eligible expenses by completing a Claim Form and attaching receipts and submitting both to the plan administrator.

- You have until **April 30th** of the calendar year after you terminate from County service to submit claims for eligible expenses incurred prior to and including the date of your termination. The Health Care Flexible Spending Account is eligible for continuation under COBRA.

Dependent Care:

- A maximum of $5,000 may be set aside each year.

- A participant can be reimbursed for eligible childcare expenses for dependent children under the age of 13. The account also covers individuals (including a parent), who according to the IRS's definition of a dependent, is physically or mentally incapable of caring for his or her own needs and dependent upon the employee.

- Expenses claimed through the Dependent Care Spending Account (DCSA) may not be claimed on a tax return at the end of the year.

- You have until **April 30th** of the calendar year after you terminate from County service to submit claims for eligible expenses incurred prior to and including the date of your termination to ConnectYourCare**.**

LONG – TERM DISABILITY (LTD)

- Long-Term Disability (LTD) is administered by ***Aetna.*** The LTD plan provides coverage for Public Safety and Non-Public Safety Employees.
- This coverage provides two-salary replacement options of either 50% or 60% of base pay up to the allowable maximum per month in the event of a disability.
- The benefits will be reduced by other income benefits such as workers' compensation, Social Security and disability retirement benefits.
- Benefits will begin after **180** days of disability.
- This is a voluntary benefit program. The employee pays 100% of the premium cost based on an insurance premium rate times their annual salary.
- The premium rate deduction is taken once (1) a month (first [1st] pay period) on an after-tax basis.
- An employee's premium amount changes automatically with the effective date of a salary increase.
- A 12-month waiting period applies to any pre-existing condition(s).
- New employees are eligible to enroll in the Long-Term Disability Plan at the time of hire without completing an *Evidence of Insurability* (EOI) Form.
- If a new employee does not enroll at the time of hire, they will have to complete the EOI process at the time of enrollment (e.g., open enrollment, qualifying event). The EOI process could result in a medical examination and the employee must utilize a provider or facility designated by Aetna for the exam. It is the responsibility of the employee to pay the cost of the medical examination(s).

EMPLOYEE ASSISTANCE PROGRAM (EAP)

- A ***confidential counseling and referral service*** for employees, dependents, and household members. The EAP can assist with family, financial, work, and personal issues.
- Counselors are available to talk with you and your household members on the telephone or in-person. The plan provides up to eight (8) counseling sessions.
- Easy access to service 24 hours a day, seven (7) days a week via 877-334-0530, a toll-free number.

VOLUNTARY BENEFIT PLANS

The following voluntary benefit plans are offered to County employees in addition to the health benefits plans provided by the County:

Individual Short-Term Disability (STD):

- The Individual Short-Term Disability plan is administered by Unum.
- This coverage provides replacement of 60% of your salary in the event of a disability due to a ***covered off-the-job*** accident and/or illness including maternity.
- Deductions are taken bi-weekly on an after-tax basis.
- Health questions are not required for amounts up to 60% not to exceed $5000.
- This is a voluntary benefit program. The employee pays 100% of the premium cost based on the plan and elimination period selected.
- You will choose the elimination period (the time you will have to be off work before your STD benefits begin) and a monthly benefit that will meet your financial needs. A policy outlining the details of the plan will be sent to the address on file for you. If you terminate employment with the County, you can convert to direct bill and pay the same premium rate.

Whole Life Insurance:

- The Whole Life Insurance plan is administered by Unum.
- This plan provides life insurance for a spouse, children, and yourself.
- The plan is in addition to your County-provided Basic, Supplemental, and/or Extra Life Insurance and it provides a death benefit as well as it builds cash value and earns interest.
- Deductions are taken bi-weekly on an after-tax basis.
- The plan has an Accelerated Death benefit, if you are diagnosed with a medical condition, that limits your life expectancy to 12 months or less.
- This is a voluntary benefit program. The employee pays 100% of the premium cost.
- The cost you pay for the plan will depend on your age and smoking/non-smoking status.
- A policy outlining the details of the plan will be sent to the address on file for you. If you terminate employment with the County, you can convert to direct bill and pay the same premium rate.

