Queen Anne's County Public Schools

2026 - 2027
Benefits Overview Guide

QUEEN ANNE'S COUNTY
PUBLIC SCHOOLS
Where Our Future Begins

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This benefits guide describes the highlights of benefits for all eligible employees in non-technical language. Your specific rights to benefits under the plan are governed solely, and in every respect, by the official plan documents and not the information in this summary. If there is any discrepancy between the descriptions of the programs as contained in this brochure and the official plan documents, the language of the official documents shall prevail as accurate. Please refer to the plan-specific documents for detailed plan information. Any plan benefits may be modified in the future as decided by Queen Anne's County Public Schools.

Welcome to Your Queen Anne's County Public Schools Benefits

Queen Anne's County Public Schools (QACPS) takes pride in offering a comprehensive and competitive benefits package to our employees. QACPS, through all of our benefits partners, offers you a benefits program that allows choice and flexibility. Through this guide, you can choose the benefits that are best for you and your family.

2026 Open Enrollment

Open Enrollment is Tuesday, June 2 through Friday, June 19, 2026
Open Enrollment is your only opportunity to make benefits changes without a qualifying life event!

All employees are encouraged to meet face-to-face with Decision Support Specialists (DSSs) from Bolton, during Open Enrollment. The DSSs are trained specifically on our benefits and can answer questions and assist with your enrollment. Employees can schedule an appointment to meet with a DSS online at https://go.oncehub.com/qacps. Once on the site, select your location (or one nearest to you) to schedule a time to meet with a DSS.

Anyone who schedules an appointment will have their name entered in a raffle for a chance to win one of nine (9) $25 gift cards to Royal Farms or Chick-fil-A. Winners will be drawn starting on June 3. The earlier you schedule your appointment, the more opportunities you will have to win.

What's New This Year

QACPS is replacing several current coverage options with new plans that offer enhanced value, broader benefits, and competitive rates. See below for highlights of each update.

- **New Accident Insurance through Prudential:** This plan offers enhanced injury and treatment benefits at a lower cost. It also includes a higher wellness benefit that is easier to earn, since routine dental and vision exams now qualify. The plan also includes +25% youth organized sports benefit. Please see page 19 for more information.
- **New Hospital Indemnity Insurance through Prudential:** This plan expands support for maternity and newborn care as well as mental health services. It also makes the wellness benefit more accessible by allowing routine dental and vision exams to qualify. Please see page 20 for more information.
- **New Critical Illness Insurance through Symetra:** This new plan offers higher coverage amounts for spouses and dependent children, along with more competitive rates. No health questions are required to enroll, and your rates are based on the age at which you purchase the policy and will not increase over time. Open Enrollment offers a valuable opportunity to increase your coverage or enroll in new coverage. Please see page 21 for more information.
- **New Permanent Life Insurance with Long-Term Care through Chubb:** Chubb Lifetime Benefit Term will be available beginning September 1, 2026. The plan offers lower rates, lifelong protection, and enhanced long-term care (LTC) benefits. Unum Whole Life will remain on payroll deduction for members who are already enrolled, but it will be closed to new enrollments. Please see page 24 for more information.

QACPS continues to evaluate ways to improve the quality of your health care and keep our health plans competitively priced, while controlling costs for you and QACPS. We encourage you to become and remain engaged in these efforts by being educated on the plans and using them wisely. Be sure to participate in Employee Wellness programs and activities, and partner with your physician to get appropriate preventative screenings. Also, consider programs like mail order pharmacy and generic prescriptions to lower your copays and overall plan costs.

Benefits Eligibility

Employee Eligibility

Full-time employees, as defined by QACPS, are benefits eligible. Administrative employees will receive the appropriate level of benefits associated with their position.

Dependent Eligibility

You may enroll your eligible dependents in the same plans you choose for yourself. Eligible dependents include your legal spouse, dependent children, and disabled adult children. The Dependent Eligibility Documentation Requirements are built in to the bswift platform.

When to Enroll

Open Enrollment: You can enroll during the annual Open Enrollment period. This year, Open Enrollment will run from June 2 through June 19, 2026. Coverage for all benefits will be effective on September 1, 2026.

New Hire: You must enroll within 30 days of your eligibility/hire date. If you don't enroll for coverage within 30 days of your eligibility date, you won't receive health coverage during the plan year, unless you have a qualifying life event (see Making Changes on page 6 for details). Coverage for all benefits will begin on the 1st of the month following your date of hire, unless you are hired on the 1st of the month then they will begin immediately.

