Prince George's County Government
Rushern L. Baker, III, County Executive

HEALTH BENEFITS OPEN ENROLLMENT GUIDE

ACTIVE EMPLOYEES

CALENDAR YEAR 2019

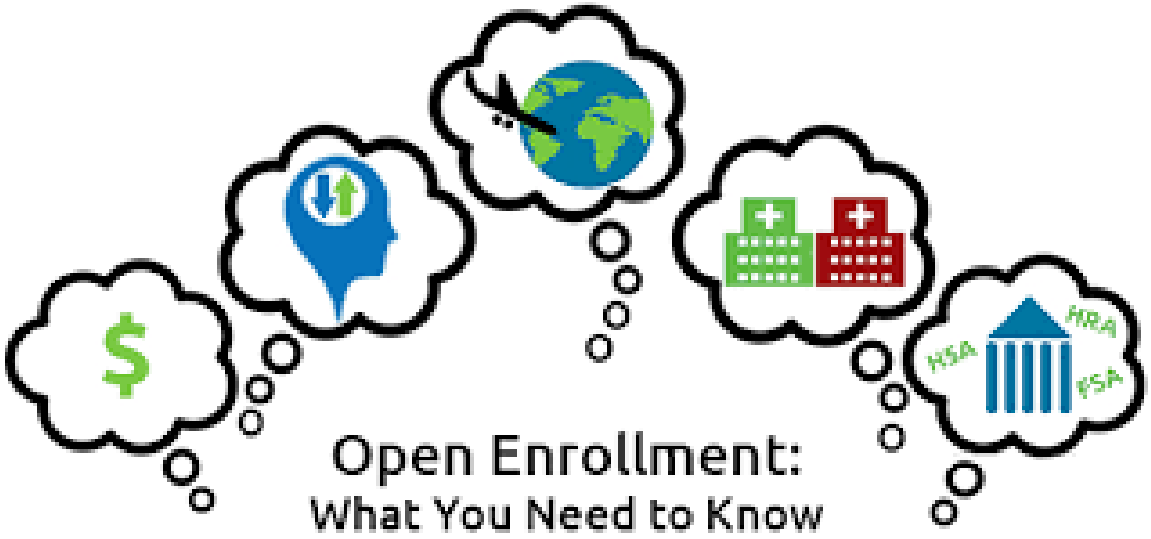
"Enroll or Make a Change, You Know What This Means, It's Open Enrollment 2019!"

Open Enrollment 2019

October 3, 2018 – October 26, 2018

Prince George's County Government
Office of Human Resources Management
Benefits Administration Division
1400 McCormick Drive, Suite 245
Largo, Maryland 20774

Health Benefits



Active Employees

CALENDAR YEAR 2019

OPEN ENROLLMENT
October 3, 2018 – October 26, 2018

2019 Health Benefits Enrollment Guide
Table of Contents

2019 Health Benefits Enrollment Guide
Table of Contents

NON-DISCRIMINATION STATEMENT

Prince George's County Government complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. **Prince George's County Government** does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Prince George's County Government:

- Provides free aid and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters; and
    - 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; and
    - Information written in other languages.

If you need these services, contact Karen W. Gooden, Esq., Deputy Director, in the Office of Human Resources Management.

If you believe that **Prince George's County Government** 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: Karen W. Gooden, Esq., Deputy Director, 1400 McCormick Drive, Suite 351, Largo, MD 20774, 301-883-6344, or fax to 301-883-6325, KWGooden@co.pg.md.us.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Karen W. Gooden, Esq., Deputy Director, is available to assist 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 telephone at U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019 or 800-537-7697 (TDD).

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

Español (Spanish)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1 (800) 368-1019 or 1 (800) 537-7697 (TDD).

繁體中文 (Chinese) Chinese

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 (800) 368-1019 or 1 (800) 537-7697 (TDD).

한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1 (800) 368-1019 or 1 (800) 537-7697 (TDD). 번으로 전화해 주십시오.

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1 (800) 368-1019 or 1 (800) 537-7697 (TDD).

Français (French)

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1 (800) 368-1019 or 1 (800) 537-7697 (TDD).

Tagalog (Tagalog – Filipino)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1 (800) 368-1019 or 1 (800) 537-7697 (TDD).

Русский (Russian)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1 (800) 368-1019 or 1 (800) 537-7697 (TDD).

አማርኛ (Amharic)

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1 (800) 368-1019 or 1 (800) 537-7697 (TDD).

èdè Yorùbá (Yoruba)

AKIYESI: Bi o ba nsọ èdè Yorùbú ọfé ni iranlọwọ lori èdè wa fun yin o. Ẹ pe ẹrọ-ibanisọrọ yi 1 (800) 368-1019 or 1 (800) 537-7697 (TDD).

اُردُو (Urdu)

خبردار :اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال
11 (800) 368-1019 or 1 (800) 537-7697 (TDD). کریں

Kreyòl Ayisyen (French Creole)

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1 (800) 368-1019 or 1 (800) 537-7697 (TDD).

Português (Portuguese)

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1 (800) 368-1019 or 1 (800) 537-7697 (TDD).

العربية (Arabic)

ملحوظة :إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان .اتصل برقم 1 -xxx-xxx-xxxx (
(800) 368-1019 or 1 (800) 537-7697 (TDD).- هاتف الصم والبكم:

ગુજરાતી (Gujarati)

ચુના: જો તમે જરાતી બોલતા હો, તો ન:લ્કુ ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છ. ફોન કરો
1 (800) 368-1019 or 1 (800) 537-7697 (TDD).

Persian-Farsi

اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد ، داشته باشید حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید 1 (800) 368-1019 or 1 (800) 537-7697 (TDD). تماس حاصل نمایید.

GRANDFATHER NOTICE

The Prince George's County Government Health Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the 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 that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what may possibly cause a plan to change from a grandfathered health plan status can be directed to the Benefits Administration Division at (301) 883-6380 or 1-800-634-5231 (press option two [2] for Benefits). You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

PRIVACY NOTICE

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.

Why have you been sent this Notice?

Prince George's County Government (County) is required under the Medical Privacy Rules of the Health Insurance Portability and Accountability Act, Public Law 104-191 (HIPAA) to provide all of its employees and retirees eligible to participate in its healthcare plans with this Privacy Notice (Notice). This Notice concerns the personal, protected health information you have provided to the County as a condition of your employment and in connection with the provision of health or life insurance benefits provided to you. Prince George's County Government takes your privacy seriously. Your information will not be used or disclosed without your written permission, except as described in this notice or as otherwise permitted by Federal and State laws. For example, in general and subject to specific conditions, we will not use or disclose your psychiatric notes; we will not use or disclose your protected health information for marketing; and, we will not sell your protected health information, unless you give us a written authorization.

How do we use your information?

We restrict access to your personal information to those employees of the County who need to know the information in order to provide services to you. We maintain physical, electronic and procedural safeguards that comply with HIPAA regulations to protect the security of your personal information. The County uses your protected health information for the following purposes:

- for administrative purposes related to our health care plans and other benefits, such as, accessing your health information to review the performance of our administrator or for underwriting, premium rating, and other activities relating to health coverage; however, we will not use your genetic information for underwriting purposes;
- to evaluate the quality of care that you receive; and
- to inform you of health related benefits or services that may be of interest to you.

With whom do we share your information?

The County may share your personal information without your written permission to the vendors that assist the County in providing services to you. If we share your information, we will ensure that the vendors do not disclose or use your information for any other purpose, except as permitted by law.

When do we share your information?

There are limited circumstances when the County is permitted or required to disclose health information without your signed permission. These situations include:

- for public health purposes;
- for medical emergencies;
- for use by medical examiners, coroners and funeral directors and organ donation organizations;
- for judicial and administrative proceedings and law enforcement purposes;
- for specialized government functions, such as military, intelligence and correctional activities; and
- when otherwise required by law.

What are our duties?
The County is required by law to:

- maintain the privacy and security of your health information;
- provide this Notice of our duties and privacy and security procedures;
- follow the procedures described in this Notice; and
- the County reserves the right to change privacy and security procedures and make the new procedures effective for all information that the County maintains. Revised notices will be made available to you.

What if there is a breach of unsecured protected health information?
You must be notified in the event of a breach of unsecured protected health information. A "breach" is the acquisition, access, use, or disclosure of protected health information in a manner that compromises the security or privacy of the protected health information. Protected health information is considered compromised when the breach poses a significant risk of financial harm, damage to your reputation, or other harm to you. This does not include good faith or inadvertent disclosures or when there is no reasonable way to retain the information. You must receive a notice of the breach as soon as possible and no later than 60 days after the discovery of the breach.

What are your rights?
You have the right to:

- request that the County restricts how it uses or discloses your health information, please note, that the County will consider your request but is not legally required to agree to it, unless your request relates to payment or healthcare operations (but not for carrying out treatment) in situations where you have paid the healthcare provider out-of-pocket in full; in this case, the County is required to implement the restrictions that you request;
- request that the County communicate with you about health matters in a confidential manner;
- inspect and copy your health information (fees may apply, but any fee must be limited to the cost of labor involved in responding to your request if you requested a copy of an electronic health record);
- request additions or corrections to your health information;
- receive an account of how the County has disclosed your information for reasons other than treatment, payment, related administrative purposes (Note: this exception does not apply to electronic health records) and disclosures requested by you; and
- obtain a paper copy of this notice upon request.

How to contact us

If you would like to exercise your rights, or if you feel that your privacy rights have been violated or if you need more information, contact the Office of Human Resources Management, Benefits Administration Division at (301) 883-6380 or 1-800-634-5231 (press number two [2] for Benefits, then select option nine [9]) with this information.

The Office of Human Resources Management
1400 McCormick Drive, Suite 245
Largo, Maryland 20772

All complaints will be investigated and you will not suffer retaliation for filing a complaint. If you believe that your rights have been violated, you may also file a complaint with the Office of Civil Rights of the U.S. Department of Health and Human Services in Washington D.C.

October 3, 2018


Stephanye R. Maxwell, Esq., CPM
Director, OHRM

Dear County Employee:

"Enroll or Make a Change, You Know What This Means! It's Open Enrollment 2019!" The annual open enrollment period will begin October 3 through October 26, 2018, for the health benefit plans. I encourage you to take this opportunity to review the health benefit plans you currently have and decide if you need to make changes to your existing benefit plan options for calendar year 2019.

Open enrollment is a time for you to review updated materials on the current health benefit plan options and make plan changes that would support the needs of you and your family. Making the right choices for your health benefit plan options will assist you and your family with living a healthier lifestyle now, as well as in the future. Please take a moment and mark the important dates mentioned above on your calendar.

Health Benefit Plan Changes

Each year, the Office of Human Resources Management (OHRM) reviews the level of benefit coverage, claims experience and utilization data under the health benefit plans. It is important to note that Prince George's County Government (County) is not making any changes to the current co-payments, co-insurance or deductibles under the health benefit plans for calendar year 2019. While the County is not making any changes to the health benefit plans, I would like to take this opportunity to encourage you to review the Reminders that begin on page seventy-seven (77) through page eighty (80) for the plans.

Health Benefit Plans Premium Rates

A review of the claims experience and utilization data revealed that we are still incurring a number of high dollar claims under the medical and prescription plans. In an effort to keep pace with the projected costs, some of the health benefit plans will experience a premium rate increase for calendar year 2019. The premium rate increases for calendar year 2019 are as follows:

- The Cigna Healthcare HMO medical plan will increase by 5.6%
- The Cigna Healthcare PPO medical plan will increase by 5.6%
- The Kaiser Permanente HMO medical plan will increase by 7.5%
- The Base and Buy-up plan options under the Vision Service Plan (VSP) will increase by 2.5%

The premium rates for calendar year 2019 **did not** increase for the following plans: Express Scripts, Inc., prescription, Aetna Dental Preferred Provider Organization (DPPO), Aetna Dental Maintenance Organization (DMO) and Aetna Life and Long-term Disability (LTD) Plans. Please see pages eighty-six (86) and eighty-seven (87) that will outline the premium rate costs.

Health Benefit Plans Enrollment Process

OHRM is pleased to announce, again this year, we will collect the enrollments and/or changes for the core health benefit plans (e.g., medical, prescription) via **on-line** through the Employee Self-Service (ESS) enrollment portal. It is important for you to know your User ID and password for ESS. You must work with the Help Desk in the Office of Information Technology to either obtain or reset your User ID and/or password. The Benefits Division in OHRM **cannot** provide or reset the User ID and/or password for you.

Please refer to pages thirteen (13), fourteen (14), fifteen (15), sixteen (16), and twenty-nine (29) and thirty (30) for details on the enrollment process for the County's core health benefit plans. **The Benefits Division staff will be available at various County locations to assist you only with completing your enrollment(s) and/or change(s) on-line during the open enrollment period.** The schedule on page seventeen (17) outlines the locations, dates and times the Benefits Division staff will be available to assist you with completing your enrollment(s) and/or change(s) on-line. In addition, on pages 15 and 16 is a Reference Guide for ESS that will assist you in completing your enrollments and/or changes in the system.

If you are adding an eligible dependent, you must submit documentation (e.g., marriage, birth certificate) to the Benefits Division by the close of business, Friday, October 26, 2018. Please feel free to mail (envelope must be postmarked by October 26th), fax (301- 883-6358), bring to a provider session, email benefits@co.pg.md.us or hand deliver the document(s) to the Benefits Division. It is important for the first and last names and last four digits of your social security number be written on the document(s). **Failure to provide the Benefits Division with a copy of the document(s) will result in the dependent(s) not being enrolled in the health benefit plan(s) for calendar year 2019.**

The voluntary benefit plans that will be offered through Unum (Group Accident, Group Critical Illness, Whole Life and Individual Short-Term Disability) and Legal Resources or Legal Shield (Legal Plan) will require you to contact the iBenefit Call Center at 1-877-242-1553 and speak with an Enrollment Benefits Specialist to enroll or increase the level of coverage under these plans. Please see pages eighteen (18) through twenty-five (25) to learn more on the offerings under the plans. If you are currently enrolled with Legal Resources and would like to either terminate the plan or change to Legal Shield's plan, you will need to complete a Cancellation Form (Form) to cancel the Legal Resources' plan. Please contact the Benefits Division for the Form to terminate the Legal Resources plan.

Remember, the Legal Resources' plan has a twelve (12) month enrollment requirement in which you must remain enrolled in the plan for the previously stated time-period before you will be allowed to cancel the plan. The Aflac Supplemental Dental plan will require you to either meet in person with an Aflac representative or contact them at (410) 394-9617. The details of the offerings under this plan are outlined on page twenty-six (26).

It is important for you to adhere to the enrollment processes outlined above so that you will have the benefit plans you want for calendar year 2019. The Benefits Division will make **no** exceptions to the enrollment process. **It is also strongly recommended for you to review your paychecks on January 4th, 18th and February 1, 2019, to ensure you have the benefit plan(s) and level of coverage that you elected. If your paycheck deductions are incorrect, you will have until the close of business, Thursday, February 14, 2019, to contact the Benefits Division to correct the error.**

We hope that you will use this Open Enrollment Guide (Guide) as a valuable source of important information about the County's health benefit plans. We strongly encourage you to read the Guide to learn more about the changes and requirements of the health benefit plans for calendar year 2019. This Guide also includes a list of the dates, times and locations of each of the provider sessions. These sessions will provide you with opportunities to discuss with the health benefit plan providers any questions that you may have about the plans. Additionally, each provider session will have plenty of giveaways and raffle drawings.

OHRM will continue its efforts to offer health and wellness programs and activities so you can adopt lifestyle behavioral changes that will make a healthy you. We encourage you to incorporate changes in your lives that will result in a healthier lifestyle in 2019.

OHRM strongly encourages you to complete an on-line health assessment and receive a valuable tool that will provide you with information to make lifestyle choices to improve your health. A health assessment is an easy questionnaire about your health and well-being. It is completely confidential and it allows you to make lifestyle choices that will improve your health. **How do you complete the on-line health assessment?** It is as simple as going to page seventy-two (72) and seventy-three (73) and selecting the website you will need to access and complete the on-line health assessment.

We invite you to come out and join us at one of the provider sessions listed on pages twenty-eight (28) and eighty-four (84). Please feel free to contact the Benefits Division at (301) 883-6380 (press option nine [9]) or (800) 634-5231 (press number two [2] for Benefits Division, then select option nine [9]), if you have any questions.

Don't forget to mark the open enrollment dates on your calendar. **"Enroll or Make a Change, You Know What This Means! It's Open Enrollment 2019!"**

Sincerely,

Stephanye R. Maxwell

Stephanye R. Maxwell, Esq., CPM
Director

What's Changing for the Health Benefit Plans in 2019?

Premium Rate Increases

The premium rate increases for calendar year 2019 are as follows:

- The Cigna Healthcare HMO medical plan will increase by 5.6%
- The Cigna Healthcare PPO medical plan will increase by 5.6%
- The Kaiser Permanente HMO medical plan will increase by 7.5%
- The Base and Buy-up plan options under the Vision Service Plan (VSP) will increase by 2.5%

The premium rates for calendar year 2019 **did not** increase for the following plans: Express Scripts, Inc., prescription, Aetna Dental Preferred Provider Organization (DPPO), Aetna Dental Maintenance Organization (DMO) and Aetna Life and Long-term Disability (LTD) Plans. Please see pages 86 and 87 that will outline the premium rate costs.

How to Enroll or Make Changes to the County Health Benefit Plans

Open Enrollment starts on **October 3, 2018, and ends on October 26, 2018.** During this period, you will enroll and make changes to the health benefit plans **on-line** for the calendar year 2019. You will access the Employee Self-Service (ESS) module at https://portal.sap.mypgc.us to complete the on-line enrollment process. On pages 15 and 16, is the ESS Open Enrollment Quick Reference Guide to assist you in completing the on-line enrollment process.

Please note due to the processing of payroll the system will be unavailable **ALL DAY on Tuesday, October 9th and October 23rd.**

Note: It is important that you do not access the system during the time periods noted above for it will negatively impact the payroll process.