VOLUNTARY BENEFIT PLANS (cont'd)

Group Critical Illness Insurance Plan:

- The Group Critical Illness plan is administered by Unum.
- The plan pays a lump sum benefit at the first diagnosis of a covered critical illness. Illnesses covered by the plan include: heart attack, stroke, major organ transplant, paralysis, End-Stage Renal (Kidney) Failure and other covered illnesses.
- Illnesses covered for cancer include invasive and non-invasive cancer.
- $50 Wellness Benefit is included.
- Deductions are taken bi-weekly on an after-tax basis.
- This is a voluntary benefit program. The employee pays 100% of the premium cost that is based on age, tobacco status and the benefit amount selected.
- Family coverage options are available for spouse and children.
- Eligible children are automatically covered at 25% of the employee benefit amount.
- The information outlining the details on this policy will be sent to the address on file for you. If you terminate coverage with the County, you can port to direct bill and pay the same premium rate.

Group Accident Insurance Plan:

- The Group Accident Insurance plan is administered by Unum.
- This plan provides 24-hour coverage for accidents or injuries incurred **on or off the job** and payments can be used, however you choose.
- The plan provides coverage for accidental death and catastrophic accident benefits.
- The plan helps with out-of-pocket expenses such as, deductibles, co-payments, and non-medical costs associated with a covered accident or injury.
- $50 Wellness Benefit is included.
- Some examples of covered injuries include, but are not limited to, burn, concussion, fracture/dislocations, paralysis, plus more.

Group Accident Insurance Plan (Cont'd):

- Examples of covered benefits include, but are not limited to, ambulance service, Emergency Room (ER), hospital admission, blood plasma and surgery**.**
- Deductions are taken bi-weekly on an after-tax basis.
- Family coverage options are available. Spouses and dependent children (under age 26) are eligible, if the employee applies for coverage.
- The information outlining the details on this policy will be sent to the address on file for you. If you terminate coverage with the County, you can port to direct bill and pay the same premium rate.

The County has two providers that administer the following legal plans:

Legal Resources

- A wide variety of legal services are covered in full for your monthly fee. Some services covered at 100% include, credit problems, family law, traffic violations and preparation of wills. Please see the plan brochure for additional coverage of legal services.
- Deduction is $17 per month on an after-tax basis the first pay period of the month.
- There are no co-payments, deductibles or restrictions on use and this plan provides coverage for yourself and qualified dependents (dependents ages 19-23 must be full-time students).
- **The plan has a requirement that an employee must remain enrolled for twelve (12) months.**
- You will be required to select a law firm from the administrator's network.
- Attorney fees not covered in full are provided at a 25% discount.

Legal Shield

- A wide variety of legal services are covered in full for your monthly fee. Some services covered at 100% include credit problems, family law, traffic violations, defense and preparation of wills. Please see the plan brochure for additional coverage of legal services.
- Deductions are taken on an after-tax basis.
- There are no co-payments, deductibles or restrictions on use and this plan provides coverage for yourself and qualified dependents (unmarried dependents up to age 23 must be full-time students).
- You will be required to select an attorney from the firm in the administrator's network.

VOLUNTARY BENEFIT PLANS (cont'd)

Legal Shield (Cont'd)

- Attorney fees not covered in full are provided at a 25% discount.

Supplemental Dental Insurance:

- The Supplemental Dental Insurance is administered by **Aflac.**
- Choose your own dentist. **Aflac** does **not** use a network of dentists.
- There are no precertification requirements. Your dentist and you choose the treatment.
- There are no deductibles.
- Pays an annual wellness benefit.
- Premiums start as little as $5.73 per week.
- This plan will work in conjunction with the County's dental plan(s) and/or any other outside dental plan you may be enrolled.
- Aflac will send you information outlining the details on this individual policy to the address on file for you. If you terminate employment with the County, and were enrolled in the plan for at least one (1) month, you can convert to direct bill and pay the same premium.
- **For additional information, you can contact Aflac's Customer Service at 301-875-6397 or 1-800-992-3522.**