Qualifying Life Events: The choices you make when you are first eligible are in effect for the remainder of the plan year that ends on August 31. Once you enroll, you must wait until the next Open Enrollment period to change your benefits unless you have a qualifying life event as defined by the IRS (birth, marriage, divorce, loss of coverage, change in dependent's eligibility).

You have 30 days from the date of your qualifying life event to make changes to your coverage and provide any required documentation.

How to Enroll

You may self-enroll on bswift by following the Online Enrollment Instructions below. If you have a question, need your password reset, or are having technical issues, please send an email to service@boltonusa.com.

Online Enrollment Instructions

Step 1: Sign in to bswift

Username: Your username is first initial of first name + full last name + year of birth. For example: If your name is Jane Anderson and you were born in 1970, your username would be janderson1970. Go to https://qacps.bswift.com/ to enroll.

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

Step 2: Get Started

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

Next you will review your **Family Information**. Eligible dependents can be added on this page. You must agree that both your Personal and Family Information is correct before you can proceed, then click Continue.

Step 3: Begin Your Enrollment and Enroll

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

Your elections from FY26 have been copied to FY27 except for your Flexible Spending Account plan elections. The total benefit cost, per pay period, will appear on the right side of the enrollment screen.

Step 4: Confirm Enrollment Selections

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

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

Decision Support Specialists will be available to assist on-site at locations around the County beginning June 3rd through June 12th, 2026

Call center appointments are available 11am-8pm on weekdays beginning June 2nd through June 19th during Open Enrollment. You will be called at your scheduled time.

If you are adding any dependents or making any beneficiary changes, please gather that information in advance of the appointment. Click here to schedule an appointment with a Decision Support Specialist or go to https://go.oncehub.com/QACPS.

Making Changes to Your Benefits

The choices you make when you are first eligible are in effect for the remainder of the plan year that ends on August 31. Once you enroll, you must wait until the next Open Enrollment period to change your benefits or add or remove coverage for dependents, unless you have a qualifying life event as defined by the IRS. Life event changes must be made within 30 days of the qualifying event.

The following are examples of a qualifying life event:

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

Lifestyle Change/ Event	Documentation Required
Marriage	Marriage Certificate
Divorce	Divorce Decree
Legal separation	Separation Agreement where the terms of the agreement permit a change in coverage
Birth or adoption	Birth Certificate or adoption papers
Changes in employment status from part-time or full- time or vice versa	No documentation required - Human Resources will confirm
Your child loses eligibility for dependent coverage	No documentation required
Your spouse gains or loses coverage under another plan	Letter from spouse's employer verifying the change
You go on or return from a leave of absence	No documentation required - Human Resources will confirm

Effective Date of Coverage

Benefit changes take effect the 1st of the month following receipt of the proper documentation. The effective date for births and adoptions will be made retroactive to the actual date of the birth / adoption.

Your Cost for Health Coverage

Your PER PAYCHECK payroll deductions for medical, pharmacy, dental, and vision coverage are shown in the tables below. Premiums from the tables below are deducted from 26 paychecks, September 2026 through August 2027, respectively. Actual payroll amounts may vary slightly.

Medical, Pharmacy, Dental, and Vision Premiums

Regular Employees Hired before 7/1/2024

Plan Type	Total Annual Cost Employee + Employer	Total Monthly Cost Employee + Employer	Employer Contribution per pay	Employee Contribution per pay
EPO Plan				
Employee	$10,631.52	$885.96	$408.90	$0
Employee + Child	$16,618.32	$1,384.86	$575.25	$63.92
Employee + Spouse	$24,632.76	$2,052.73	$852.67	$94.74
Family	$26,949.60	$2,245.80	$932.87	$103.65
EPO Marathon Health Center Plan				
Employee	$9,614.40	$801.20	$369.78	$0
Employee + Child	$15,026.88	$1,252.24	$520.16	$57.80
Employee + Spouse	$22,270.32	$1,855.86	$770.90	$85.66
Family	$24,382.92	$2,031.91	$844.02	$93.78
PPO Plan				
Employee	$11,543.76	$961.98	$377.39	$66.60
Employee + Child	$22,152.12	$1,846.01	$681.60	$170.40
Employee + Spouse	$30,536.04	$2,544.67	$822.12	$352.34
Family	$33,330.00	$2,777.50	$897.35	$384.58

Your Cost for Health Coverage (cont.)