The Benefits Division staff will be available to assist you with entering your enrollments and/or changes to the health benefit plans during the open enrollment period. Please refer to page 17 for a listing of the dates, times, and locations where staff will be available to assist you.

The on-line enrollment process will apply to the following core benefits:

- **Medical**
  - Cigna (HMO, PPO)
  - Kaiser Permanente (HMO)
- **Dental**
  - Dental DMO
  - Dental PPO
- **Prescription**
- **Vision**
  - Base Plan
  - Buy-Up Plan
- **Extra Life Insurance**
- **Long-Term Disability**
- **Flexible Spending Accounts**
  - Health Care – Maximum is $2650
  - Dependent Care – Maximum is $5000
- **Opt-Out Credits**
  - Medical Opt-Out – Annual medical opt-out credit is $400 a year ($15.38 per payday)
  - Prescription Opt-Out – Annual prescription opt-out credit is $200 a year ($7.69 per payday)

NOTE: **The on-line enrollment process needs to be completed only if you are requesting to enroll, make changes or terminate a core benefit plan(s). You must complete the on-line enrollment process to enroll or continue enrollment in the flexible spending accounts (Health and/or Dependent Care).**

(Continued from previous page)

If you are currently enrolled in the medical and/or prescription opt-out credit(s) and want to continue the credits in calendar year 2019, and are **not** enrolling or making changes to any other core benefit plan (as noted on page thirteen (13), you do **not** need to complete the on-line enrollment process.

A copy of your medical card must be submitted to the Benefits Division or in an envelope postmarked by October 26, 2018. The medical card confirms your coverage through a County employee/retiree or outside medical plan. It also enables you to continue your enrollment in the medical opt-out credit plan for calendar year 2019. **Failure to send the Benefits Division a copy of your card will result in your removal from the medical opt-out credit plan for calendar year 2019.**

Please feel free to mail (inter-office or USPS), fax (301-883-6358), bring to a provider or computer session, email benefits@co.pg.md.us or deliver a copy of the medical card to the Benefits Division (RMS Building – Suite 245). Please write your first and last names and employee number on the document.

A full-time, part-time or Limited Term Grant Funded (LTGF) employee that is actively working 15 or more hours per week can enroll in one or more of the **voluntary benefit plan(s)** listed below. You must contact the iBenefit Call Center at 1-877-242-1553 to enroll in the Unum and Legal plans. **If you want to elect the Aflac Supplemental Dental plan, please call (410) 394-9617 to speak with a representative.**

Unum
- Group Accident
- Group Critical Illness
- Whole Life Insurance
- Individual Short-Term Disability (STD)

Aflac
- Supplemental Dental Insurance

Legal Resources
- Legal Plan

Legal Shield
- Legal Plan

NOTE: The Enrollment Benefit Specialists will be available to discuss and enroll you in the voluntary benefit plans at the provider sessions listed on pages 28 and 84. Please check with the Personnel Liaison in your agency to determine if arrangements have been made with iBenefit or Aflac to have a representative(s) come to your agency.

Employee Self-Service (ESS)
Open Enrollment Quick Reference Guide

You can access the ESS Open Enrollment module at https://portal.sap.mypgc.us

Please reference the tutorial for accessing the ESS module at
http://pgcwfd00.sap.mypgc.us:8080/WFD/wa/SAPTMID/~tag/published/index.html?show=book%21BO_C60F21065C8765B7

OPEN ENROLLMENT QUICK REFERENCE GUIDE TOOL BAR

NOTE: The steps outlined below will take you through the entire on-line open enrollment process. However, if you do not want to go through the entire process and you just want to enroll and/or make changes to a Health Benefit Plan follow steps four (4) and seven (7); Insurance Plans (Life and/or Long-Term Disability) follow steps five (5) and seven (7); and the Health and Dependent Care Flexible Spending Accounts follow steps six (6) and seven (7).

Step One (1): Personal Profile

Click on step 1 to view your personal profile, such as name, address, etc. (This step is optional)

Step Two (2): Dependents and Beneficiaries

Click on step 2 if you would like to check your current dependent (e.g., spouse and/or children) and beneficiary information. If you are adding a dependent(s) to your health benefit plans during the open enrollment period, **you must add them through this process**. This will ensure that a dependent(s) is listed when you make your health benefit plan elections.

- To add a dependent or beneficiary, click on the icon (**Dependents and Beneficiaries**)
- Select "Add" and a drop down list will appear.
- Select the Dependent Type (e.g., spouse, child or beneficiary) from the drop down list.
- Fill in dependent information on the screen. Note: The asterisk (*) fields are required fields and must be completed.
- Select Save – **If you are adding more than one dependent or beneficiary, select "Save and Back" to add your additional dependents and/or beneficiaries.**

Note: Beneficiary updates and/or changes made through the Open Enrollment portal will not become effective until January 1, 2019. You can update or change your beneficiary(ies) immediately through the Employee Self-Service (ESS) on-line enrollment portal under Anytime Changes.

Step Three (3): Benefits Summary

Click on step 3 to see a snapshot of your current enrollments in the health benefit plans.

Step Four (4): Health Benefit Plans

- Click on step 4 to enroll or make a change(s) to a health benefit plan(s) [e.g., medical, dental, prescription, vision].
- For example, to enroll or make a change to a medical plan, click on the icon and select the medical plan and coverage level (e.g., Individual, Two-Person, Family) you want.
- Under "Enroll Dependents," select the dependent(s) you want to cover.
- Click on "Add" to complete the change.
- To enroll or make a change to the prescription, dental, or vision plans, follow the process outlined above.
- Go to step 7 and follow the steps to **SAVE** enrollment or changes made to the health benefit plans.

Medical and Prescription Opt-Out Credit Plans If you want to opt-out of the medical and/or prescription plans, click on the opt-out option under the medical and/or prescription plans.

- Select "Add" to complete your change.

ESS Open Enrollment Quick Reference Guide *(Continued)*

- Go to step 7 and follow the steps to **SAVE** enrollment or changes made to the medical and/or prescription opt-out credit plans.

Step Five (5): Insurance (e.g., Life and Long -Term Disability) Plans

Click on step 5 to make a change to the Basic Life insurance plan and/or enroll or change the Extra Life or Long-Term Disability insurance plans.

Basic Life Insurance

- To change your option level (from two [2] times to one [1] times your salary or vice versa), click on the icon and make your selection. **Note: If you are electing one (1) times your salary it will automatically put you in the Life Insurance Opt-Out Credit.**
- To designate a beneficiary(ies), select the name(s) of your beneficiary(ies) from the list under **"Designated Beneficiaries"** and apply the percentage amount. **Note: The percentage amount must be whole numbers and must equal 100%. (Contingent Beneficiaries are optional).**
- Click "Add."
- Go to step 7 and follow the steps to **SAVE** changes made to the Basic Life Insurance plan.

Long-Term Disability Plan

- Click on the icon and select your coverage option (50% or 60%).
- Select "Add."
- Proceed to Extra Life if you are enrolling or making changes to that option. If not, go to step 7 and follow the steps to **SAVE** enrollment or changes made to the Long-Term Disability plan.

Extra Life Insurance

- Click on the icon and select the option level (1X, 2X, 3X or 4X your salary).
- Select "Add."
- Repeat the process listed under the Basic Life insurance (second bullet) to select your beneficiary(ies).
- Go to step 7 and follow the steps to **SAVE** enrollment or changes made to the Extra Life Insurance plan.

Step Six (6): Flexible Spending Accounts

- Click on step 6 to continue your participation or enroll in the Health and/or Dependent Care Flexible Spending Accounts for 2019. Your current annual election amount **will not** transfer from calendar year 2018 to 2019. **Therefore, to continue your participation for calendar year 2019 in the Health Care and/or Dependent Care Flexible Spending accounts, you MUST complete this step (6).**
- To continue your participation or enroll for calendar year 2019 click on the icon and enter the annual dollar amount you want for calendar year 2019.
- Click **"Calculate"** to obtain your bi-weekly cost.
- Select **"Add."**
- After you select **"Add,"** your 2019 election should state **"New."**
- Go to step 7 and follow the steps to **SAVE** enrollment or changes made to the Health Care and/or Dependent Care Flexible Spending Accounts.
- **If you do not see your new annual election amount and the word "New", you have not followed correctly the steps to continue or enroll in the Health Care and/or Dependent Care Flexible Spending Accounts for calendar year 2019. To ensure you will continue or be enrolled in the Health Care and/or Dependent Care Flexible Spending Accounts for calendar year 2019, repeat bullets one (1) through five (5) above. Otherwise, you will not be enrolled for calendar year 2019.**

Note: You must complete step 6 even if you want to elect the same annual amount that you elected in calendar year 2018. Failure to complete step 6 will result in you not being enrolled in the Health Care and/or Dependent Care Accounts for calendar year 2019.

Step Seven (7): Review and Save

- Click on step 7 to review your 2019 open enrollment benefit elections.
- Click on the "SAVE" icon. It is imperative that you SAVE any enrollments or changes made in steps 4 through 6 so they can be updated to the ESS system.
- You will see the message; "**Data Saved Successfully**."
- Click the "**PRINT** Benefit Elections Summary" option to print your Benefit Confirmation for your records.

Employee Self-Service (ESS)
Computer Assistance Schedule

October 3, 2018 through October 26, 2018

Dates/Time	Location
October 17, 2018 from 10:00 a.m. – 2:00 p.m. **October 18, 2018** from 10:00 a.m. – 2:00 p.m. **October 19, 2018** from 10:00 a.m. – 2:00 p.m.	County Administration Bldg. Room 3087 – Computer Lab 14741 Gov. Oden Bowie Drive Upper Marlboro, MD 20772
October 24, 2018 from 12:30 p.m. – 4:00 p.m. **October 25, 2018** from 12:30p.m. – 4:00 p.m.	MOC Building Multi-Purpose Room 8400 D'Arcy Road Forestville, MD 20747
October 11, 2018 from 10:00 a.m. – 2:00 p.m. **October 16, 2018** from 1:00 p.m. – 4:00 p.m. **October 18, 2018** from 10:00 a.m. – 2:00 p.m. **October 25, 2018** from 1:00 p.m. – 4:00 p.m.	RMS Building Room 159 – Computer Lab 1400 McCormick Drive Largo, MD 20774

The on-line enrollment portal closes at 11:59 p.m. on October 26, 2018.

Group Accident Insurance (Unum)

Unum's Group Accident Insurance can pay lump-sum benefits based on the injury you receive and the treatment you need, including emergency-room care and related surgery. The benefit can help offset the out-of-pocket expenses that medical insurance does not pay, including deductibles and co-pays. A wellness option can pay an annual benefit for preventive care.

What is covered?
The list of covered injuries includes:

- Broken bones
- Burns
- Torn ligaments
- Lacerations
- Coma due to a covered injury
- Eye injuries
- Ruptured discs
- Concussion

Some covered expenses may include:

- Emergency-room treatment
- Doctor office visit
- Hospitalization
- Occupational therapy
- Speech therapy
- Physical therapy

See the schedule of benefits for a full list of covered injuries and expenses.

Advantages of the plan

- Coverage is available to all eligible employees who are actively at work.*
- You can buy coverage for your spouse and dependent children.
- No health questions to answer. If you apply, you automatically receive the base plan.
- This plan includes convenient payroll deduction, so you don't have to remember to write a check for your premiums.
- Coverage is portable. You may take the coverage with you if you leave the company or retire without having to answer new health questions. Unum will bill you directly.
- Coverage becomes effective on the first day of the month in which payroll deductions begin.
- Benefits are paid for accidents that occur on or off the job.
- This plan includes a Wellness Benefit. Based on the plan selected by your employer, this benefit can pay $50 per calendar year per insured individual if a covered health screening test is performed, including blood tests, stress tests, colonoscopies, chest X-rays and mammograms. There is an additional charge for this feature. A full list of covered tests will be provided in your certificate.

Important: To enroll, please call the iBenefit Communications (iBC) Call Center at **1-877-242-1553**, Monday through Friday, from 9:00 A.M. to 5:00 P.M Eastern Standard Time.

*Eligible employees must be actively at work to apply for coverage. Being actively at work means on the day the employee applies for coverage, the individual must be working at one of his/her company's business locations, or the individual must be working at a location where he/she is required to represent the company. If applying for coverage on a day that is not a scheduled workday, the employee will be considered actively at work as of his/her last scheduled workday. Employees are not considered actively at work if they are on a leave of absence.

Employees must be legally authorized to work in the U.S. and actively working at a U.S. location. Spouses and dependents must live in the U.S. to receive coverage.

(Continued from previous page)

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations that may affect any benefits payable

CU-4247 (5-17)

Group Critical Illness Insurance (Unum)

Unum's Group Critical Illness Insurance can help protect your finances from the expense of a serious health problem, such as a stroke or heart attack. Cancer coverage is also available. You choose a lump-sum benefit that's paid directly to you at the first diagnosis of a covered condition. You can use the benefit any way you choose.

What is covered?

Covered conditions:

- Heart attack
- Blindness
- Major organ failure
- End-stage renal (kidney) failure
- Occupational HIV
- Coronary artery bypass surgery (pays 25% of lump-sum benefit)
- Benign brain tumor
- Cancer
- Carcinoma in situ* (pays 25% of the lump-sum benefit)

Covered conditions with time limitations:

- Stroke (evidence of persistent neurological deficits confirmed at least 30 days after the event)
- Coma (resulting from severe injury lasting 14 consecutive days or more)
- Permanent paralysis (complete and permanent loss of the use of two or more limbs for a continuous 90 days as a result of a covered accident)

Please refer to the policy for complete details about these covered conditions.

Advantages of the plan

- Coverage is available to eligible employees who are actively at work.**
- You can buy coverage for your spouse ages 17 to 64 with purchase of employee coverage.[1]
- All eligible dependent children ages newborn until their 26th birthday, regardless of marital or student status, are automatically covered at 25% of the employee benefit amount at no additional cost. Eligible children are covered for the same conditions as the employee and the following specific childhood conditions: cerebral palsy, cleft lip or palate, cystic fibrosis, Down syndrome and spina bifida. Diagnosis must occur after the child's coverage effective date.
- You can use this coverage more than once. If you receive a full benefit payout for a covered illness, your coverage can be continued for the remaining covered conditions. The diagnosis of a new covered illness must occur at least 90 days after the most recent diagnosis. Each condition is payable once per lifetime.
- You get affordable rates when you buy this coverage through your employer, and the premiums are conveniently deducted from your paycheck.
- Coverage is portable. You may take the coverage with you if you leave the company or retire, without having to answer new health questions. Unum will bill you directly.
- Coverage becomes effective on the first day of the month in which payroll deductions begin.
- Wellness Benefit – Based on the plan selected by your employer, this benefit can pay $50 per calendar year per insured individual if a covered health screening test is performed, including blood tests, stress tests, colonoscopies, mammograms, chest X-rays. A full list of covered tests will be provided in your certificate.
- Recurrence Benefit – This benefit can provide an additional payout for a second occurrence of benign brain tumor, coma, heart attack and stroke. Twelve months must elapse between occurrences of the same condition. A benefit payout of 50%, based on the plan selected by your employer, will be paid for the second occurrence of one of the covered conditions listed above.

Reduction of benefits – The benefit amount for the employee and spouse reduces by 50% on the first policy anniversary date after the insured individual's 70th birthday. Premiums will not be reduced. For coverage purchased after age 70, benefit amounts will not be reduced.

(Continued from previous page)

Termination provisions
If you choose to cancel your coverage under the policy, your coverage ends at 12:00 midnight on the first of the month following the date you provide notification to your employer. Otherwise, your coverage under the policy ends on the earliest of the following:

- Date this policy is cancelled
- Date you are no longer in an eligible group
- Date your eligible group is no longer covered
- Date of your death
- Last day of the period for which you made any required contributions
- Last day you are in active employment unless continued due to a covered layoff or leave of absence or due to an injury or sickness. Coverage for your dependent children ends on the earliest of the date your coverage under the policy ends or the date a dependent child no longer meets the definition of dependent children. Unum will provide coverage for a payable claim that occurs while you are covered under this policy.

Important: To enroll, please call the iBenefit Communications (iBC) Call Center at **1-877-242-1553**, Monday through Friday, from 9:00 A.M. to 5:00 P.M Eastern Standard Time.

* Carcinoma in situ is defined as cancer that involves only cells in the tissue in which it began and that has not spread to nearby tissues.

Employees and spouses may be covered under a policy or the Spouse Rider, but not both.

**Eligible employees must be actively at work to apply for coverage. Being actively at work means on the day the employee applies for coverage, the individual must be working at one of his/her company's business locations, or the individual must be working at a location where he/she is required to represent the company. If applying for coverage on a day that is not a scheduled workday, the employee will be considered actively at work as of his/her last scheduled workday. Employees are not considered actively at work if they are on a leave of absence.

Employees must be legally authorized to work in the U.S. and actively working at a U.S. location. Spouses and dependents must live in the U.S. to receive coverage.

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations that may affect any benefits payable. For complete details of coverage and availability, please refer to policy form CI-1, or contact your Unum representative.

Whole Life Insurance (Unum)

Unum's Whole Life Insurance is designed to pay a death benefit to your beneficiaries, but it can also gain cash value you can use while you are living. This benefit offers an affordable, guaranteed level of premium that won't increase due to age. Unlike term life insurance offered through the workplace, this coverage can continue into retirement.

Advantages of the plan

- Coverage is available to eligible employees age 15 to 80 who are actively at work.*
- You can buy coverage for your spouse and dependent children.
- The policy accumulates cash value at a guaranteed rate of 4.5%.** Once your cash value builds to a certain level, you can borrow from the cash value or use it to buy a smaller "paid-up" policy with no more premiums due.
- You get affordable rates when you buy this policy through your employer, and it is paid for through convenient payroll deduction.
- You own the policy so you can keep this coverage if you leave the company or retire. Unum will bill you directly.
- Coverage becomes effective on the first day of the month in which payroll deductions begin.
- During enrollment, you may be able to get this insurance up to a specified amount without answering any health questions. No medical exam will be required.

Who can get coverage?