Your PER PAYCHECK payroll deductions for medical, pharmacy, dental, and vision coverage are shown in the tables below. Premiums from the tables below are deducted from 26 paychecks, September 2026 through August 2027, respectively. Actual payroll amounts may vary slightly.

Medical, Pharmacy, Dental, and Vision Premiums

Regular Employees Hired after 6/30/2024

Plan Type	Total Annual Cost Employee + Employer	Total Monthly Cost Employee + Employer	Employer Contribution per pay	Employee Contribution per pay
EPO Plan				
Employee	$10,631.52	$885.96	$368.01	$40.89
Employee + Child	$16,618.32	$1,384.86	$511.33	$127.83
Employee + Spouse	$24,632.76	$2,052.73	$757.93	$189.48
Family	$26,949.60	$2,245.80	$829.22	$207.30
EPO Marathon Health Center Plan				
Employee	$9,614.40	$801.20	$332.81	$36.98
Employee + Child	$15,026.88	$1,252.24	$462.37	$115.59
Employee + Spouse	$22,270.32	$1,855.86	$685.24	$171.31
Family	$24,382.92	$2,031.91	$750.24	$187.56
PPO Plan				
Employee	$11,543.76	$961.98	$355.19	$88.80
Employee + Child	$22,152.12	$1,846.01	$596.40	$255.60
Employee + Spouse	$30,536.04	$2,544.67	$822.12	$352.34
Family	$33,330.00	$2,777.50	$897.35	$384.58

Medical Coverage
(Includes Pharmacy, Dental, & Vision)

You have a choice between three medical options:

- Two (2) Exclusive Provider Options (EPO)
- One (1) Preferred Provider Option (PPO)

All plans give you access to a quality network of practitioners and hospitals in Maryland along with access to a national network. CareFirst does not require a referral, so you may receive services from any provider. However, the benefit you receive will be based upon the network status of the provider as well as the plan you are enrolled in.

An **EPO** does not provide coverage if you visit an out-of-network provider. If you do incur costs with an out-of-network provider, you will be responsible for 100% of the cost.

In-network benefits are provided when you use Preferred Providers or In-network Providers.

The **EPO Marathon Health Center Plan** uses the same network, copayments, and out-of-pocket limits as the current EPO plan with two key differences:

- Annual physicals must be completed for both employee and spouse, if covered, at the Marathon Health Center and
- Primary Care visits for non-Marathon providers are $50 per visit. To maintain plan eligibility, annual physical exams must be completed through Marathon between May 1, 2026 and April 30, 2027.

A PPO covers care provided both inside and outside the plan's provider network.

You will pay more out of your own pocket when you use practitioners who do not belong to the Preferred Provider Network. You will be required to pay a deductible and a greater portion of the cost of medical treatment. You may also need to file the claim.

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

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

Based on the continued success of our Marathon health center and improved health results of our members, we are excited to announce a ***10% premium savings*** over our traditional Select EPO BlueChoice Advantage plan for employees who select the Marathon Health Center Plan.

Medical Coverage
(Includes Pharmacy, Dental, and Vision)

	EPO Medical Plan & EPO Marathon Health Center Plan*		PPO Medical Plan	
Plan Features	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Calendar Year Deductible - Individual	None	No coverage	None	$200
Calendar Year Deductible - Family	None	No coverage	None	$600
Annual Calendar Year Out-of-Pocket Maximum - Individual	$1,600	No coverage	$1,200	$1,200
Annual Calendar Year Out-of-Pocket Maximum - Family**	$4,800	No coverage	$3,600	$3,600
Prescription Annual Calendar Year Out-of-Pocket Maximum - Individual**	$5,100	No coverage	$5,100	$5,100
Prescription Annual Calendar Year Out-of-Pocket Maximum-Family**	$10,200	No coverage	$10,200	$10,200
Lifetime Maximum	Unlimited	No coverage	Unlimited	Unlimited
Copayments				
Office Visit PCP	$20 copay	No coverage	$20 copay	You are responsible for deductible & coinsurance for services by participating providers
Office Visit Specialist	$40 copay	No coverage	$30 copay	You are responsible for deductible & coinsurance for services by participating providers
Hospital Facility (outpatient)	$40 per visit	No coverage	$40 per visit	You are responsible for deductible & coinsurance for services by participating providers

*To maintain plan eligibility in the Marathon Health Center Plan, annual physical exams must be completed through Marathon between May 1, 2026 and April 30, 2027.
**Plan has a separate maximum for medical and drug expenses which accumulate independently.

Medical Coverage
(Includes Pharmacy, Dental, and Vision)

	EPO Medical Plan & EPO Marathon Health Center Plan*		PPO Medical Plan	
Plan Features	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Practitioner (at hospital) Inpatient	$0	No coverage	$0	You are responsible for deductible & coinsurance for services by participating providers
Practitioner (at hospital) Outpatient	$30	No coverage	$30	Practitioner (at hospital) Inpatient
Well Care				
Adult Routine Physical Exam	100% of the AB	No coverage	100% of the AB	80% of "AB" after deductible
Routine GYN Exam	100% of the AB	No coverage	100% of the AB	80% of "AB" after deductible
Well Child Visits	100% of the AB	No coverage	100% of the AB	No deductible for Well Child Visits
Type of Service				
Hospital Inpatient Pre-admission review/ approval Required	$100 per day ($300 max per admission)	No coverage	$100 per day ($300 max per admission)	80% of "AB" after deductible
Outpatient Diagnostic-Lab	100% of "AB" after $20 copay	No coverage	100% of "AB" after $20 copay	Paid in-network benefit***
Radiation Therapy, Chemotherapy & Renal Dialysis - Facility Billed	100% of "AB" after $40 member copay	No coverage	100% of "AB" after $40 member copay	80% of "AB" after deductible
Radiation Therapy, Chemotherapy & Renal Dialysis - Practitioner in Facility	100% of "AB" after $30 member copay	No coverage	100% of "AB" after $30 member copay	80% of "AB" after deductible
Radiation Therapy, Chemotherapy & Renal Dialysis - Practitioner in Office	100% of "AB" after $30 member copay	No coverage	100% of "AB" after $30 member copay	80% of "AB" after deductible
Chiropractic Services (unlimited visits)	100% of "AB" after $30 member copay	No coverage	100% of "AB" after $30 member copay	80% of "AB" after deductible
Inpatient Mental health	$100 per day ($300 max per admission)	No coverage	$100 per day ($300 max per admission)	80% of "AB" after deductible

*To maintain plan eligibility in the Marathon Health Center Plan, annual physical exams must be completed through Marathon between May 1, 2026 and April 30, 2027.
**Plan has a separate maximum for medical and drug expenses which accumulate independently.
***Non-participating providers can bill you up to total charges.
"AB" = Allowed Benefit

Medical Coverage
(Includes Pharmacy, Dental, and Vision)

	EPO Medical Plan & EPO Marathon Health Center Plan*		PPO Medical Plan	
Plan Features	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Prescription Drugs: Retail (up to a 34-day supply)				
Generic	$10 copay	No coverage	$10 copay	$10 copay
Preferred Brand	$35 copay	No coverage	$35 copay	$35 copay
Non-Preferred Brand	$50 copay	No coverage	$50 copay	$50 copay
Prescription Drugs: Mail Order (up to a 100-day supply)				
Generic	$16 copay	No coverage	$16 copay	$16 copay
Preferred Brand	$60 copay	No coverage	$60 copay	$60 copay
Non-Preferred Brand	$90 copay	No coverage	$90 copay	$90 copay
Maintenance Drugs: Mail Order (up to a 100-day supply)				
Generic	$16 copay	No coverage	$16 copay	$16 copay
Preferred Brand	$60 copay	No coverage	$60 copay	$60 copay
Non-Preferred Brand	$90 copay	No coverage	$90 copay	$90 copay

*To maintain plan eligibility in the Marathon Health Center Plan, annual physical exams must be completed through Marathon between May 1, 2026 and April 30, 2027.
**Plan has a separate maximum for medical and drug expenses which accumulate independently.
***Non-participating providers can bill you up to total charges.
“AB” = Allowed Benefit

Medical Coverage Features

Marathon Health Center

The Marathon Health Center covers up to 90% of your comprehensive and primary care needs with no out-of-pocket costs. All of QACPS fulltime employees regardless of health insurance coverage will have access to the Health Center; Dependents of employees, retirees and retiree dependents, all of whom must be on the QACPS's health plan, can access Marathon Health Services including virtual care and 24/7 access to manage your care. Marathon providers are dedicated to your healthcare and are easy to reach at convenient locations near your home or work, as well as virtually (by phone or video). For more information, visit https://clients.marathon.health/qachealth.