The Life coverage option available for your spouse is an individual policy. Spouse coverage (either individual or term) is subject to at least one health question.

- Individual spouse coverage – This coverage can be purchased without purchasing employee coverage. The minimum policy amount is $2,000. Individual spouse coverage is available for issue ages 15-80. If you leave your employer, you can keep your spouse's policy and be billed directly at home.

There are two Life coverage options available for your children. You may purchase an individual policy, a Child Term Life benefit or both.

- Individual child coverage – This coverage can be purchased without purchasing employee or spouse coverage**. Each policy covers one child or grandchild;** you can purchase coverage for each of your eligible children/grandchildren. Coverage is available up to $50,000. Your children can keep it, even if you leave your employer.

- Child Term Life benefit – Employees must purchase coverage to add the Child Term Life benefit. **Each policy with this benefit covers all eligible children.** Coverage is available from $1,000 to $10,000 and ends when your policy ends or when the last child turns 25. At age 25, children are guaranteed the right to buy an individual Whole Life policy at five times the amount of their rider. Coverage will be cancelled if employee coverage is cancelled.

Additional coverage options

- **Living Benefit Option Rider** – Automatically included at no extra charge on this policy is a Living Benefit Option Rider. You can request up to 100% of the death benefit amount (to a maximum of $150,000) if you are diagnosed with a medical condition that limits life expectancy to 12 months or less. Any payout you receive while you are living would reduce the amount of the benefit that would be paid to your beneficiaries when you die.

- **Waiver of Premium** – This benefit is included with this coverage for employees ages 15 to 55. If you become disabled for at least six months and are under age 65, you won't have to pay the premium for your policy. Unum will waive your premium while you are receiving benefits until you recover and return to work.

- **Long Term Care** – This rider provides benefits if an employee is chronically ill and receiving Qualified Long Term Care services.

Important: To enroll, please call the iBenefit Communications (iBC) Call Center at **1-877-242-1553**, Monday through Friday, from 9:00 A.M. to 5:00 P.M Eastern Standard Time.

(Continued from previous page)

*Eligible employees must be actively at work to apply for coverage. Being actively at work means on the day the employee applies for coverage, the individual must be working at one of his/her company's business locations, or the individual must be working at a location where he/she is required to represent the company. If applying for coverage on a day that is not a scheduled workday, the employee will be considered actively at work as of his/her last scheduled workday. Employees are not considered actively at work if they are on a leave of absence.

**The policy accumulates cash value based on a non-forfeiture interest rate of 4.5% and the 2001 CSO mortality table. The cash value is guaranteed and will be equal to the values shown in the policy. Cash value will be reduced by any outstanding loans against the policy.

Employees must be U.S. or Canadian citizens, or have a green card, and working in the U.S. to receive coverage. Spouses and dependents must live in the U.S. to receive coverage.

When you buy life insurance, you name the people who will receive the money from the policy when you die. These people are called beneficiaries. Unum will pay benefits to the beneficiaries in one lump sum; however, if a beneficiary is a minor (typically younger than 18, but this may vary by state) and no financial guardian has been appointed, the benefits will be paid to that minor through a Unum Retained Asset Account.

A Unum Retained Asset Account is a fund held in Unum's general account for the named minor beneficiary. The account accrues interest regardless of Unum's actual investment performance, and, while not FDIC insured, the account funds are fully guaranteed by Unum.

For more information about the retained asset account, please contact Unum.

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations that may affect any benefits payable. For complete details of coverage and availability, please refer to policy form L-21848, or contact your Unum representative.

Underwritten by: **Provident Life and Accident Insurance Company**, Chattanooga, Tennessee] unum.com.

CU-4247 (5-17)

Individual Short-Term Disability Insurance (Unum)

Unum's Individual Short Term Disability Insurance protects a portion of your income if you are unable to work due to a covered injury or illness. This coverage can pay a monthly benefit to provide some income during a time of need. Common reasons people use this coverage include injuries, a covered pregnancy and digestive problems — such as gall bladder surgery.

Advantages of the plan

- Coverage is available to eligible employees age 17 to 69 who are actively at work.*
- You can choose a monthly benefit between $400 and $5,000 for covered disabilities due to injury or illness.
- Coverage of up to 60% of your gross monthly salary may be offered.
- The affordable premium is based on your age when you buy the insurance and will not increase as you get older.**
- Your policy is guaranteed renewable, until age 72, as long as you pay the premiums on time.
- Your plan includes a Waiver of Premium, included at no extra charge, for covered injuries and illnesses. This means you don't have to pay your premiums after 90 days of total disability or the elimination period (whichever is longer). They'll be waived as long as the disability continues, up to the maximum benefit period.
- This plan includes convenient payroll deduction, so you don't have to remember to write a check for your premiums.
- You own the policy so you can keep this coverage if you leave the company or retire. Unum will bill you directly.
- Coverage becomes effective on the first day of the month in which payroll deductions begin.

Policy provisions

Pre-existing condition limitation – If you have a pre-existing condition within a 12-month period before your coverage effective date, benefits will not be paid for a disability period if it begins during the first 12 months the policy is inforce. A pre-existing condition is a condition for which symptoms existed (within 12 months before your coverage effective date) that would cause a person to seek treatment from a physician or for which a person was treated or received medical advice from a physician or took prescribed medicine. The determination of whether your condition qualifies as pre-existing will be based on the date of disability and not the date you notify Unum.

Pregnancy – Nine months after coverage becomes effective, pregnancy is considered the same as any other covered illness. The available monthly benefits will be paid upon fulfillment of the elimination period. Benefits will not be paid if the insured individual gives birth within nine months after the coverage becomes effective. However, medical complications of pregnancy may be considered as any other covered illness, subject to the pre-existing condition limitation.

Important: To enroll, please call the iBenefit Communications (iBC) Call Center at **1-877-242-1553**, Monday through Friday, from 9:00 A.M. to 5:00 P.M Eastern Standard Time.

**Premiums can be changed only if we change them on all policies of this kind inforce in the state in which the policy is issued.

* Eligible employees must be actively at work to apply for coverage. Being "actively at work" means that on the day the employee applies for coverage, he/she must be working at one of his/her company's business locations, or at a location where he/she is required to represent the company. If applying for coverage on a day that is not a scheduled workday, the employee will be considered actively at work as of his/her last scheduled workday. Employees are not considered actively at work if they are on a leave of absence.

Employees must be U.S. citizens, Canadian citizens working in the U.S., or have a green card, to receive coverage.

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations that may affect any benefits payable. For complete details of coverage and availability, please refer to policy form or contact your Unum representative.

Legal Plan (Legal Resources or Legal Shield)

Legal plans help pay for attorney fees for services such as wills, home sale/purchase, adoptions, divorce, consumer protection and tax audit. **Prince George's County Government has two (2) vendors you can select from that administer the plan, *Legal Resources* or Legal Shield***. Below is an overview.

Services	Legal Resources	Legal Shield
Parent Coverage	Parents and Spouse's Parents receives a 25% discount off Attorney Fees	Family members and friends of an employee enrolled in the Legal Shield plan are eligible to enroll in the plan for the same monthly premium rate charged to the employee. For more information on this benefit, contact Legal Shield at 1-800-654-7757.
Divorce (Uncontested) Divorce (Contested)	Fully Covered (no waiting period) Advice and Consultation; 25% Discount	Fully Covered Advice and Consultation; 25% Discount
Adoption (Uncontested)	Fully Covered	Fully Covered
Traffic Ticket Defense	Fully Covered	Fully Covered, Nationwide (15-day waiting period)
Will Preparation Standard Will Powers of Attorney Living Wills Codicils Complex Wills	 Fully Covered Fully Covered Fully Covered Fully Covered Consultations covered in full; 25% Discount	 Fully Covered Fully Covered Fully Covered Fully Covered All Consultations covered in full; 25% Discount
Document Preparation Deeds, Affidavits, Demand Letters, Mortgages, Promissory Notes	Fully Covered, no limits	Fully Covered
Purchase or Sale of Home	100% Attorney Fees covered on buying, selling, or refinancing primary residence	Fully Covered
Identity Theft Defense	**Fully Covered for household** • Work with Certified ID Theft Risk Management Specialist • ID Theft Resolution/Restoration Assistance • Annual Credit Report	**Fully Covered for ten (10) family members** • Work with Licensed, Private Investigators • Credit Monitoring (Financial, Medical, Criminal +) • Full Identity Restoration, $5 Million Guarantee • Covers up to eight minor children • Mobile App - 24/365 Easy Access/Emergencies
Immigration Assistance	Consultation and Document Review fully covered; 25% Discount	Consultation and Document Review fully covered; 25% Discount
Financial and Tax Planning Services	Consultation and Document Review fully covered; 25% Discount for preparation of a Financial Plan	Consultation and Document Review fully covered; 25% Discount
Enrollment Requirement	Must remain enrolled for twelve (12) months	None
DUI	100% Attorney fees covered first offense DUI	Covered - Consultation and Document Review, 25% discount for trial defense
Tenant Disputes	100% Attorney fees covered as Tenants	Covered - Increasing Trial Defense hours each year beginning with 60 in 1st year to 300 in 5th year
Consumer Protection (Civil Action) and Civil Litigation in District Court (Defendant and Plaintiff)	100% Attorney Fees covered for household	Covered - Increasing Trial Defense hours each year beginning with 60 in 1st year to 300 in 5th year
Additional Legal Coverage	Any legal matter not covered in full is covered with one hour of initial consultation and then a 25% attorney discount.	
Plan Cost	$17.00 per month (1st paycheck of month) Identity Theft Services included with legal plan at no extra cost.	**Legal plan only** - $7.27 per paycheck, $15.75 per month **Identity Theft only** - $6.90 per paycheck **Legal plan & Identity Theft** - $11.86 per paycheck

The legal providers offer comprehensive services. The above is an overview. You may obtain brochures with a complete list of covered items at an open enrollment provider session.

***Note: The number of Attorneys in the Legal Resources network is 13,000 nationwide. Members selects law firm from a well-established local law firm network. There is no limit on fully covered benefits for the following services: Attorney telephone calls, Attorney letters on your behalf and Contract, Document Review of personal Legal Documents.**

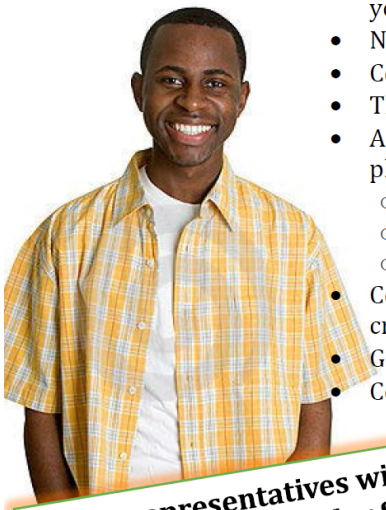
***Note: Legal Shield has worked with over 100,000+ law firms and attorneys nationwide. Provider Law Firms must be AV rated by Martindale Hubble, the National Law Firm Directory. A Mobile App can be downloaded for easy access and emergencies 24/7/365.**

Aflac Supplemental Dental Plan

Enhances Your Current Dental Plan!
Reduces Any Out of Pocket Expenses!
No Network – Choose Any Dentist!

WHAT IS AFLAC DENTAL?

- Does not replace your current dental plan – it improves what you already have
- No annual deductible or any out of pocket costs
- No precertification requirements – If your dentist recommends the treatment, you do not have to ask Aflac for permission
- No annual reviews – Coverage is guaranteed-renewable for life
- Completely portable if you ever leave Prince George's County Government
- The first five (5) years the plans maximum payout increases by $100 per year
- Aflac Dental pays cash benefits to the policyholder regardless of any other plans in place:
  - Pays up to $100 per preventative service
  - Pays up to $350 per crown
  - Pays up to $750 for oral surgery, gum treatment, and prosthetic repair
- Covers dental procedures from basic cleanings and preventative care to crowns, prosthetics, or major services
- Great for families
- Coverage per person costs less than one dollar a day



Aflac representatives will be at the scheduled Provider Sessions during Open Enrollment

All policies will go into effect Jan. 1ST, 2019

FOR MORE INFORMATION OR TO ENROLL IN AFLAC DENTAL PLEASE CONTACT THE AFLAC OFFICE FOR PRINCE GEORGE'S COUNTY

PHONE: (410) 394-9617
EMAIL: PRINCEGEORGES.AFLAC@GMAIL.COM.

What Happens During Open Enrollment?

Open enrollment is the time when you may cancel your health benefit plans and/or make the following changes:

- Enroll in a medical, dental, vision or prescription plan, long-term disability, extra life insurance, flexible spending accounts and/or medical and prescription opt-out-credits;
- Change from one medical plan to another;
- Change from one dental plan to another;
- Add an eligible dependent that is not currently covered. You must provide a copy of the marriage or birth certificate and social security number;
- Cancel enrollment in any of your health benefit plan(s) for you or your dependent(s); and
- Increase or decrease the amount of extra life insurance or long-term disability insurance.

You must complete the on-line enrollment process to enroll or make a change to the County's health benefit plans. If you do not complete the on-line enrollment process, the following will apply:

- The 2018 calendar year election you have on file for the medical, dental, prescription, vision, long-term disability, extra life insurance, medical, prescription and/or life insurance opt-out credit (LOC) plans will remain in force for the 2019 calendar year. Remember, as noted on pages 14 and 29, you must submit proof of medical insurance to remain enrolled in the Medical Opt Out Plan for calendar year 2019. Please see pages 13, 14, 15, 16, 29 and 30 for details on the enrollment process.

- The enrollment in the health and/or dependent care flexible spending accounts **will not** transfer from calendar year 2018 to 2019. **To continue your participation or enroll in the Flexible Spending Accounts for 2019, you MUST complete the on-line enrollment process. The on-line enrollment process MUST be completed even if you are electing the same amount you had in calendar year 2018. Please refer to the Quick Reference Guide on pages 15 and 16, step six (6) for further instructions.**

In addition, a full-time, part-time or Limited Term Grant Funded (LTGF) employee that is actively working fifteen (15) or more hours per week, can enroll and increase the level of coverage for the following voluntary benefit plans (accident, critical illness, whole life, short-term disability, supplemental dental and legal). The process to enroll or make changes to the voluntary benefit plans is outlined on pages 14 and 30.

What, When and Where are the Open Enrollment Provider Sessions?

The open enrollment provider sessions are an opportunity for you to attend a Benefit Fair with each of the health benefit plan providers. It will also allow you to learn more about the health benefit plans and ask questions or express your concerns to the providers. The Benefits Division staff will be at the provider sessions to answer any questions you may have on the administrative processes that govern the core health benefit plans. The Enrollment Benefits Specialists from iBenefit and Aflac Supplemental Dental will also be available to meet with you on-site at the provider sessions or by telephone (iBenefit Call Center) during the open enrollment period, if you are interested in enrolling in the voluntary benefit plans. **The open enrollment sessions are as follows**:

<table>
<tr><th colspan="2">2019 Open Enrollment Sessions – ALL PROVIDERS</th></tr>
<tr><td><u>Wednesday, October 10, 2018</u>
10:00 a.m. – 2:00 p.m.
RMS Building – First Floor Lobby
1400 McCormick Drive
Largo, MD</td><td><u>Friday, October 26, 2018</u>
10:00 a.m. – 2:00 p.m.
RMS Building – First Floor Lobby
1400 McCormick Drive
Largo, MD</td></tr>
<tr><td><u>Wednesday, October 17, 2018</u>
10:00 a.m. – 2:00 p.m.
County Administration Building (CAB)
Lower Level Lobby
14741 Governor Oden Bowie Drive
Upper Marlboro, MD</td><td rowspan="2">“Enroll or Make a Change, You Know What This Means, It’s Open Enrollment 2019”</td></tr>
<tr><td><u>Wednesday, October 24, 2018</u>
12:30 p.m. – 4:00 p.m.
Maintenance Operations Center (MOC)
8400 D’Arcy Road
Forestville, MD</td></tr>
</table>

The Last Day of Open Enrollment is October 26, 2018.

<u>Reminder</u>: Prince George's County policy states that County IDs must be worn when entering County buildings.

Remember, the Employee Self-Service (ESS) portal (the on-line enrollment process) will close at 11:59 p.m., on October 26, 2018.

Enrollment Process Q & A

Do I Need to Complete the On-line Enrollment Process During Open Enrollment?

A: Yes, you must complete the on-line enrollment process (see Quick Reference Guide on pages 15 and 16 to:

- Enroll or continue in the **Flexible Spending Accounts (FSAs)**
  - Health Care Spending Account.
  - Dependent Care Spending Account.

Note: To continue your participation or enroll in the Flexible Spending Accounts for 2019, you MUST complete the on-line enrollment process. The on-line enrollment process MUST be completed even if you are electing the same amount you had in calendar year 2018. Please refer to the Quick Reference Guide on page 16, step six (6) for further instructions.

- Enroll in or make changes to a core health benefit plan(s).
- Add or terminate a dependent on the health benefit plan(s).
- Enroll in the Medical and/or Opt-Out Credit Plans for calendar year 2019. **This applies to employees who were not enrolled in the Medical and/or Prescription Opt-Out Credit Plans in calendar year 2018.**

Note: You must SAVE the changes submitted through the ESS on-line enrollment process. When you hit the **SAVE** button, this will update your enrollment(s) and/or change(s) to the **ESS** on-line system. Once the enrollment(s) and/or change(s) has been updated to the system, you will receive the message **"Data saved successfully." Please print the page designated as the confirmation statement (see Quick Reference Guide on page 16, step seven [7] since it is your printed record of the enrollment(s) and/or change(s) you completed through the ESS on-line system.**

Do I Need to Complete the On-line Enrollment Process if I Am Not Making Any Changes During Open Enrollment?

A: No, you DO NOT need to complete the on-line enrollment process, if you are electing to keep the same plan or level of coverage for the medical, dental, prescription, vision, extra life insurance or long-term disability plans. Also, if you are enrolled in the medical and/or prescription opt-out credits, they will rollover from the 2018 to the 2019 calendar year.