Hours: Sat & Sun. Closed | Mon. 10am-6pm | Tues. 7am-5pm | Wed. 10am-6pm | Thu. 7am-5pm | Fri. 8am-12pm

Services:

- Annual physical exams
- Chronic condition management
- Full-scope family medicine
- Men's & women's health
- Mental Health
- No-cost on-site lab work
- School and sports physicals
- Select on-site medications at little to no cost
- Sick and urgent care

Simply Better Health App

sb health
simply better health

Your Employee Benefits

- A mobile version of your benefits plan and easy access to your medical ID cards.

Your Health Information

- A secure record of your health conditions, prescriptions, allergies, etc.

Medical Care

- A triage tool and geo-locator to help find the best care.

Health Resources

- Personalized health tools, education, news, etc.

First Response

- A tool to help you share your health information with first responders.

To learn more, go to **help.sbhealthapp.com** or scan the QR code. App code: **QACOPS.**

Medical Coverage Features

410-497-8300
NurseRachel@ourclinicalteam.com

Scan QR code: once it opens, save contact info by scrolling down and tap "save to contact".

Meet Nurse Rachel!

Hi, my name is Rachel. I am a Registered Nurse with 10+ years' experience helping individuals navigate healthcare needs. Certified by the Commission for Case Manager Certification (CCMC), my passion is assisting people to achieve the best possible health outcomes utilizing the benefits plan and resources offered by their employer. As a confidential clinical resource offered by Queen Anne's County Public Schools I am available to you and your family members on your health plan when needed. As a liaison between CareFirst and you, I may personally reach out to you to coordinate care and offer suggestions to better navigate our complex healthcare market. I am hoping you will input my contact information into your "contacts" so if you see a call or email from me, you will recognize who it is. Any interactions we have will never be shared with your employer. I am truly here to assist with any needs regarding your health.

Accarent Health

Accarent Health provides access to over 250 specialized medical procedures and treatments — from knee replacements to organ transplants — without any out-of-pocket costs for you. Enjoy care from top-rated providers, with the added benefit of personalized case management, exclusive concierge services, and travel assistance tailored to your health needs.

Services:

- Comprehensive Care Selection: Access to adult and pediatric procedures at top-rated centers.
- Concierge Benefits: Personalized case management and potential travel support, tailored to your needs.
- Zero Out-of-Pocket Costs: Full waiver of copays and deductibles within the Accarent Health Network.

For members confronting complex medical needs, Accarent Nurse Case Managers are ready to stand by your side. They will offer clinical support, advocate for you at Accarent centers like Johns Hopkins and Christiana Care, and ensure a seamless transition of care from the facility back to your local physician.

Interested in learning more or ready to discuss your options? Accarent Nurse Case Managers are here to answer your questions and to provide step-by-step guidance, ensuring you receive nothing but the best care. Call **866-771-0697** or email casemanagement@accarenthealth.com.

Discover the full spectrum of providers and services at www.accarenthealth.com.

Accarent HEALTH

Medical Coverage Features

CancerNavigator

CancerNavigator is available to all health plan employees and family members. The CancerNavigator service provides no-cost education and guidance to cancer patients as they navigate the many decisions that follow a cancer diagnosis. The CancerNavigator service is delivered by oncology-certified Nurse Navigators. The service consists of:

- Proactive Outreach: Nurse Navigators will connect with health plan members with recent cancer diagnoses through direct outreach or direct calls from members.
- Tailored Education & Guidance: Nurse Navigators will deliver materials tailored to each person's cancer diagnosis, geographic area, and needs.
- Quick Access to Top Doctors & Hospitals: Nurse Navigators will help members make appointments, get second opinions, and/or transition care to doctors well-equipped to treat the patient's specific diagnosis.

If interested, call CancerNavigator's dedicated phone line at **410-988-3797** Monday-Friday from 8am-6pm ET.