For the Medical Opt-Out Credit, a copy of your medical card must be submitted to the Benefits Division or in an envelope postmarked by October 26, 2018. The medical card confirms your coverage through a County employee/retiree or an outside medical plan. It also allows you to continue your enrollment in the medical opt-out credit plan for calendar year 2019. **Failure to send the Benefits Division a copy of your card will result in you not being enrolled in the medical opt-out credit plan in calendar year 2019.**

Please feel free to mail (inter-office or USPS), fax (301-883-6358), bring to a provider or computer session, email (benefits@co.pg.md.us) or bring a copy of the medical card to the Benefits Division (RMS Building – Suite 245). The Benefits Division requests, that you write your first, last name and employee number on the document.

Can I only enroll or make changes to the health benefit plans during the provider sessions?

A: ***No, you can enroll or make changes to the health benefit plans anytime during the open enrollment period. The open enrollment period starts October 3, 2018 through October 26, 2018. The on-line enrollment portal will close at 11:59 p.m., on October 26, 2018.***

Do I Need to Meet with an Enrollment Benefits Specialist During Open Enrollment To Enroll in the Voluntary Benefit Plans?

A: Yes, Enrollment Specialists from iBenefit will be on-site at each of the Open Enrollment Provider and Medical Plan Provider Only Sessions to assist you with enrolling, iBenefit does not do changes to the voluntary benefit plans. You can contact the iBenefit Call Center at 1-877-242-1553. Please note, an Enrollment Benefits Specialist will **ONLY** assist you with understanding and enrolling in the voluntary (accident, enhanced critical illness, whole life, short-term disability [STD] and legal) benefit plans. If you are interested in the Aflac Supplemental Dental plan, you can either contact them at (410) 394-9617 or meet with an Aflac representative at one of the provider sessions outlined on pages 28 and 84.

Please contact the Benefits Division for materials on the voluntary benefit plans noted above. You can also obtain the materials from a provider session listed on pages 28 and 84. You will need to contact the iBenefit Call Center to enroll in one of the plans noted above. Please check with the Human Resources Liaison(s) in your agency to determine if they requested a representative from iBenefits and/or Aflac to come to your location.

If I am currently enrolled in a voluntary benefit plan and want to make a change (increase or decrease level of plan coverage) or want to cancel the plan what do I need to do?

A: You must contact the provider directly to make a change to an existing plan(s) or to cancel Enrollment in a plan(s). The contact information for the voluntary benefit plan providers is outlined on page eighty-three (83). iBenefit can provide you with a Customer Service Form that will allow you to make changes to the Unum plans only; however, it will need to be forwarded to Unum by you. As noted above, you must contact the other carriers (Legal Shield, Legal Resources and Aflac) to make changes to those plans.

How Do I Cancel My Enrollment in the FOP Dental Plan?

A: To cancel your enrollment in the FOP dental plan, you must contact the FOP directly by calling (301) 952-0882. **The change cannot be made through the County's on-line enrollment process.**

What Kind of Changes May I Make During This Open Enrollment Period?

Open enrollment is the time when you may cancel a benefit plan(s) and/or make the following changes:

- Enroll in a core health benefit plan (medical, dental, vision, flexible spending accounts [health and/or dependent], opt-out credits [medical, prescription and life insurance], long-term disability and extra life insurance), and/or the voluntary benefit plans (short-term disability, enhanced critical illness, accident, whole life, group legal and supplemental dental insurance);
- Change from one medical plan to another;
- Change from one dental plan to another;
- Add an eligible dependent that is not currently covered. To add your dependent to the health benefit plans, you must provide a copy of the marriage, birth certificate or other supporting documentation and social security number to the Benefits Division. Please note that during the open enrollment provider sessions, the Benefits Division staff is unable to make copies of your documents for the dependent(s) being added. A copy of your document(s) must be submitted to the Benefits Division or in an envelope postmarked by October 26, 2018. **Failure to send the Benefits Division a copy of your document(s) will result in your dependent(s) not being enrolled in the health benefit plan(s) for calendar year 2019.**
- Please feel free to mail (inter-office or USPS), fax (301) 883-6358, bring to a provider or computer session, email benefits@co.pg.md.us or bring a copy of the document(s) to the Benefits Division (RMS Building, Suite 245). Your first and last name along with your employee ID number must be provided on the document(s).
- Cancel enrollment in any health benefit plan(s) for you or your dependent(s).
- Increase and decrease the amount of extra life insurance or long-term disability insurance.

NOTE: Limited Term Grant-Funded (LTGF) employees may enroll or increase the level of coverage for the voluntary benefit plans (short-term disability, whole life, group legal insurance, enhanced critical illness, accident, and supplemental dental).

What Happens to My Enrollment in the Health and Life Insurance Plans, If I Take an Approved Leave of Absence from Work?

You can take an approved leave of absence (i.e., military, FMLA, disability, leave without pay [LWOP]) in a pay or non-pay status. The health benefit plans may continue or you can elect to terminate the plan(s) until you return to work. If you are on approved military, FMLA or disability leave with a non-pay status and you elect to continue your health benefit plans, the payment of premiums for the plans could go into arrearage until you return to work. An approved leave status of LWOP with non-pay will result in you having to pay the employer and employee share while on leave. A termination of the health benefit plan(s) while on approved leave will require you to enroll in the plan(s) **within forty-five (45) days of returning to work**. Otherwise, you will have to wait until the next open enrollment period following your return to work to enroll in the plan(s).

The life insurance plan(s) will continue for a specified period if you are on approved military, FMLA or disability leave. A LWOP status results in the plan(s) being discontinued at the end of the month following the date the leave of absence took effect.

OHRM strongly encourages you to contact the Benefits Division prior to a leave of absence to discuss your health benefits coverage. You can contact the Benefits Division at (301) 883-6380 (select option eight [8]) or 1-800-634-5231 (press two [2] for Benefits Division and then select option eight [8]).

What Happens to My Enrollment in the Voluntary Benefit Plans, Flexible Spending Accounts (FSAs) and Opt-Out Credits While I Am on Leave Without Pay (LWOP)?

Your enrollment in the voluntary benefit plans, flexible spending accounts (FSAs) and Opt-Out credits will terminate when you are placed in a LWOP status.

If you want to continue enrollment in the voluntary benefit plans, you must contact the provider of the plans directly. They will advise you on how to continue coverage in the voluntary benefit plans and the process for reactivating the plans when you return to work. If you do not reactivate your enrollment in the plans, you can elect to enroll in the plans during the next open enrollment upon returning to work. However, the provider will require you to complete the Evidence of Insurability (EOI) process.

Your enrollment in the FSAs and Opt-Out credits will also terminate when you are placed in a LWOP status. You will have until April 30th of the calendar year following your LWOP status to submit any eligible expenses incurred prior to and including the termination date of the FSA account(s) to the administrator, ConnectYourCare.

Please contact the Benefits Division on the above stated telephone numbers if you have questions about the continuation of your coverage in the plans previously stated.

How Do I Enroll in a core Health Benefit Plan(s) or Make a Change to My Existing Benefit Plan(s) During Open Enrollment?

You must complete the on-line enrollment process to enroll or make a change(s) to a core health benefit plan(s) by 11:59 p.m., Friday, October 26, 2018. The enrollment process for the health benefit plans is outlined on pages 13, 14, 15, 16, 29 and 30 . If you want to enroll or make changes to a voluntary benefit plan(s), you must meet with an iBenefit Enrollment Specialist or the Aflac – Supplemental Dental representative at one of the Open Enrollment or Medical Plan Provider Sessions; or call the iBenefit Call Center during the open enrollmemt period. See page 14 and 30 for details on the voluntary benefit enrollment process.

NOTE: **You will *not* be able to make changes to the County's core health benefit plan(s) by meeting with the Aflac Enrollment Benefits Specialist or through the iBenefit Call Center. They can only assist you with enrolling in the voluntary benefit plan(s).**

May I Make Changes to the core Health Benefit Plans During the 2019 Calendar Year?

The only time you can make a change to your core health benefit plan(s) during the 2019 calendar year (outside of open enrollment) is if you or one of your dependent(s) has a qualified family status change. See page thirty-four (34) for more information on a qualified family status change.

What is a Qualified Family Status Change?

- *Birth* - You must complete an Enrollment/Change Form (Form)* to add your newborn child to your health benefits coverage, and submit the Form to the Benefits Division within forty-five (45) days of the birth of your newborn child. **If you fail to add your newborn child to the coverage within the forty-five (45) day timeframe, you will have to wait until the next open enrollment period to make the change unless your dependent experiences a family status change such as loss of coverage gained from a source outside the County. The Benefits Division will not make an exception to this requirement.**

  Please do not wait until you receive the birth certificate and social security number before you add the newborn child to your health benefit plan(s). The Benefits Division will send a letter to the address on file for you requesting a copy of the birth certificate and social security number. It is imperative that you respond with the requested documentation by the stated deadline in the letter.
- Death, divorce, legal separation, limited divorce, adoption or marriage;
- Termination or commencement of employment. Retirement is **not** a qualified family status change;
- Change in employment status from part-time to full-time;
- Covered dependent ceasing to be an eligible dependent; and
- Loss of health benefits coverage.

The above stated will allow you to add, change and/or terminate a health benefit plan(s). Please contact the Benefits Division with any questions and to obtain additional information on other qualified family status changes and get a Form.

NOTE: Family status change(s) must be made within forty-five (45) days of the qualifying event.

Newborns will be covered as of their date of birth, if you add the newborn to your health benefits coverage within forty-five (45) days of the birth of your child. Coverage for dependents you have adopted or legal guardianship will be effective the date of the court order, if you add the dependent to your health benefits coverage within forty-five (45) days of the signed court order. Please see page thirty-five (35) for the termination date of coverage for dependents covered as a result of legal guardianship.

The effective date for all other family status changes will be the first of the month following receipt of the Enrollment/Change Form. If notification is received after the end of the month in which the qualifying event occurs, the effective date of the change will be the first of the next month and there will be no refund of health benefit plan premiums even if the event results in a reduction in the coverage level.

***The Benefits Division transitioned to the Enterprise Resources Planning (ERP) system as of July 1, 2015. The Benefits Division is working on the process to enable all qualified family status changes to be done on-line via the ERP system. As a result, this process will replace the Enrollment/Change Form. Details for the ERP on-line process will be sent under separate cover.**

Who are Eligible Dependents?

◊ A Spouse (to include a same sex spouse) can be added to the health benefit plan(s);

◊ Children under age 26. (The coverage for children ends the last day of the month in which they turn age 26.) This includes stepchildren and children of the same-sex spouse. **Note**: If you are only adding the step-children or children of the same-sex spouse, you must submit the marriage certificate and the children's birth certificates and social security numbers. The birth certificate must list the spouse's name as the parent;

◊ Children certified to be totally unable to support themselves because of mental or physical disability occurring prior to age 26. **Medical documentation to support your dependent's disability must be submitted for approval. Please contact the Benefits Division for additional information on the approval process. A dependent will not be added to the health benefit plans until an approval is received**;

◊ Legal Ward or Guardianship up to age 18. Dependents are terminated at the end of the month in which they turn age 18 or when the guardianship ceases, which is generally at age 18;

◊ Children that you are in the process of adopting and of whom you have custody. Employees must submit a copy of the Petition for Adoption and the Temporary Custody Order;

◊ Legally adopted children. Employees must submit a copy of the Judgment or Decree of Adoption upon termination of the Temporary Custody Order in order to continue coverage;

◊ Children legally adopted in a foreign country. Employees must provide a certified copy of the English translation of the birth certificate and adoption order;

◊ Children for whom you have assumed a legal and financial responsibility. Employees must provide a copy of the Court Order granting legal custody or guardianship; and

◊ Dependents for which a Qualified Medical Child Support Order has been received by the Benefits Division.

What Documentation is required to Add a Dependent(s)?

To add your dependent to the health benefit plans, you **must** provide a copy of the marriage, birth certificate(s), or other supporting documentation and social security number to the Benefits Division. A court order, birth certificate and social security number are required for legal guardianship. An adoption of a child(ren) requires an adoption court order and/or adoption papers. Please note that during the open enrollment provider sessions, the Benefits Division staff is unable to make copies of your documents for the dependent(s) being added. **Failure to submit a copy of the supporting documentation will result in your dependent(s) not having coverage as of January 1, 2019.**

Can Your Dependent(s) Select a Different Health Benefit Plan(s) than You, the Member?

No, your dependent(s) must be enrolled in the same health benefit plans that you select. However, you do not have to enroll a dependent in every plan that you select.

Do I Select a Primary Care Physician (PCP) if I Enroll in a Cigna Medical Plan?

You are not required to select a PCP because the medical plans are open access network plans. The Open Access In-Network OAPN (HMO) and in-network option of the Open Access Plus OAP (PPO) medical plans require you to use a provider in the network in order for the plan to provide payment for covered services. If you use a provider that is not in the network, you will be responsible for payment of the services you incurred under the Open Access In-Network OAPN (HMO) medical plan. However, the Open Access OAP (PPO) plan allows you to utilize a participating provider in the network and the coverage outlined under the in-network option applies or you can use a non-participating provider and the out-of-network option provides coverage for the medical services. The applicable deductible and co-insurance applies to services covered under the PPO out-of-network option. Cigna will apply the reasonable and customary amount to the payment of claims for medical services under the out-of-network option.

To obtain a list of the Cigna network providers, you can access Cigna's website at www.cigna.com, pick up a Cigna Directory during open enrollment, call the Member Services Department at 1-800-244-6224, or you can simply ask the provider if they are a network provider for the Open Access In-Network OAPN (HMO) or Open Access Network OAP (PPO) medical plans.

How Can I Be Sure My Services Will Be Covered Since I Do Not Live in the Cigna Service Area?

The County provides you with two options, Open Access Plus In-Network OAPN (HMO), and Open Access Plus Preferred Provider Organization OAP (PPO) medical plans through Cigna. The Open Access Plus in-network OAPN (HMO) and Open Access Plus OAP (PPO) in-network option medical plans have a national provider network that has participating providers in most areas across the country. The Benefits Division encourages you to make sure the provider participates in the network by asking if they accept the Cigna Open Access Plus In-Network OAPN (HMO) or Open Access Plus OAP (PPO) medical plan. You can also call Cigna at 1-800-244-6224 to speak with a representative or access www.mycigna.com to locate a participating provider under the medical plans.

Do I Have to Select a Primary Care Dentist (PCD) if I Enroll in the Aetna DMO Dental Plan?

Yes, if you enroll in the Aetna DMO plan, in order to use your dental plan benefits you *must* complete the Aetna DMO PCD Election Form (PCD Election Form) on page eighty-five (85) and select a PCD for you and your covered family members. A copy of the PCD Election Form must be submitted to the Division in an envelope post-marked by October 26, 2018. You can mail (USPS) the PCD Election Form, fax to (301) 883-6358, bring to a provider session, email to benefits@co.pg.md.us, or deliver it to the Benefits Division (RMS Building, Suite 245). To obtain a list of participating PCDs, you can visit Aetna's *DocFind* on-line provider directory at www.aetna.com, or obtain a paper directory of participating PCDs at an open enrollment provider session. You can also contact Member Services at 1-877-238-6200 to obtain the name of a PCD in the area where you reside. **Please note that if you do not select a PCD, you will not be able to use your DMO dental plan benefits on January 1, 2019.**

NOTE: **If there is not a network in the area where you reside, you may select a PCD in the area where you work, provided a network is available. You must indicate your work address on the Aetna DMO PCD Election Form (Form). A copy of the Form is on page 85 and available on the Intranet.**

Cigna

Cigna One Guide®

The **Cigna One Guide®** service can help you make smarter, more informed choices and get the most from your plan. It's our highest level of support that combines the ease of a powerful app with the personal touch of live customer service. Your One Guide personal support, tools and reminders can help you stay healthy and save money. Get in touch with the new Cigna One Guide team by telephone, click to chat or via the enhanced myCigna app. To get started quickly, follow these five easy steps:

1. **Log in to myCigna.**℠ Just visit **myCigna.com** to start or finish customizing your very own health journey. Watch a quick video at Cigna.com/myCigna-tour to get a sneak peek at all the great tools that are available to you.

2. **Set your preferences.** Once your account is set up, manage your profile to let us know the best way to contact you with important health information, like your Explanation of Benefits or claim updates.

3. **Find care.** You can search through all of the doctors in your network to find one you like. Keep these tips in mind to help avoid surprise expenses and get the most out of your plan:
   - › Make sure doctors and facilities are covered by your plan; and
   - › Know before you go. Search for lower-cost options, like urgent care centers, instead of the ER, if you can't see your doctor immediately.

4. **Connect with us, 24/7/365.** We are here whether you need to change doctors, transfer a prescription or you already have care like a surgery planned. We are here to make things easier, **24/7/365** and help you every step of the way.

   › Call the number on your Cigna ID card. If you don't have one, don't worry, you can download a copy from the app.

5. **Get the most from your plan.** The new **Cigna One Guide®** team is ready to help you every step of the way. Our personal support begins with making sure you select in-network providers and facilities and make the most of your current coverage. Call or click to chat with a Personal Guide any time.

Cigna Healthcare *(Continued)*

6. **Get the most from your plan.** The new **Cigna One Guide®** team is ready to help you every step of the way. Our personal support begins with making sure you select in-network providers and facilities and make the most of your current coverage. Call or click to chat with a Personal Guide any time.

At Cigna, we understand that navigating your health care isn't always easy. And we're here to help with Cigna One Guide®, a highly personalized support system designed to make it easy to get the most out of your health care benefits.

Cigna has a variety of programs that can save you money and help you improve your health.

- **Cigna Care Designation/Centers of Excellence:** We know you want to visit a doctor who has a good reputation and provides quality care at an affordable cost. So, Cigna has identified the top performers in their network by awarding them with a **Cigna Care Designation on myCigna.com. Doctors in twenty-two (22) different medical specialties are evaluated annually for quality and cost, and only those who meet certain Cigna cost-efficiency and quality measures receive the recognition.** To find one of these doctors in the myCigna.com directory, just look for the "blue C" symbol.