CloseKnit: The Virtual Care Option

CloseKnit securely connects you with a doctor, day or night, through your smartphone, tablet, or computer. CloseKnit doctors will provide you with a consultation, diagnosis, and even prescriptions (when available and appropriate). They are all U.S. board-certified, licensed, and credentialed medical professionals. It's a convenient and easy way to get the care you need, wherever you are. You can get care for other needs such as:

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

To schedule a Virtual Care appointment, go to closeknit.com or download the CloseKnit mobile app.

Pharmacy Coverage

Some prescription drugs require Prior Authorizations. Prior Authorization ensures you achieve the maximum clinical benefit from the use of specific targeted drugs. Your physician or pharmacist must call to begin the Prior Authorization process. For the most up-to-date Prior Authorization list, visit CareFirst Pharmacy at www.carefirst.com/rx.

Prescription Drug Copay: Brand Name vs. Generic Equivalent

The copay is the dollar amount the pharmacy will collect for your prescription. You will receive a 34-day supply for a single copay. Copays are determined by the type of prescription drug purchased. If you choose a brand name prescription drug when a generic prescription drug is available, you will pay the appropriate copay plus the difference in cost between the brand name and the generic drug.

Specialty Prescription Drug Copay Assistance

With PrudentRx Copay Assistance, program enrollment is automatic when you are prescribed a covered specialty medication.

Qualifying drugs are covered at no copay to the member. Copay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient cost share for select specialty medications. The PrudentRx Solution will assist members in obtaining copay assistance from drug manufacturers to reduce or eliminate out-of-pocket expenses.

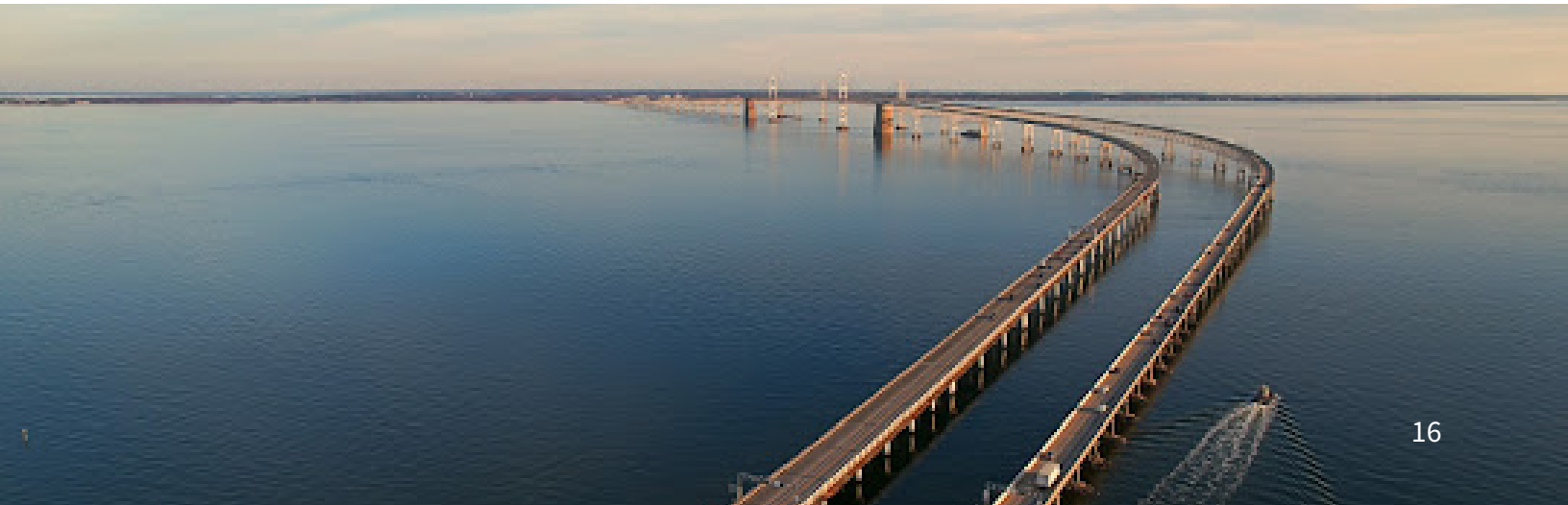
Mail Service Pharmacy Helps Save You Money

The Mail Service Pharmacy offers a convenient way to fill prescriptions with fast, accurate home delivery. Plus, it's an easy way to save on your maintenance medications. Once you register at www.carefirst.com/rx, you'll have access to:

- Convenient home or office delivery service
- E-prescribing capabilities available to your physician
- View claims, balances and prescription history
- Manage account settings and payment methods

Members can sign up by calling CareFirst Pharmacy Services at 800-241-3371 or by completing the Mail Service Pharmacy Order Form.