Online Health Assessment: Taking a health assessment is a quick and easy way to learn more about your health today, and to figure out how you can improve your health in the future. After completing the health assessment, you'll get a report that includes your wellness score, as well as recommended programs. This report is a great tool to share with your doctor and use as a guide to help you set and achieve healthy goals.

Cigna (*Continued)*

At Cigna, we understand that navigating your health care isn't always easy. And we're here to help with Cigna One Guide®, a highly personalized support system designed to make it easy to get the most out of your health care benefits.

Cigna has a variety of programs that can save you money and help you improve your health.

- **Cigna Care Designation/Centers of Excellence:** We know you want to visit a doctor who has a good reputation and provides quality care at an affordable cost. So, Cigna has identified the top performers in their network by awarding them with a Cigna Care Designation on my Cigna.com. **Doctors in twenty-two (22) different medical specialties are evaluated annually for quality and cost, and only those who meet certain Cigna cost-efficiency and quality measures receive the recognition**. To find one of these doctors in the myCigna.com directory, just look for the "blue C" symbol.

  Online Health Assessment: Taking a health assessment is a quick and easy way to learn more about your health today, and to figure out how you can improve your health in the future. After completing the health assessment, you'll get a report that includes your wellness score, as well as recommended programs. This report is a great tool to share with your doctor and use as a guide to help you set and achieve healthy goals.

- **Health coaches:** Get one-to-one support to help you reach your health goals.
- **Health and Wellness Discounts:** Get discounts on the health products and programs you use every day such as:

  › Weight management and nutrition
  › Vision and hearing care
  › Alternative medicine
  › Healthy lifestyle and fitness

  Just use your ID card when you pay and let the savings begin.

Cigna (*Continued)*

- **Healthy Babies Program**: Enroll in this prenatal program designed to help you and your baby stay healthy during your pregnancy and in the days and weeks following your baby's birth.

- **Lifestyle Management Programs:** If weight, tobacco or stress are affecting your health or your ability to live an active life, it may be time to make some changes. A health coach can provide you with personalized support to help you:
  - › Learn to manage your weight using a non-diet approach that helps you build confidence, change habits, eat healthier and become more active; and
  - › Develop a personal quit plan to become and remain tobacco free; and
  - › Understand the sources of your stress, and learn to use coping techniques to better manage stress both on and off the job.

You can use an on-line or telephone coaching program or both for the support you need.

- **Free Diabetic Supplies**
  - The Cigna medical plan you are enrolled in will cover your diabetic supplies at 100%.
  - You may even be eligible for a FREE glucose meter.
  - To obtain one of these glucose meters and test strips at no cost through Cigna Home Delivery Pharmacy, please call 1-800-238-4778 for details.

Cigna *(Continued)*

- **24-Hour Telephone Support**: Whenever you need us, just call the toll-free number printed on the back of your Cigna ID card 24 hours a day, seven days a week, 365 days a year. The 24-hour telephone support can provide the following:

  › Answers to health, claims and plan questions; or
  › Order an ID card, update information and check claim status; or
  › Find a health advocate for help with improving specific health issues; or
  › Speak with a Spanish speaking service representative or someone who can translate one of 200 languages.

Telehealth Services – Cigna members will be able to access telehealth services to treat minor medical conditions (colds, flu, allergies, headaches, etc.). Connect with a board-certified doctor via video or phone when, where and how it works best for you. Visit their website or call to register, AmwellforCigna.com 855-667-9722 or MDLIVE forCigna.com 888-726-3171.

Kaiser Permanente

Kaiser Permanente Provides Care Where You Need It

- Five (5) urgent care medical centers open 24 hours a day, 7 days a week.
- Thirty (30) multi-specialty medical centers.

New and expanded:

- Gaithersburg, MD
- Largo, MD
- Glen Burnie, MD
- South Baltimore County, MD
- Tysons Corner, VA
- Downtown Baltimore City, MD
- Towson, MD
- Harford County, MD
- Alexandria, VA (coming in 2019)
- Bowie, MD (coming in 2020)
- Heymarket (coming in 2019)
- Stafford (coming in 2019)

Many services under one (1) roof:

- Family medicine
- Internal medicine
- Lab
- Obstetrics/gynecology
- Pediatrics
- Pharmacy
- Radiology
- Specialties
- Vision

Find a facility near you. Visit *kp.org/locations*.

Kaiser Permanente (*Continued*)

You Can Use Your Mobile Device To:

- Video Visit with your Primary Care Provider at **NO additional charge**; or
- Email your doctor's office; or
- View most lab results; or
- Order prescription refills; or
- Schedule and change routine appointments; or
- Refill most prescriptions; or
- View past visits and more; or
- Just download the Kaiser Permanente app at no cost from your preferred app site.

You Have A Healthcare Team Focused On You

Choose your PCP and OB/Gyn at kp.org/doctor—change at any time.

Kaiser Permanente doctors:

- Are carefully selected and board certified;
- Use our electronic systems to help discover gaps in patient care;
- Are up-to-date and connected to your care team through your electronic health record; and
- Can schedule most specialty consultations right in the exam room to take place within seven (7) days.

Urgent Care

At your Kaiser Permanente Urgent Care Plus Center, you get:

- Board certified emergency department physicians who are capable of handling any problem you may have day or night;
- Less wait time and lower co-pays than a typical hospital emergency room;
- 24/7 pharmacy and laboratory services;
- Advanced imaging services including Cat Scan (CT), Magnetic Resonance Imaging (MRI), and ultrasound;
- Expanded observation services, with ability to observe patients for up to 24 hours; and
- Expanded Urgent Care hours at Woodbridge, VA medical center.

Kaiser Permanente (*Continued*)

Call 1-800-777-7904 (1-800-700-4901, TTY) to schedule an appointment, or just come on in, whichever is more convenient for you. If you believe you are experiencing a medical emergency, call 911.

Video Visits
Why book a video visit with Kaiser Permanente?

If you're short on time but have a health matter that needs attention, you can see a doctor face to face, without visiting the office. Video visits are easy, secure, and part of your coordinated care, so you can always get the care you need.

Get care for just about anything:

- Follow -up visits
- Minor burns/sunburn
- Cuts and wounds
- Skin rash/infection
- Flu
- Sore throat
- Backaches

And much more. Video visits are available at no co-pay or co-insurance. Book on-line at kp.org or call our appointment line.

When you speak to one of our advice nurses, the nurse may be able to schedule a same-day video consult with one of our emergency room physicians using the camera on your computer, tablet, or telephone.

Healthy Lifestyles
Get the advice, encouragement, and tools you need to make healthy changes, such as:

- Eating Healthy
- Losing Weight
- Quitting Smoking
- Reducing Stress

Kaiser Permanente (*Continued*)

- Sleep Management
- Pain Management
- Mental Health and Depression
- Diabetes Management

To pick the program you want, sign on to kp.org/healthylifestyles.

Start now, take advantage of being a Kaiser Permanente member and have access to programs and classes that are offered at our medical centers to help you live healthier, such as:

- Prenatal and Lamaze;
- Breastfeeding;
- Nutrition;
- Fall Prevention:
- Insulin Information sessions:
- Osteoporosis Awareness; or
- Commit to Quit.

For more information on these programs and the many more offered to Kaiser Permanente members, please visit www.kp.org/healthylifestyles.

Wellness Coaching

Partner with a coach today to:

- Focus on healthy habits—Make healthy behavior changes to help you manage your weight, quit tobacco, reduce stress, get more active, or make healthier food choices;
- Create a customized plan—Work with your coach to outline manageable steps you can take to reach your goals. Little changes over time can help you achieve long-term success;
- Schedule convenient telephone sessions - coaching takes place over the telephone, so you can set up calls at times that work for you; and
- Wellness coaching is available at no charge for Kaiser Permanente members.

Coaching is offered in English and Spanish. No referral is needed. Coaches also have access to a language line to facilitate coaching in most languages.

Simply pick up the telephone and call to get started. Call 1-866-862-4295, Monday through Friday, from 7 a.m. to 8 p.m., Eastern Standard Time (EST) to make an appointment.

Aetna Dental

Aetna Dental DMO

The Aetna Dental DMO is personal and affordable. You will get care that is easy on your budget, and you can enjoy the following features of the DMO dental benefit plan:

- A primary care dentist to manage your dental care. You choose the dentist from the dental network. Your primary care dentist can refer you to specialists when necessary.
- No deductibles.
- No annual dollar maximums.

For more information about the DMO dental plan, go to: www.aetnadmodental.com.

Aetna Dental PPO

The Aetna Dental PPO plan provides you with freedom. You can pick any licensed dentist in the network or you can go outside the dental plan's network. If you go to an in-network dentist it will cost you less, but the choice is yours. Either way, you will enjoy these features:

- No referrals.
- No need to choose a primary care dentist.

For more information about the PPO dental plan, go to: www.aetnappodental.com.

Dental ID Cards

Good news. Life just got simpler. You no longer need a member ID card to get care with Aetna Dental.

Aetna wants to make doing business easier than ever. Plus, no card means no plastic and that's better for the environment – and good for everyone.

Aetna Dental (*Continued*)

How will my dentist know I'm an Aetna Dental PPO or DMO® member? When you go to your dentist, tell the office your name, date of birth and Member ID# (or your social security number).

But what if I want a card?

Easy — use our mobile app or go on-line. Log in to your secure member website at **www.aetna.com**. Your ID card will appear on your personal benefits page. You can print out an ID card for you and your dependents by clicking on **"Get an ID card."**

For DMO Members, if your electronic ID card says, **"No Election"** or **"Invalid Choice,"** then your plan requires you to choose a Primary Care Dentist (PCD) who is in our network. Until you choose one, your benefits and claims may be limited to emergency services only. To be effective on the first (1st) of the month, PCD selections must be received at Aetna by the fifteenth (15th) of the prior month. In order to schedule an appointment with a PCD, your name must appear on the monthly roster sent to PCDs.

Call 1-877-238-6200 if you have any questions 24 hours a day, 365 days a year.

Aetna Navigator Health Information Guide

You can make the most of your dental benefit plans using the Aetna Navigator to find answers and access information on the following items:

- Review who is covered on your plan;
- Find a dentist who participates in your network;
- Compare in-and out-of-network costs for the most common dental procedures before you visit the dentist. You will also see how much you can save by visiting an Aetna network dentist;
- Print your Health History Report this is a handy summary of your dental visits, tests and more. You can share it with your dentist;
- Link to health information on-line; and
- Communicate with Member Services.

It's easy to get started! Go to www.aetna.com. Click on "Register Now" in the "Members: Secure Information" section.

Aetna Dental (*Continued*)

Aetna Mobile — find what you need, wherever, whenever

The Aetna Mobile app will allow you to access your ID card or dental benefits information when you're on the go. In order to install the Aetna Mobile app, go to the Play Store, search for "Aetna Mobile," it will be the app, with the blue icon and download.

Aetna Life Insurance

Aetna Life EssentialsSM Progrm* — Extra protection adds up to extra value at no extra cost.

Aetna Life Essentials adds value to your life insurance policy by helping you make the most of every stage of your life. The program gives you and your family access to free resources during your lifetime and afterward:

- **Funeral services** — Manage all funeral details through Everest Funeral Planning and Concierge Services.
- **Accelerated death benefit** — Access a portion of your life insurance benefit, if you're terminally ill, before your death.
- **Legal services** — Benefit from on-line estate planning services.
- **Physical services** — Gain access to discount vision, hearing and fitness programs.
- **Care advocacy** — Receive professional counseling over the phone from a master's level social worker.
- **End-of-life support** — Visit the Aetna Compassionate Care^{SM} website. Also, talk to a licensed social worker to prepare for this challenging time of life.

Visit: www.aetna.com/aetnalifeessentials

*****Legal Reference™ Program services are independently offered and administered by ARAG® Insurance Company of Des Moines, Iowa. Aetna does not participate in attorney selection or review, and does not monitor ARAG services, content or network. Everest Funeral Planning and Concierge Services ("Services") are independently administered by Everest Funeral Package, LLC ("Everest"). Access to these services is not insurance, may be discontinued at any time without notice and is void where prohibited. Everest is solely responsible for furnishing these services and Aetna makes no guarantee or representations as to their quality or suitability. In no event will Aetna be responsible or liable for any acts or omissions by Everest and its agents, employees or representatives in connection with the services provided.

Aetna Life Essentials℠ Program

Specific features of life insurance plans vary, depending on employers and states. Plan features and availability may vary by location and are subject to change. Plans contain exclusions and limitations. See policy or plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Information is believed to be accurate as of the production date; however, it is subject to change.

Express Scripts Prescription

My Rx Choices® makes it easy to find lower-cost alternatives available under your program to your current medications—either on-line or by calling Express Scripts at the number on the back of your card. To find lower-cost options on-line:

1. **Log on to** www.express-scripts.com/choices. If you're a first-time visitor to the website, you'll need to register, so have your member identification (ID) number and a recent prescription number handy.
2. **Select a medication that you take on an ongoing basis or enter the name of your medication.**
   My Rx Choices will search for available options and show you how much you could save by choosing available lower-cost options.
3. **Print the prescription savings report to discuss with your doctor.** Your doctor can review your choices and, as appropriate, write a new prescription for you.

***Consumer Reports Best Buy Drugs*™** In addition to saving you money, some lower-cost medications could be rated as *Consumer Reports Best Buy Drugs*. When visiting **My Rx Choices** on-line, click the *Consumer Reports Best Buy Drugs* icon to find out more about those alternatives. This additional information may be helpful when discussing lower-cost alternatives with your doctor.

The Prince George's County Government understands that you and your doctor need new ways to help reduce your healthcare costs. With **My Rx Choices,** you can do exactly that—without compromising quality.

Generics vs. Brand-Name Drugs

If you're taking a brand-name drug, ask your doctor whether an available generic may be right for you. FDA-approved generic drugs are safe and effective, and they must meet the same U.S. Food and Drug Administration standards of quality and purity as brand-name drugs. They provide the same health benefits as the brand versions but at a lower cost to you. **By considering a generic medication,** you're taking an important step in becoming more engaged in your prescription drug therapy.

If you have any questions, please call Express Scripts Member Services at the number on the back of your card, or visit us on-line at www.express-scripts.com.

Express Scripts Prescription *(Continued)*

Express Scripts' Extended Payment Program

Paying for your mail-order prescriptions just got easier.

Express Scripts has created a Program to help make your mail-order prescriptions more affordable. It's called the Extended Payment Program (EPP).

EPP allows you to spread your prescription payments over **three (3)** credit or debit card installments so you don't have to pay all at once. And there's no waiting—your medication will be shipped after the very first payment.

When you're enrolled in EPP it will apply to every mail-order prescription for you and your eligible dependents going forward. If at any point you wish to opt out of the Program, you may call Member Services or visit www.express-scripts.com.

Facts about EPP

- If you decide to cancel EPP at any time, payment for the remainder of your current prescriptions will be your responsibility.
- If the payment plan ends, invoices incurred while enrolled in EPP will continue to be charged in three (3) installments. New invoices will require your regular co-payments in full.

To learn more about Express Scripts' Extended Payment Program, please visit www.express-scripts.com or call Member Services toll-free at the number on the back of your prescription drug ID card.

Express Scripts Prescription *(Continued)*

***Worry Free Fills*™ Program**

Refill your mail-order prescriptions automatically.

Ordering prescriptions and taking your medications are among the most important things you can do. But ordering isn't always easy to remember. You might even find it inconvenient. And that is why Express Scripts has created the **Worry-Free Fills™** Program, so your prescriptions can be refilled automatically.

You can enroll your eligible prescriptions in **Worry-Free Fills** when you order your first refill. If they're already enrolled, there's no need to call for refills. As you near the end of your current supply, Express Scripts automatically sends your next refill, using your existing address and payment information.

To enroll in **Worry-Free Fills,** visit www.express-scripts.com, or call Member Services at the number on the back of your prescription card.

Medications that qualify for *Worry-Free Fills* include:

- Cardiovascular medications, such as antiarrhythmic, calcium channel blockers, antihypertensive, beta- blockers, cholesterol-lowering medications, diuretics, and ACE inhibitors
- Certain HIV medications
- Diabetes medications
- Oral contraceptives
- Osteoporosis medications
- Parkinson's disease medications
- Thyroid medications
- Asthma and COPD medications, such as theophylline

For safety and other reasons, prescriptions for some medications are never allowed to be filled automatically. Specialty medications, controlled substances, and over-the-counter medications are examples.

Express Scripts Prescription *(Continued)*

When a prescription expires and you or your doctor sends in a new prescription without an amendment, the medication will automatically be re-enrolled in **Worry-Free Fills**. If there's a change in the prescription, you'll need to re-enroll in the Worry-Free Fills Program**.**

To see if you're eligible for **Worry-Free Fills** and to enroll your prescriptions, visit www.express-scripts.com or call Member Services toll-free at the number on the back of your prescription drug ID card.

If you enroll in the **Worry-Free Fills** program, please note that Express Scripts has a standard maintenance and review process. Standard maintenance will include an automated process for review and reporting of the drugs that qualify for the **Worry-Free Fills** program. Updates to the exclusion list are made as a part of the standard maintenance; therefore, the qualified medications under the program are subject to change. If your medication is no longer a qualified drug you will be notified by Express Scripts.

Express Scripts Specialist Pharmacists…

Can help you understand your medications *and* could help you save money. Express Scripts, which manages the prescription drug benefit for the Prince George's County Government, offers a great way to help members safeguard their health. You now have 24/7 access by telephone to the expertise and personalized support of Express Scripts Specialist Pharmacists and they are available through your prescription drug benefit at no additional cost.

Express Scripts Specialist Pharmacists have expertise in the medications used to treat specific conditions, such as high blood pressure, high cholesterol, depression, diabetes, asthma, osteoporosis, or cancer. This expertise comes from additional training in these medications, combined with experience gained from helping people with similar conditions.

Express Scripts Specialist Pharmacists can work with you and your doctor to help safeguard your health.

Often members with multiple conditions see multiple doctors, who may be unaware of what other doctors are prescribing. Express Scripts reviews *all* your medications on file from *all* your doctors and pharmacies to look for drug interactions that may be harmful.