Save Money: For two copays through the Mail Service Pharmacy, you will receive one (1) three-month supply of medication, saving money from having to fill three (3) one-month supplies at retail.



Dental Coverage

Good dental hygiene is important for your overall health. Visit an in-network dentist for the best coverage so you save money on dental services. Search for an in-network provider at **CareFirst.com**

CareFirst PPO

Plan Features	In-Network	Out-of- Network
Calendar Year Deductible - Individual (waived for Preventive Services)	$25	$25
Calendar Year Deductible - Family (waived for Preventive Services)	$75	$75
Calendar Year Maximum	1,500 per member	$1,500 per member
Diagnostic and Preventive Services (e.g., X-rays, cleanings, exams)	100%	100%
Basic and Surgical Services (e.g., fillings, extraction, root canals)	80% after deductible	80% after deductible*
Major restorative services e.g., dentures, crowns bridges	50% after deductible	50% after deductible*
Major restorative services (e.g., dentures, crowns, bridges)	50% after deductible	50% after deductible*
Orthodontia (dependent up on age 19)	50%	50%
Dependent Orthodontia Lifetime Maximum	$1,500 per member	$1,500 per member

**Non-participating providers may bill you the difference between the CareFirst allowed benefit and the provider's total charge.*

Vision Coverage

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

BlueVision Plus

Plan Features	In-Network	Out-of-Network
	You pay:	**Plan reimburses you:**
Exam every 12 months	No cost	Up to $36
Frames every 12 months	$20 copay*	Up to $30
Lenses every 12 months		
Single Vision	$20	Up to $42
Lined Bifocal	$20	$67
Lined Trifocal	$20	$90
Contact lenses every 12 months (in lieu of lenses and frames)		
Medically Necessary	Covered in full Davis Vision Contacts:$40 copay	Up to $80
Elective: Single	$97 allowance	Up to $71
Elective: Bifocal	$127 allowance**	Up to $97

**Davis Vision Collection Frames only; all other frames: $100 allowance, you pay balance plus $20 frame copay*
***Davis Vision Collection Contacts: $40 copay*

Finding an In-Network Provider

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

New: Prudential Accident Insurance

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

Accident insurance through Prudential helps you be prepared for the unexpected. It's more affordable than you think, and covers fractures, dislocations, cuts, and more. You'll also receive a lump-sum payment to use however you like—from medical expenses like co-pays and transportation to non-medical expenses like babysitters, groceries or even pizza delivery. And submitting a claim online is simple with a three-step process. Prudential makes it easy to get your benefits when you need them most so you can focus on getting well.

QACPS as selected a new carrier, Prudential, for the Accident plan. The new plan provides wider coverage at a lower cost.

Plan Features:

- The Accident plan pays cash directly to you to be used however you choose.
- This is a 24-hour policy, covering on- and off-the-job injuries.
- You can cover yourself, your spouse, and your children.
- This policy pays an additional 25% benefit if your child (ages 18 and under) is injured while playing organized sports.
- Includes coverage for concussions, eye injuries, MRIs, CAT scans, ER and Urgent Care visits, ambulance services, and hospitalizations. Many other conditions and injuries are covered - see plan summary in bswift for more details.
- Other enhancements include benefits for cranial surgery, medical appliances, and therapies including cognitive behavioral, respiratory, and vocational.
- Includes a $100 Wellness Screening benefit for each covered family member. With over 52 covered screenings, Prudential makes it easy to receive your annual wellness benefits!

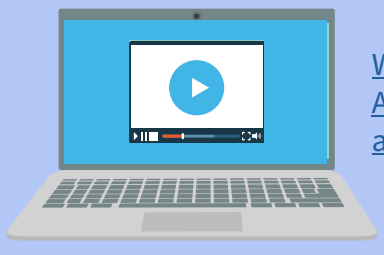
Benefit Example

Jess had a serious bike accident. Although he has a good medical plan, his expenses were more than the expected. After an ambulance trip to the ER he was diagnosed with a concussion and a broken thigh which resulted in a long healing journey. Fortunately, Jessie didn't have to dip into his savings because he had Accident coverage.