Express Scripts Prescription *(Continued)*

If there is a potential problem with certain medications, an Express Scripts Specialist Pharmacist will review the prescription and contact you or your doctor to help make sure your medications will work safely together and work well for you.

These pharmacists could also help you save money on your prescriptions.
Taking your medication as your doctor directed is one of the best ways to help maintain or improve your health. But to take your medication regularly, it helps when it's affordable.

Express Scripts Specialist Pharmacists can help you see if there are any **lower-cost alternatives available under your plan.** They can work with your doctor to help you get the best drug for you.

You can address your concerns privately.
Like all our pharmacists, Express Scripts Specialist Pharmacists have the time to talk to you on the telephone—*in private*, 24/7—to help you understand and manage your medications.

This means that you can feel comfortable asking personal and sensitive questions about your medications—without the concern of bystanders listening to your conversation.

During your conversation, the pharmacist is fully available to help you understand how your medications work and their potential benefits for you.

An easy way to take advantage of this enhanced pharmacy support is to get your prescriptions through the mail from the **Express Scripts Pharmacy™**. You'll also benefit from the convenience of having medications delivered right to you. With the **Express Scripts Pharmacy™,** you'll get:

- Up to a 90-day supply of medication—which could be at a lower cost than at a local retail pharmacy; and
- 24/7 access to benefit specialists, who can answer questions and also arrange for you to talk to an Express Scripts Specialist Pharmacist; and
- An easy refill process over the telephone, by mail, or on-line.

You can call an Express Scripts Specialist Pharmacist to help you understand and manage your medications. Just call the toll-free number on your prescription drug ID card.

Express Scripts Prescription *(Continued)*

Remember….

Prince George's County Government has Exclusive Home Delivery. This allows members to receive two fills of their maintenance medication at a retail store. After the second fill at retail, members will pay a 100% co-pay penalty until they move to the Express Scripts Pharmacy.

Express Scripts Mobile Application

The Express Scripts mobile application (app) is an innovative tool that helps members make better decisions for healthier outcomes – anytime, anywhere. The app is compatible with most iPhone®, iPad®, Android™, Windows Phone® and BlackBerry® mobile devices and can be downloaded for free from the iTunes, Google Play, Windows Phone and BlackBerry App World app stores.

Locate a Pharmacy
Find the one closest to you

Switch to Home Delivery
Save the runaround, and maybe some money

Drug Information
Get more detailed medication info

Prescription ID Card
With you whenever you need it

Scan the QR code to download the Express Scripts app from your mobile device's app store, or visit **Express-Scripts.com**

Vision Service Plan (VSP)

- VSP has an enhanced Member Vision Card that members can access if they would like a vision insurance card. The print-on demand card is available through the member site at vsp.com. Please note that Protected Health Information (PHI) such as, the member ID number, social security number and date of birth are not included on the card. VSP is committed to protecting the privacy and security of their members and their data.
- Visit vsp.com from your computer or smart phone to access features such as, your benefits and claims, find a doctor, special offers and articles on eye health. On page sixty-one (61), is the Create an Account on VSP.com flyer that provides you with more details.
- VSP has a passion for people, and their vision doesn't stop at those with VSP coverage. VSP believes everyone deserves to see well. That's why VSP actively seeks opportunities to give back to the community with programs like Sight for Students and Eyes of Hope.
- As of January l, 2013, the VSP Diabetic Eyecare Plus (DEP Plus) Program was added as an enhancement. The DEP Plus Program provides coverage for additional eyecare services targeted specifically for members with Type one (1) or Type two (2) diabetes, glaucoma, or age-related macular degeneration (AMD). No referral needed --pay only $20 co-pay for services. On page sixty-two (62), is the Diabetic Eyecare Plus flyer that provides you with more details.
- New hearing aid discounts for VSP Members. VSP Members receive discounts on hearing aids through TruHearing. For information, please visit vsp.truhcaring.com or call TruHearing at 877-396-7194. On page sixty-three (63), is the TruHearing flyer that provides you with more details.
- Contact Lens Rebates. VSP and Bausch+ Lomb Rebate, as a VSP member, you'll be eligible to receive savings via mail-in rebates when you purchase your annual supply of participating Bausch + Lomb contact lenses from your VSP doctor. Whether you're a new or existing contact lens wearer, you can take advantage of this VSP member exclusive. Just visit the “Exclusive VSP Members Rebates & Special Offers" on vsp.com to learn more.
- VSP has developed an innovative way to shop for eyewear. To meet the demands of the changing marketplace, VSP has developed Eyeconic, an exciting on-line optical store that offers members easy access to quality eyewear brands. To see the latest, check out eyeconic.com today.
- Big Value. More Savings with VSP Vision Care.

Vision Service Plan (VSP) (Continued)

- Get Social with VSP. Check out vspblog.com, join us on Facebook and Twitter, and check out YouTube channel, where you can catch the latest eye care news, enter contests, interact with VSP employees, and more.
- With Exclusive Member Extras, savings never looked so good. VSP puts members first by providing exclusive special offers from VSP and leading industry brands, totaling more than $2,500 in savings. On page sixty-four (64), is the VSP Exclusive Member Extras flier that provides you with more details.

Get access to the best in eye care and eyewear with Prince George's County, Maryland and VSP® Vision Care.

Why enroll in VSP? As a member, you'll receive access to care from great eye doctors, quality eyewear, and the affordability you deserve, all at the lowest out-of-pocket costs.

You'll like what you see with VSP.

- **Value and Savings.** You'll enjoy more value and the lowest out-of-pocket costs.
- **High Quality Vision Care.** You'll get the best care from a VSP network doctor, including a WellVision Exam®—the most comprehensive exam designed to detect eye and health conditions.
- **Choice of Providers.** The decision is yours to make—choose a VSP network doctor, a participating retail chain, or any out-of-network provider.
- **Great Eyewear.** It's easy to find the perfect frame at a price that fits your budget.

Using your VSP benefit is easy.

- **Create an account at vsp.com.** Once your plan is effective, review your benefit information.
- **Find an eye doctor who's right for you.** Visit **vsp.com** or call **800.877.7195**.
- **At your appointment, tell them you have VSP.** There's no ID card necessary. If you'd like a card as a reference, you can print one on **vsp.com**.

That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP provider.

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options. Choose from featured frame brands like bebe®, Calvin Klein, Cole Haan, Flexon®, Lacoste, Nike, Nine West, and more.[1] Visit **vsp.com** to find a Premier Program location that carries these brands. Plus, save up to 40% on popular lens enhancements.[2] Prefer to shop online? Check out all of the brands at **eyeconic.com®**, VSP's preferred online eyewear store.

VSP
Vision care for life

Enroll in VSP today.
You'll be glad you did.
Contact us. **800.877.7195**
vsp.com

Your VSP Vision Benefits Summary

VSP Coverage Effective Date: 01/01/2019

Prince George's County, Maryland and VSP provide you with a choice of affordable vision plans – choose the plan that's right for you.

Base Plan **VSP Provider Network:** VSP Signature

Benefit	Description	Copay
	Your Coverage with a VSP Provider	
WellVision Exam	• Focuses on your eyes and overall wellness • Every calendar year	$10
Prescription Glasses		$10
Frame	• $150 allowance for a wide selection of frames • $170 allowance for featured frame brands • 20% savings on the amount over your allowance • $80 Costco® frame allowance • Every other calendar year	Included in Prescription Glasses
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children • Every calendar year	Included in Prescription Glasses
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 35-40% on other lens enhancements • Every calendar year	$50 $80 - $90 $120 - $160
Contacts (instead of glasses)	• $150 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every calendar year	Up to $60
Diabetic Eyecare Plus Program	• Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details. • As needed	$20

Buy-up Plan **VSP Provider Network:** VSP Signature

Benefit	Description	Copay
	Your Coverage with a VSP Provider	
WellVision Exam	• Focuses on your eyes and overall wellness • Every calendar year	$10
Prescription Glasses		$10
Frame	• $250 allowance for a wide selection of frames • $270 allowance for featured frame brands • 20% savings on the amount over your allowance • $135 Costco® frame allowance • Every calendar year	Included in Prescription Glasses
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children • Every calendar year	Included in Prescription Glasses
Lens Enhancements	• Progressive lenses • Anti-reflective coating • Average savings of 35-40% on other lens enhancements • Every calendar year	$0 $10
Contacts (instead of glasses)	• $200 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every calendar year	Up to $60
Diabetic Eyecare Plus Program	• Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details. • As needed	$20

Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. • 30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam.
	Retinal Screening • No more than a $39 copay on routine retinal screening 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 • After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor

Your Coverage with Out-of-Network Providers

Get the most out of your benefits and greater savings with a VSP network doctor. Your coverage with out-of-network providers will be less or you'll receive a lower level of benefits. Visit **vsp.com** for plan details.

Exam ..... up to $55	Lined Bifocal Lenses ..... up to $75	Progressive Lenses ..... up to $75
Frame ..... up to $70	Lined Trifocal Lenses ..... up to $100	Contacts ..... up to $150
Single Vision Lenses ..... up to $50		

Coverage with a participating retail chain may be different. Once your benefit is effective, visit vsp.com for details. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.

1. Brands/Promotion subject to change.
2. Savings based on network doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Available only through VSP network doctors to VSP members with applicable plan benefits. Ask your VSP network doctor for details.

Discover the information you need:

- Once your benefit is effective, check your coverage.
- Find a provider who's right for you and your family.
- Exclusive Member Extras that maximize your savings.
- View your personalized Vision Savings Statement after your appointment.
- Print a member vision card if you'd like one.

Create your account on vsp.com today!

vsp Vision care for life

As the only national not-for-profit vision care company, VSP® Vision Care is committed to providing members with the best care. If you have diabetic eye disease, glaucoma, or age-related macular degeneration (AMD), you can receive your routine eye care and follow-up medical eye care services from your VSP doctor. You can also receive preventive retinal screenings if you have diabetes, but don't show signs of diabetic eye disease.

VSP® Vision care for life

Protect your eyes with a WellVision Exam®.

A WellVision Exam is the most thorough eye exam available and allows your VSP doctor to identify the early onset of medical conditions. If needed, your doctor can begin to provide monitoring and treatment that can help prevent vision problems and coordinate with your primary care physician to ensure you're getting the best care.

It's easy to use.

Visit your VSP doctor whenever you need to—services are covered with just a copay. No referral is needed.[1]

- Find the VSP doctor who's right for you. To find a VSP doctor, visit **vsp.com** or call **800.877.7195**.
- **At your appointment, tell them you have VSP.** There's no ID card necessary. If you'd like a card as a reference, you can print one on **vsp.com**.

That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP doctor.

29 MILLION AMERICANS HAVE DIABETES[2]

Questions? **vsp.com | 800.877.7195**

1. Some health plans require a referral from a primary care physician. 2. National Diabetes Statistics Report, 2014

VSP Diabetic Eyecare Plus Program coverage is only available through a VSP doctor and pays secondary to other medical insurance coverage. This coverage is for diabetes-related eyecare services and doesn't cover routine eye exams. Contact your VSP doctor for an appointment to use your routine eyecare benefits.

JOB#9488CM 02/15

Save Up to 60% on Brand-name Hearing Aids

TruHearing™

Like vision loss, hearing loss can have a huge impact on your quality of life. However, the cost of a pair of quality hearing aids usually costs more than $5,000, and few people have hearing aid insurance coverage.

TruHearing® makes hearing aids affordable by providing exclusive savings to all VSP® Vision Care members. You can save up to 60% on a pair of hearing aids with TruHearing. What's more, your dependents and even extended family members are eligible, too.

In addition to great pricing, TruHearing provides you with:

- Three provider visits for fitting and adjustments
- 45-day trial
- Three-year manufacturer warranty for repairs and one-time loss and damage replacement
- 48 free batteries per hearing aid

Plus, with TruHearing you'll get:

- Access to a national network of more than 3,800 hearing healthcare providers
- Straightforward, nationally-fixed pricing on a wide selection of the latest brand-name hearing aids
- Deep discounts on batteries shipped directly to your door

Best of all, if you already have a hearing aid benefit from your health plan or employer, you can combine it with TruHearing prices to reduce your out-of-pocket expense even more!

Here's how it works:

Contact TruHearing.
Call **877.396.7194**. You and your family members must mention VSP.

Schedule exam.
TruHearing will answer your questions and schedule a hearing exam with a local provider.

Attend appointment.
The provider will perform a hearing exam, make a recommendation, order the hearing aids through TruHearing, and fit them for you.

Learn more about this VSP Exclusive Member Extra at truhearing.com/vsp or, call 877.396.7194 with questions.

The relationship between VSP and TruHearing is that of independent contractors. VSP makes no endorsement, representations or warranties regarding any products or services offered by TruHearing, a third-party vendor. TruHearing is solely responsible for the products or services offered by them. Savings based on a survey of national average retail hearing aid prices compared to average TruHearing pricing. Actual customer savings will vary. Three follow-up visits must be used within one year after the date of initial purchase. Forty-five-day trial and hearing aid returns, repairs, and replacements subject to provider and manufacturer fees. For questions regarding fees, contact TruHearing customer service. Not available in the state of Washington.

JOB#5007-16-VCOA 6/16

SET YOUR SIGHTS ON SAVINGS.

With Exclusive Member Extras, savings never looked so good. We put our members first by providing exclusive special offers from leading industry brands, totaling more than $2,500 in savings.

- Extra $20 to spend on featured frame brands[1,3]
- Instant savings and satisfaction guarantees on popular lenses[2,3]
- Savings on LASIK at NVision and TLC eye centers
- Mail-in rebate savings and free trials on popular contact lens brands
- Savings on digital hearing aids and replacement batteries for you and your extended family through TruHearing[4]
- Savings on EyePromise vitamins for improved visual performance, night driving, and dry eye
- Financing for vision care expenses with the CareCredit credit card
- Discounts and savings for you and your family on medical care, prescription drugs, lab work, and more with VSP® Simple Values[5]

PREMIER PROGRAM

Visit vsp.com to find Premier Program locations that offer a wide selection of featured frame brands, Bonus Offers, and so much more.

For more great offers, scan or visit vsp.com/specialoffers.

1. Brands/promotions subject to change. 2. Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. 3. Available only to VSP members with applicable plan benefits. 4. Offer not available in WA. 5. Some members may not be eligible for this program; visit vsp.com/simplevalues for terms and conditions.

BAUSCH+LOMB
CareCredit
EXTRA $20 TO SPEND
eyeconic
EyePromise
Eyezen+
NVISION
sunsync LIGHT-REACTIVE LENSES
TLC Laser Eye Centers
Transitions
TruHearing
UNITY
VSP SIMPLE VALUES

JOB#45645-VCOM 5/15

Did You Know That…

ConnectYourCare – Medical Flexible Spending Account

Paying for health care is now easier ***and*** less expensive with Flexible Spending Accounts (FSAs) from ConnectYourCare.

A Medical Flexible Spending Account is a tax-advantaged account that allows you to use pre-tax dollars to pay for qualified medical care expenses. You choose how much money you want to contribute to an FSA at the beginning of each plan year and can access these funds throughout the year.

Account Benefits

- **Multiple uses.** There are hundreds of eligible expenses for your Health Care FSA funds, including prescriptions, some over-the-counter items, doctor office copays, health insurance deductibles and coinsurance. FSA funds may even be used for eligible expenses for your spouse or federal tax dependents.

- **Easy to access.** Funds in the account are easily accessed with your payment card. Your account balance is available at any time on-line, through the ConnectYourCare mobile app, or over the phone.

- **Tax advantages.** Since FSA contributions are not taxed, you can reduce your taxable income by the amount you contribute to your FSA. You can then use those pre-tax dollars to pay for eligible health care expenses that would have otherwise been paid with post-tax dollars.

- **Rapid reimbursements**. Paying for health care expenses is easy when you use your payment card. If you do not use your card, you can quickly and easily create your claim on-line. Once you submit your receipts, you'll receive reimbursement within just a few days.

- **Information at your fingertips.** Your on-line account and the mobile app provide quick access to account information, claims details and education tools.

- **Customer Service available any time.** Live customer service representatives are available to assist you 24 hours a day, seven days a week at 1-877-292-4040.

Important Account Information:

- **Contribution Limits** — **The maximum annual amount you can contribute to this account is $2,650.**

- **Funds Expiration** — Funds do not roll over; you must use all of your funds by the last day of your plan year's grace period. Leftover funds in your account at the end of the grace period are forfeited, as required by the IRS.

ConnectYourCare – Medical Flexible Spending Account *(Continued)*

- **Balance and eStatement** — By frequently checking your account balance on-line or by using the mobile app, you will have a good idea of the amount of funds available in your account. You will also be able to obtain an eStatement in your on-line account.

- **Save Your Receipt**s — Although your payment card eliminates the need to file paper claims, the IRS requires that your charges be verified. **Always save your itemized receipts** in case ConnectYourCare requests them to confirm a purchase or for tax purposes. **It's easy to submit your receipts on-line or using the mobile app!**

TIP: Take a picture of your itemized receipts with your telephone's camera, then you'll always have a copy in case it's needed.

ConnectYourCare – Dependent Care Flexible Spending Account

The Dependent Care FSA helps save you money by allowing you to set aside pre-tax funds for eligible dependent day care expenses so you and/or your spouse, can work, look for work or attend school full-time.

Account Benefits

- **Easy to use.** Simply pay for your qualified dependent care expenses out of pocket and request reimbursement from your account once the care has been provided.

- **Many eligible expenses.** Your account covers before school or after school care (other than tuition expenses), custodial care for dependent adults, licensed day care centers, nursery schools or preschools, placement fees for a dependent care provider (such as an au pair), care of an incapacitated adult who lives with you at least eight hours a day, child care at a day camp, private sitter, late pick-up fees, summer and holiday day camps.
    - **Ineligible expenses include** care for children ages 13 and older, educational expenses including school tuition fees, expenses for food, clothing, sports lessons, field trips, entertainment, transportation and overnight camps, registration fees, late payment fees, care for dependent while sick employee stays home, payment for services not yet provided (payment in advance), and medical care.

- **Easy to submit receipts**. You will need to submit an itemized receipt as documentation, but it's easy to submit receipts on-line or using the mobile app.

- **Information at your fingertips.** Your on-line account and the mobile app provide quick access to account information, claims details and education tools.

- **Customer Service available any time.** Live customer service representatives are available to assist you 24 hours a day, seven days a week at 1-877-292-4040.

ConnectYourCare Dependent Care Flexible Spending Account *(Continued)*

Important Account Information:

- **Contribution Limits —$5,000 annually for a single person or married couple filing a joint income tax return, and $2,500 annually for each married participant who files a separate income tax return.**

- **Funds Expiration** — Funds do not roll over; you must use all of your funds by the last day of your plan year's grace period. Leftover funds in your account at the end of the grace period are forfeited, as required by the IRS.

- **Save Your Receipts** — Receipts must include the name of the dependent, the dates the care was provided, a description of the care provided, the provider name and the amount paid. **ALWAYS SAVE YOUR RECEIPTS!**

TIP: Take a picture of your itemized receipts with your telephone's camera, then you'll always have a copy in case it's needed.

Mobile Application

ConnectYourCare offers a secure, interactive mobile application for iPhone, Android and Windows devices. Use it to view account information, call customer service, or take a photo of your receipt with your mobile device and upload it directly to the system. Simply download the free app from the iPhone App Store, Android Market or the Windows Store, and you will have the following features at your fingertips:

- View account balance, account alerts and transaction history.
- View all claims, your claims that require action, and claims details.
- Submit a new claim.
- View FAQs.
- Receive Account Alert push notifications.
- Click to call Customer Service.
- **Upload Claim Documentation** - a quick and easy way to submit documentation!
- Take a photo with your telephone's camera or choose existing image.
  - Image is submitted in seconds.
  - No need for faxing or mailing.
  - Image is saved with claim as a record of submission.

ConnectYourCare *(Continued)*

Mobile Texting

Our Mobile Alerts feature lets you access account information at any time using text messaging! Once signed up, you may send a text request for your account balance, last five claims or last five contributions.

And, most importantly, you may opt into an alert service that lets you know immediately after you use your healthcare payment card when the purchase requires additional documentation. *This way, you always know when to save your itemized receipts.* Here's how it works:

- You must be registered to use the service. Register by clicking on the Mobile Alerts link in your on-line account. An activation code will be sent to your phone, so make sure your phone is nearby. Follow the on-line instructions to enter your activation code and complete the registration.
- Add 410-941-0898 to your contact list so you can easily get account information on the go.
- Receive text messages immediately after any card swipe that requires receipts.
- Update your mobile alert settings at any time on-line.
- Send text request.
- **BAL** for account balances.
- **CONT** for last five contributions.
- **HELP** for text command instructions.
- **STOP** to opt out of mobile alerts.
- Update your mobile alert setting at any time on-line.

Employee Assistance (EAP) and Worklife Program

KEPRO provides the following EAP services to employees and dependents:

- **Counseling** - Your benefit includes up to eight (8) face-to-face counseling sessions with a licensed, professional EAP counselor. These sessions are confidential, and there is no co-pay required to utilize the services. Your EAP provides a wide range of services for all types of personal problems. Some issues frequently addressed and resolved by the EAP are family/ relationship problems, parenting difficulties, work-related concerns, work/life balance, bereavement, alcohol and substance use.
- **Childcare, Eldercare, and Daily Living Consultations and Referrals** - Information and referrals are available on a variety of family matters, including pre-natal care, day care, summer camp, adoption, adult day care and assisted living care. Daily living referrals includes, but is not limited to, pet care services, relocation, apartment/housing locators, and vacation/travel.
- **Legal and Financial Consultations** - The Legal and Financial benefit include a free thirty (30) minute consultation with a local attorney or telephonic consultation with a financial specialist regarding legal or financial concerns. If you retain an attorney to represent you after your consultation, you will receive a 25% discount. Employer related issues are excluded.
- **On-line EAP and Worklife Resources** - EAPHelpLink.com is an interactive web based resource providing a wide array of tools to help resolve issues quickly and effectively. Resources include a Savings Center, Tax Preparation tools, e-Learning courses, and a Relocation Center.
- **Monthly On-line Seminars** - KEPRO provides monthly webinars on topics such as Communicating Effectively, Coping with Change, Positive Thinking, Estate Planning, and Financial Fitness.
- **Communications -** KEPRO provides monthly wellness tip sheets, posters, webinars and onsite wellness trainings. Additionally, employees will receive a quarterly newsletter to address a variety of wellness and worklife issues. Leadership will also receive a quarterly newsletter to assist them in dealing with workplace and performance issues.
- **How to Contact the EAP -** The EAP is easy to use and is available to you 24/7. You can call the EAP services line at 1-877-334-0530 or access information on-line at www.eaphelplink.com with the password – Prince George's County.

How Can I Reduce My Health Benefits Costs?

- **Enroll in a Health Care Flexible Spending Account (FSA)** – A Health Care FSA allows you to increase your purchasing power and reduce your yearly taxable income by using your pre-tax dollars to pay for you and your family's eligible, out-of-pocket health care expenses. The money you set aside in this FSA account can pay for co-pays, annual deductibles, co-insurance and other eligible expenses. **Remember, the maximum annual amount that can be set aside in this account is $2,650.**

- **Enroll in a Dependent Care FSA Account** – The Dependent Care FSA allows you to use pre-tax dollars to pay for childcare services that make it possible for you and your spouse to work. **This account cannot be used to cover any medical care costs for your dependent(s)**. Under certain circumstances, it also may be used to help pay for the care of elderly parents or a disabled spouse or parent.

  You must complete the on-line enrollment process to enroll or continue (i.e. remain enrolled for 2019) the FSAs. Please see pages 13, 14, 15, 16, 29, and 30 for details on the enrollment process. You have until April 30, 2019, to submit claims for eligible expenses incurred during calendar year 2018 for reimbursement under the Health Care and Dependent Care FSAs. **The time period to submit a claim also applies to the grace period. See page seventy-eight (78) for more information on the grace period.**

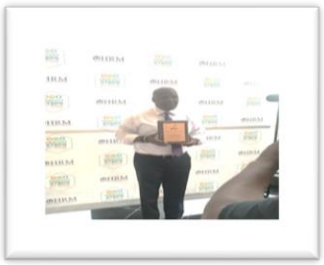
- **Utilize the Prescription Plan Mail-Order Service** – Receive a three-month supply of a prescription drug for a lower cost. **Note: The County's prescription plan requires all maintenance medications to be purchased through the mail order.**

- **Select Generic Prescriptions over Brand** – Ask your doctor to prescribe generic drugs instead of brand-name drugs. **The prescription plan (plan) has a mandatory generic program requirement. The mandatory generic program will result in the plan providing coverage of generics for all brand medications that have a generic alternative. You may still opt to receive a brand medication; however, the plan will only provide coverage that equates to the amount of the generic alternative. You will be responsible for the copayment for a generic plus the cost difference between the brand and generic medication.**

- **Request Formulary Versus Non-Formulary** – A formulary is a preferred drug which is proven to be more effective and sometimes less expensive than a similar non-formulary drug. Ask your doctor to review Express Script's list of formulary drugs to select an appropriate medication for you.

- **Use the Prescription Plan Website** – You can see what a specific prescription drug will cost you, discover ways to save, order refills and track the status of your order on-line at www.express-scripts.com.

- **Drop Ineligible Dependent(s)** – You must complete the on-line enrollment process before changes can be made to your enrollment options (i.e., individual, two-person or family coverage) and plan premiums. **Remember, the Employee Self-Service (ESS) on-line enrollment portal closes at 11:59 p.m., on October 26, 2018**. You will not be able to enroll or make any changes to your health benefit plan(s) once the on-line portal closes.



Living healthy and well is for a lifetime and not just for today! The Office of Human Resources Management (OHRM) remains committed to providing employees with health and wellness information designed to assist in making informed choices as it pertains to one's overall health. OHRM understands the importance of getting an annual physical, eating a healthy diet and incorporating physical activity as a part of one's daily routine. These are all important factors for maintaining good physical, mental and emotional health.

OHRM has continued the "*Healthy Steps Rewards Program*" (Program) in calendar year 2018. As in previous years, the Program continues to be packed with wellness activities to "Move Everyone towards Living Healthy for a Lifetime and not just for Today." The wellness activities are designed to help employees focus on their "Mind, Body and Soul" while earning wellness points. The new offerings under the Program for 2018 are a In-Step Diabetes Program and a Hydration Challenge. The In-Step Diabetes Program is an education program that is designed to provide information on identifying, maintaining and controlling diabetes. This program is for anyone who is pre-diabetic or has diabetes.

Are you drinking enough H2O (water)? **Yes, No, not sure.** Then join OHRM in the Hydration Challenge that will start in October 2018. Watch your email for more details on this challenge. The Benefits Division of OHRM is working to roll out the Wellness App by the end of September 2018. **Stay tune and watch your email to learn how to use and know what the Wellness App will offer you!**

On June 14, 2018, OHRM hosted the annual wellness event. It was "A Day of Food, Fun, Fitness, Health and Wellness." Some of the activities offered this year at the event were a result of the feedback received from employees that attended the 2017 event. Therefore, back by popular demand this year were the massage/reflexology therapy and caricature drawings. OHRM was excited to have two health and wellness lifestyle experts, Donna Richardson and Ernestine Shephard at the event. The employees enjoyed the exercise demonstrations and the motivating words to live healthy and physical lives that Ms. Richardson and Ms. Shephard shared with them. In addition, the event featured over 50 healthy food sampling options, wellness juice and smoothie bar, Chef led cooking demonstrations, live entertainment by renowned jazz and soul singer, Navasha Daya and NAACP Image Award-nominated, jazz pianist, Marcus Johnson. Participation in the Wellness Program is easy and fun! If you are **not** participating in the Wellness Program in calendar year 2018, OHRM encourages you to consider joining the excitement in calendar year 2019!

OHRM wants to take this opportunity to encourage you to take advantage of the health and wellness offerings provided by the health benefit plans providers that are at **no cost to you**. A member enrolled in a Cigna medical plan is eligible to participate in programs to fit one's personal needs, connect with a Health Coach, access telephone seminars and webinars, obtain health and wellness articles from the Cigna Library, engage with a dashboard that features active programs, daily to-do lists and much more!! Please access mycigna.com (click on Programs and Resources) or call the Customer Service Center at the toll-free number on the back of your Cigna medical plan identification card to learn more about the wellness offerings.

The Kaiser Permanente medical plan offers its members podcasts, healthy lifestyle programs, information library to learn more about specific conditions and diseases, wellness coaching, center based classes and workshops and so much more!! You can learn more about the health and wellness offerings under the Kaiser Permanente medical plan by accessing www.kp.org or calling the Customer Service Department at the number listed on the back of your medical plan identification card.

The Aetna dental plans (DMO and PPO) offer its members deals and discounts on products and services such as, blood pressure monitors, fitness activity trackers and equipment, yoga DVD's, gym membership, acupuncture/massage services, weight management and so much more. If you are a member, learn more about these products and services by accessing aetna.com.

A participant enrolled in the Vision Service Plan (VSP) can access **vsp.com/simplevalues** and obtain valuable discounts on health wellness, lifestyle products and services. An array of discounts can be found on this site in the areas of Health and Wellness, Family Fun and Retail/Rewards. VSP also offers members savings on hearing aids through TruHearing. See the flyer on page (63) for more details.

Have you completed a health assessment this calendar year (2018)?

OHRM encourages you to complete an annual on-line Health Assessment. The health assessment provides you with important information that allows you to make lifestyle choices that will improve your health. How do you complete an on-line health assessment? See below for information on completing an on-line health assessment.

For employees enrolled in the County's Medical Plans with Cigna Healthcare:

- Go to www.mycigna.com.
- If you are new to the website, click on "Register Now:"
- Click on "MyHealth" tab to begin.

Employees enrolled in the County's Medical Plan with Kaiser Permanente:

- Go to: www.kp.org.
- If you are new to the website, click "Register Now:"
- At the Health and Wellness tab, click on "Programs & Classes."
- Click on the "Total Health Assessment:" in the left navigation.
- Click on "Start a Total Health Assessment now" to begin.

Instructions to register for the Health Assessment for Non-Cigna and Non-Kaiser Members:

- Click https://my.cigna.com/?token=3330041.
- Click "Register Now"
- Enter your personal information then click "Next"
- Click "Subscriber SSN"
- Click "Next"
- Fill in the form to create your User ID and password then click: "Next"
- Review and click "Submit"
- Review "User Agreement" then click "I agree"
- Click "Get Started"

How Much Extra Life Insurance (XLI)* May I Purchase?

You may purchase between one and four times your base pay in Extra Life Insurance (XLI), up to a maximum of $600,000. If you are a late applicant (did not enroll as a newly eligible employee) and elect to enroll in the XLI plan or increase your current option, you will need to submit proof of good health by completing the Evidence of Insurability (EOI) questionnaire. The EOI process may result in a request for additional information, including medical records and possibly an attending physician's statement. It is the responsibility of the employee to pay for the cost of any additional medical information requested. You must complete the EOI process and be approved by Aetna to elect new coverage or increase current coverage during the 2019 calendar year.

The XLI premiums are based on your salary and age. This premium is deducted from the first paycheck of each month and is an after-tax deduction. The age category chart and sample calculation below will assist you in determining your monthly premium.

Age Category	Monthly Factor Per $1000*
Under Age 25	$ .098
Age 25 to 29	.108
Age 30 to 34	.118
Age 35 to 39	.127
Age 40 to 44	.216
Age 45 to 49	.382
Age 50 to 54	.706
Age 55 to 59	1.107
Age 60 to 64	1.519
Age 65 to 69	2.911
Age 70 & over	4.694

Worksheet to Calculate Your Premium

Using your base salary, enter the number of extra life insurance increments you want and the appropriate monthly factor for your age category to determine your cost per month. A *Sample Calculation* has been provided to assist you.

$____ X ____ = $____
$____ / 1,000 = $____
$____ X monthly factor = **$____ per month**

Instructions for Calculating the Monthly Premium: Multiply your annual base pay by 1, 2, 3 or 4 depending on the extra life insurance amount you elect; round the answer to the nearest $1,000. Divide by 1,000. Use this number to multiply the monthly factor for your age category. This will provide the monthly cost of your Extra Life Insurance.

Sample Calculation

$30,373 X 2 = $60,746
$61,000 / 1,000 = 61
61 X .127 (monthly age factor for 35-39) =

7.747 (rounded to) **$7.75 per month**

***Note: The XLI is Term Life Insurance and has no cash value.**

How Much Extra Life Insurance (XLI) May I Purchase?

Extra Life Insurance *(Continued)*

Extra Life Insurance (XLI) premiums change during the year due to salary increases and age category changes. Open enrollment is a time to re-examine this benefit in light of a possible premium cost change. You may not drop or change this benefit during the 2019 calendar year because of a premium cost increase.

NOTE: ***Extra Life Insurance is in addition to the basic life insurance for two times your base pay provided by Prince George's County Government at no cost to you.***

May I Elect to Reduce My Basic Life Insurance (BLI)?

The County provides you with Basic Life Insurance (BLI) that equals to two (2) times your basic annual salary at no cost to you. **The maximum amount for the BLI is based on your salary schedule and this will apply to the maximum for the life opt out credit.**

You may also choose to reduce your coverage to a minimum of one times your base pay or the maximum for the BLI and receive a credit. Round your annual base pay to the nearest $1,000. Divide by 1,000, multiply by $2.50 and divide by 26 to determine the amount of credit you will receive if you choose to reduce your life insurance to one times your base pay. **You cannot reduce your life insurance coverage to zero.**

Does the County Offer a Long-Term Disability Insurance Program?

Yes. The County offers two options under the Long-Term Disability (LTD) Program to all eligible employees. The coverage will allow you to choose between either 50% or 60% of base pay, up to an allowable maximum per month. The premium rate is different for a public safety employee and non-public safety employee under the LTD program. Additional information on the Program may be obtained at the open enrollment provider sessions.

Rates for 2019	
Public Safety Employees	**All Other Employees (Non-Public Safety)**
.00046 for 50% of base pay	.00383 for 50% of base pay
.00673 for 60% of base pay	.00596 for 60% of base pay

In order to calculate the cost of this benefit, multiply the rate times your base pay rounded to the nearest hundred. For example, if your salary is $34,850 and you are interested in LTD insurance that would pay 50% of your salary after 180 days of disability, your calculation would be: $34,900 x .00383 = $133.667 (rounded to) $133.67 annually). Divide the annual amount by 12 to find the monthly cost for this benefit – $133.67/12 = $11.14. ***This premium is deducted from the first paycheck of each month and is an after-tax deduction.***

Does the County Offer a Long-Term Disability Insurance Program?

Long-Term Disability Program *(Continued)*

Long-Term Disability (LTD) premiums change during the year due to salary changes. Open enrollment is a time to re-examine this benefit in light of a possible premium cost change. You may not drop or change this benefit during the 2019 calendar year because of a premium cost increase.

NOTE: If you are a late applicant (did not enroll as a newly eligible employee) and elect to enroll in the LTD plan or increase your current option, you will need to submit proof of good health by completing the Evidence of Insurability (EOI) questionnaire. The EOI process may result in a request for additional information, including medical records and possibly an attending physician's statement. It is the responsibility of the employee to pay for the cost of any additional medical information requested. You must complete the EOI process and be approved by Aetna to elect new coverage or increase current coverage during the 2019 calendar year.

Reminders

Enrolling or Making Health Benefit Plan(s) Changes for 2019

To enroll in one of the County's core health benefit plans or make a change to your current core plans, you must complete the on-line enrollment process. See pages 13, 14, 15, 16, 29 and 30, for more information on the enrollment process. To enroll or make changes to the voluntary benefit plans, you must contact the iBenefit Call Center or meet with an Aflac Representative (Supplemental Dental Only) at one of the open enrollment or medical provider sessions. See pages 14 and 30 for information on the voluntary benefits enrollment process. **The iBenefit Call Center or Aflac representative will *not* be able to assist you with enrolling or making changes to the County's *core* health benefit plans. The last day to enroll or make changes to the core health benefit plans is at 11:59 p.m., on October 26, 2018, through the Employee Self-Service (ESS) on-line enrollment portal. Please note after October 26, 2018, you will not be able to make any changes to your health benefit plan(s) unless you experience a family status change.**

Confirmation of Open Enrollment Changes for the County's Health Benefit Plans

We strongly encourage you to review the paychecks that you will receive on January 4th, 18th and February 1 , 2019, to ensure the changes you requested during open enrollment were processed. If either of these paychecks do not reflect your requested change(s), you should contact the Benefits Division at 301-883-6380 (press option one [1]) or 1-800-634-5231 (press number two [2] for Benefits Division then option one [1]) by the close of business on, Thursday, February 14, 2019.

Healthcare Payment Card Reminder

Healthcare payment cards are valid for three years from the date issued. Participants will not be issued a new card each plan year, so please keep your card(s) even when you use all of your funds for the current plan year or elect not to continue the account the next plan year. When the card is near its expiration date, ConnectYourCare will automatically send you a new card a few weeks before the card expires whether or not you are enrolled in the plan. The payment card expires the last day of the month printed on the card (e.g., payment date on the card expires May 2019. The payment card will expire May 31, 2019).

iBenefit Election of Benefits Form

You will receive an Benefit Election Authorization from iBenefit that will reflect the enrollment transaction(s) you completed with an Enrollment Benefits Specialist through the iBenefit's Call Center or at an open enrollment or medical provider session(s). The Benefit Election Authorization will be sent to either your address on file or given to you, if you meet with them onsite at an agency location. This Benefit Election Authorization will serve as your record of your enrollment transactions in the voluntary benefit plans **with Unum, Legal Resources and/or Legal Shield**. **It is important that you review it carefully to ensure it is correct.** The Benefit Election Authorization will instruct you on the process to make any changes or revisions before open enrollment ends.

Aflac Premium Deduction Authorization Form

You will receive a Premium Deduction Authorization Form that will reflect the enrollment transaction you completed with an Aflac Representative for the Supplemental Dental plan only. **It is important that you review it carefully to ensure it is correct.** The Premium Deduction Authorization Form will instruct you on the process to make any changes or revisions before open enrollment ends.

Failure to review your Election of Benefits (iBenefits) or Premium Deduction Authorization (Aflac) Forms will result in you not having the voluntary benefit plans you elected for calendar year 2019.

Note*:* **The Benefit Election Authorization and Premium Deduction Authorization Forms will not reflect your enrollment in the County's core health benefit plans.**

Reminders

Flexible Spending Accounts (FSAs)

Grace Period - If you are currently enrolled in the health care and/or dependent care spending accounts and have a remaining balance on December 31, 2018, you will have until March 15, 2019, to use the remaining amount or forfeit the money. Please note you can use the health care payment card for eligible health care expenses for the amount you have left from the 2018 calendar year after December 31, 2018. It is important for you to note ConnectYourCare will exhaust the 2018 remaining funds before deducting from the 2019 annual election, if you completed the enrollment process to continue the account. If you have eligible expenses from the 2018 calendar year that you still need to submit for reimbursement, then it is strongly recommended for you to send the claims to ConnectYourCare before using the healthcare payment card on January 1, 2019. **ConnectYourCare will reject any calendar year 2018 eligible expense(s) if you have used all of the remaining funds from the 2018 calendar year at the time you submit the claim(s) for reimbursement.** All claims from calendar year 2018 must be submitted by April 30, 2019. To obtain the remaining balance in your account, you can view your eStatement on-line at www.connectyourcare.com.

Claim Year 2018 - Claims for expenses incurred under the health care or dependent care accounts from January 1, 2018, through December 31, 2018, must be submitted to **ConnectYourCare** no later than April 30, 2019.

Annual Maximums	
Health Care FSA	$2,650
Dependent Care FSA	$5,000

Note: If you lose or throw away your health care payment card, you will need to contact ConnectYourCare for a replacement card.

Claim Year 2019 - To participate in one of the Flexible Spending Accounts, you **must** enroll or renew the accounts **every year** during open enrollment. **Please see pages sixty-five (65) through sixty-eight (68) for additional information about the FSAs. Remember, you will have until April 30, 2019, to submit claims for eligible expenses incurred during calendar year 2018 for reimbursement under the health care and dependent care FSAs.**

Qualified Family Status Changes

In accordance with the rules of Section 125 of the Internal Revenue Code, qualified family status changes such as birth, marriage, and loss of health benefits coverage must be made within forty-five (45) days of the qualifying event. You must complete an Enrollment/Change Form* for a qualifying family status change to make changes to your health benefit plans enrollment within the forty-five (45) days timeframe. **The Benefits Division will not be able to make an exception to this requirement.** Please see page 34 for more information on ***Qualified Family Status Changes***, or you may contact the Benefits Division if you have any questions concerning the requirement.

***The Benefits Division transitioned to the Enterprise Resources Planning (ERP) system as of July 1, 2015. The Benefits Division is working on the process to enable all qualified family status changes to be done on-line via the ERP system. As a result, this process will replace the Enrollment/Change Form. Details for the ERP on-line process will be sent under separate cover.**

Reminders

Life Insurance/Beneficiary Designation

Keep in mind that it is important to update your beneficiary designations when you experience life changes. Your beneficiary designation identifies who receives the benefits payable under your life insurance, any payable salary, annual leave payout and County Pension, if applicable.

If you designate a minor child as your beneficiary, the Court will appoint a guardian of the minor's property, or the life insurance proceeds may be held in trust until the minor child reaches the age of majority.

Beneficiary updates and/or changes made through the Open Enrollment portal will not become effective until January 1, 2019. You can update or change your beneficiary(ies) immediately through the Employee Self Service (ESS) on-line enrollment portal under Anytime Changes. If you have any questions or concerns regarding updating or changing your beneficiary(ies) on-line please contact the Benefits Division at (301) 883-6380. To update your beneficiary designation for the Maryland State Retirement System or the 457 Deferred Compensation Plans, you may call the Pensions and Investments Division at (301) 883-6390.

Vision Plan

Vision Service Plan (VSP) is the County's eye care provider. **It is important to note that VSP does not issue identification cards; however, members can access and print an enhanced Member Vision Card (see page fifty-seven [57] for more information).** If you are choosing a participating eye doctor, simply call and make your appointment. The doctor will do the rest. If you choose a doctor outside of the network, you must pay for the services and submit the receipt, along with your name, social security number and address, to VSP. Check the VSP website, www.vsp.com, for up-to-date benefit eligibility for you and your dependents along with the list of participating providers.

Aetna Dental Plans

Please note you no longer need a member identification card (ID) to obtain services under the Aetna Dental DMO or PPO plans. When you go to the dentist, tell the office your name, date of birth and Member ID number (or your social security number). If you want an ID card, you can use Aetna's mobile app or go on-line and log into your secure member website at www.aetna.com. Your ID card will appear on your personal benefits page. You can print out an ID card for you and your dependent(s) by clicking on "**Get an ID card."** Also, you can call Aetna Member Services at 1-877-238-6200, if you have any questions. Remember, the Aetna Dental DMO plan requires you to choose a primary care dentist (PCD) in Aetna's network. If you fail to select a PCD, your benefits and claims may be limited to emergency services only. Please see pages forty-seven (47) and forty-eight (48) for more information.

Express Scripts Prescription Plan

The Express Scripts prescription plan (plan) has a mandatory generic program requirement. The mandatory generic program will result in the plan providing coverage of generics for all brand medications that have a generic alternative. You may still opt to receive a brand medication; however, the plan will only provide coverage that equates to the amount of the generic alternative. You will be responsible for the copayment for a generic plus the cost difference between the brand and generic medication.

Express Scripts Prescription Plan *(Continued)*

There is a $50 annual deductible per covered individual that must be met for retail and mail-order service prescriptions combined prior to any plan coverage. **Please remember this plan requirement when you purchase prescriptions for yourself or your covered dependent(s) on or after January 1, 2019.**

When you use the Mail-Order Service to purchase maintenance drugs for the first time, you should allow the prescription plan administrator at least fourteen (14) days to receive, process and ship your order. Refills can be ordered on-line, by mail or by telephone, and are usually delivered within three (3) to five (5) days after receipt of your order.

Continuation of Coverage While on Approved Leave Without Pay (LWOP)
If you are on approved LWOP, you may be required to pay the employee/employer portion of the health benefit premiums in order to continue your health benefits coverage with the County. Please call the Benefits Division at (301) 883-6380 (press option nine [9]) or 1-800-634-5231 (press number two [2] for Benefits Division and then select option nine [9]) to make arrangements to continue your benefits.

Work Related Injuries
Contact the County's Workers' Compensation Claims Office (The Corvel Corporation, 301-925-4024) for the handling of prescription drugs that are prescribed due to work-related injury/illness. **Do *not* use the County's prescription plan to fill these prescriptions.**

Address Change
If you recently changed your address (home or mailing), please contact the Personnel Liaison within your agency who is responsible for updating the address (home or mailing) in the County's computer system.

The Last Day of Open Enrollment is October 26, 2018!

Remember, the Employee Self-Service (ESS) on-line enrollment portal closes at 11:59 p.m., on October 26, 2018.

(See pages 13, 14, 15, 16, 29 and 30 for details on the on-line enrollment process.)

Telephone Numbers and Websites for Providers

For most plans, on-line Member Services allows you to find or change providers, request ID cards, check the status of claims and obtain information on the level of benefit coverage.

MEDICAL

Cigna
1-800-244-6224
www.mycigna.com

Kaiser Permanente
301-468-6000
1-888-225-7202 (*For members outside of the Washington, DC Metro area*)
www.kp.org

PRESCRIPTION

Express Scripts, Inc.
1-800-711-0917
www.express-scripts.com

VISION

Vision Service Plan
1-800-877-7195
www.vsp.com

DENTAL

Aetna (PPO/DMO)
1-877-238-6200
www.aetna.com
www.aetnadmodental.com
www.aetnappodental.com

Telephone Numbers and Websites for Providers

(Continued)

EMPLOYEE ASSISTANCE PROGRAM

KEPRO
1-877-334-0530
www.eaphelplink.com

LONG-TERM DISABILITY (LTD) and EXTRA LIFE INSURANCE

Aetna Long-Term Disability
1-866-326-1380
www.aetna.com

Aetna Life Insurance
1-800-523-5065
www.aetna.com

FLEXIBLE SPENDING ACCOUNTS

ConnectYourCare
1-877-292-4040
www.connectyourcare.com

Telephone Numbers and Websites For Voluntary Benefit Providers

Note: To make changes to an existing plan(s) or to cancel enrollment in these plans, you must contact the provider directly.

Voluntary Benefit Plans

- Group Accident Plan
- Individual Short-term Disability (STD)
- Whole Life Insurance
- Group Critical Illness

UNUM

1-800-635-5597
www.unum.com

LEGAL PLANS

Legal Resources
1-800-728-5768
www.legalresources.net

Legal Shield
1-800-654-7757
www.legalshield.com

SUPPLEMENTAL DENTAL INSURANCE

Aflac
410-394-9617
www.Prince Georges.Aflac@gmail.com

Mark Your Calendars!

Provider Session #1

Wednesday, October 10, 2018 – 10:00 a.m. to 2:00 p.m.
RMS Building – First Floor Lobby
1400 McCormick Drive
Largo, MD

Provider Session #2

Wednesday, October 17, 2018 – 10:00 a.m. to 2:00 p.m.
County Administration Building (CAB)
Lower Level Lobby
14741 Governor Oden Bowie Drive
Upper Marlboro, MD

Provider Session #3

Wednesday, October 24, 2018 – 12:30 p.m. to 4:00 p.m.
Maintenance Operations Center (MOC)
8400 D'Arcy Road
Forestville, MD

Provider Session #4

Friday, October 26, 2018 – 10:00 a.m. to 2:00 p.m.
RMS Building – First Floor Lobby
1400 McCormick Drive
Largo, MD

FOR OFFICE USE ONLY
Transmitted: _____
Entered: _____

PRINCE GEORGE'S COUNTY GOVERNMENT

BENEFITS ADMINISTRATION DIVISION, 1400 MCCORMICK DRIVE, SUITE 245, LARGO, MARYLAND 20774

AETNA DMO DENTAL PLAN PRIMARY CARE DENTIST (PCD) ELECTION FORM ACTIVE EMPLOYEE / RETIREE

STEP 1: Please PRINT or TYPE when you complete this form.

NAME: _____ SOCIAL SECURITY #: _____

DATE OF BIRTH: _____ **EFFECTIVE DATE OF COVERAGE**: _____

STREET: _____ PHONE-WORK: _____ HOME: _____

CITY/STATE: _____ ZIP: _____ DEPARTMENT: _____

REASON: ☐ **Open Enrollment**

☐ **New Employee** *Hire Date*: _____

☐ **Family Status Change** *Event:* _____ *Date of Event:* _____

STEP 2: Complete this section for you and the dependent(s) you are adding to the DMO dental plan as of the above effective date. **If you fail to select a Primary Care Dentist, it will result in you not being able to utilize the DMO dental plan benefits on or after the effective date of your coverage.**

FULL NAME (PRINT) First Middle Initial Last	Relationship	Sex	Social Security No.	Birth Date	Primary Care Dentist	Office ID #
	SELF					
	SPOUSE					

STEP 3: You must complete this section with the Primary Care Dentist's address.

STREET: _____

CITY/STATE: _____ **ZIP CODE:** _____

STEP 4: Read the statement below and sign your name.

By signing this form, I understand that my Aetna DMO dental planpremiums will be deducted on a pre-tax basis. No changes can be made to my dental plan enrollment during the plan year unless there is a family status change and I complete the benefits enrollment process within 45 days of the event. This form authorizes any licensed physician, hospital, or health/dental care provider to furnish my health plan with such medical information about myself and any eligible dependent, as needed. I understand that my coverage and benefits may be adversely affected by my failure to provide complete and accurate information.

_____ _____

Signature **Date**

Prince George's County Government
Schedule of Health Benefits Costs for 2019

ALL ACTIVE EMPLOYEES – (Excluding Crossing Guards)

		EMPLOYEE BI-WEEKLY	EMPLOYEE MONTHLY	COUNTY MONTHLY	TOTAL MONTHLY
MEDICAL	**KAISER PERMANENTE ***				
	Individual	52.93	114.69	344.08	458.77
	Two-Person	105.63	228.86	686.57	915.43
	Family	153.05	331.60	994.82	1,326.42
	CIGNA HMO*				
	Individual	55.33	119.88	359.66	479.54
	Two-Person	110.66	239.76	719.28	959.04
	Family	154.73	335.24	1,005.72	1,340.96
	CIGNA PPO*				
	Individual	86.68	187.81	438.23	626.04
	Two-Person	174.79	378.71	883.67	1,262.38
	Family	245.46	531.84	1,240.95	1,772.79
RXP	**PRESCRIPTION DRUG PLAN***				
	Individual	12.23	26.50	150.20	176.70
	Two-Person	24.64	53.39	302.52	355.91
	Family	31.48	68.20	386.46	454.66
VSP	**BASIC PLAN***				
	Individual	0.52	1.12	6.37	7.49
	Family	1.12	2.43	13.77	16.20
	BUY-UP PLAN*				
	Individual	0.82	1.77	10.04	11.81
	Family	2.15	4.65	26.33	30.98
DENTAL	**AETNA DENTAL PLAN (DMO)**				
	Individual	11.85	25.67	N/A	25.67
	Two-Person	18.65	40.40	N/A	40.40
	Family	23.86	51.69	N/A	51.69
	AETNA DENTAL PLAN (PPO)				
	Individual	18.02	39.04	N/A	39.04
	Two-Person	33.00	71.51	N/A	71.51
	Family	48.87	105.89	N/A	105.89

***Medical HMO - County pay 75% and Employee pays 25%**
Medical PPO – County pay 70% and Employee pays 30%
Prescription/Vision – County pays 85% and Employee pays 15%

Prince George's County Government
Schedule of Health Benefits Costs for 2019

CROSSING GUARDS
(Paid Over 20 Pay Periods)

		EMPLOYEE BI-WEEKLY	EMPLOYEE MONTHLY	COUNTY MONTHLY	TOTAL MONTHLY
MEDICAL	**KAISER PERMANENTE***				
	Individual	68.81	114.69	344.08	458.77
	Two-Person	137.32	228.86	686.57	915.43
	Family	198.96	331.60	994.82	1,326.42
	CIGNA HMO*				
	Individual	71.93	119.88	359.66	479.54
	Two-Person	143.86	239.76	719.28	959.04
	Family	201.14	335.24	1,005.72	1,340.96
	CIGNA PPO*				
	Individual	112.69	187.81	438.23	626.04
	Two-Person	227.23	378.71	883.67	1,262.38
	Family	319.10	531.84	1,240.95	1,772.79
RXD	**PRESCRIPTION DRUG PLAN***				
	Individual	15.90	26.50	150.20	176.70
	Two-Person	32.03	53.39	302.52	355.91
	Family	40.92	68.20	386.46	454.66
VSD	**BASIC PLAN***				
	Individual	0.67	1.12	6.37	7.49
	Family	1.46	2.43	13.77	16.20
	BUY-UP PLAN*				
	Individual	1.06	1.77	10.04	11.81
	Family	2.79	4.65	26.33	30.98
DENTAL	**AETNA DENTAL PLAN (DMO)**				
	Individual	15.40	25.67	N/A	25.67
	Two-Person	24.24	40.40	N/A	40.40
	Family	31.01	51.69	N/A	51.69
	AETNA DENTAL PLAN (PPO)				
	Individual	23.42	39.04	N/A	39.04
	Two-Person	42.91	71.51	N/A	71.51
	Family	63.53	105.89	N/A	105.89

***Medical HMO - County pay 75% and Employee pays 25%**
Medical PPO – County pay 70% and Employee pays 30%
Prescription/Vision – County pays 85% and Employee pays 15%

Notes

Notes

OHRM

Office of Human Resources Management