Transportation to hosp.	$500
Emergency room visit	$100
Advanced diagnostic testing	$200
X-ray benefit	$150
Concussion injury	$200
Closed thigh fracture	$2,250
Medical equipment	$100
Physical rehabilitation	$250
Benefits Paid	**$3,750**

Rates per pay:

LEARN MORE



Watch this short video on how Accident Insurance benefits you and your family.

To view the Schedule of Benefits for a full list of covered injuries and treatments and to view the list of Health Screening Tests to earn the Wellness Benefit, see the bswift Library.

Hospital Indemnity Insurance

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

New through Prudential, Hospital Indemnity Insurance pays cash benefits directly to you for covered hospital stays, whether they are planned or unexpected. These benefits can help with out-of-pocket medical costs and everyday expenses. Benefits are paid directly to you, so you can use the money where you need it most.

Did you know:

- Benefits are paid directly to you, not your provider
- Coverage includes illness, injury, pregnancy, and mental health treatment
- Benefits can help with medical bills and everyday expenses
- No medical questions are required to enroll during open enrollment
- Benefits are payable for:
  - Hospital and ICU admissions, confinement, and observation stays
  - Mental health and substance abuse facility care
  - Preventive health screenings and second medical opinions

Benefit Example

Ellen was ready to deliver boy number three and just that fast, two surprises. A healthy girl, and a C-section baby at that. The plan paid $1,500 for Ellen's admission and $600 for her four-day stay, plus $1,500 for the newborn admission and $300 for two days in the hospital—totaling $3,900 in benefits. The money meant that her spouse could take time off for their growing family. And they would have money left over for newborn expenses.

Policy Benefits	
Hospital Admission*	$1,500/admission
Daily Hospital Confinement (up to 30 days per confinement)	$150/day
ICU Admission*	$2,000/admission
Daily ICU Confinement (up to 15 days per confinement)	$300/day
Health Maintenance Screening per insured	$100/year

*Hospital and ICU Admission benefits payable up to 5 times/year

Affordable Rates Per Pay:

Employee	Employee & Spouse	Employee & Children	Family
$8.76	$17.25	$22.13	$30.62

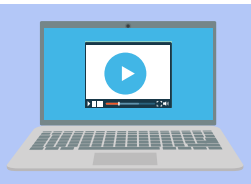
Key Benefit Highlights:

- Admission Benefits: $1,500 per hospital admission; or $2,000 per ICU admission
- Daily Confinement: $150 per day for hospital stays; or $300 per day for ICU stays
- Additional Benefits: $200 for observation stays and $100 per year for health screenings
- Newborn Admission and Daily Confinement benefits paid in addition to Mother's benefits
  - Payable when child is added to coverage within 30 days of birth.
- These benefits can provide added financial support during a hospital stay.

Keep in mind:

- Hospital stays must generally last at least 24 hours to qualify
- Benefits may be paid for multiple hospital events each year, subject to day limits or lifetime maximums
- Coverage is available for you, your spouse, and your children

LEARN MORE



Watch this short video on how Hospital Indemnity Insurance benefits you and your family.

New: Symetra Critical Illness Insurance

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

QACPS has selected a new provider, Symetra, for the Critical Illness benefit. Symetra critical illness insurance can provide lumpsum benefits for covered events that occur during childhood and adolescence, early adulthood, when planning a family, mid-life and beyond.

The new offering allows for stronger, expanded coverage for your spouse and dependent children plus more competitive rates.

Plan Features:

- The policy pays you a lump sum benefit upon diagnosis of a covered condition.
- Spouses can now be covered at 100% of the employee benefit amount up to $30,000.
- Your children under age 26 are automatically covered at 50% of your benefit amount.
- Includes a $100 Annual Wellness Screening benefit per covered family member.
- There are no health questions to qualify.
- Rates are locked in for life based on your age when you buy your policy, so the earlier you buy your policy the lower the rate will be for life.

Keep in mind:

- Covered Conditions
  - Heart attack, stroke, invasive cancer
  - Major organ failure, end-stage renal failure
  - Coma, paralysis - (covers accident and sickness)
  - Advanced Alzheimer's, Parkinson's disease, Advanced MS
- Conditions of lesser severity are covered at 25% or 50% of the benefit amount including: severe autoimmune disorders, minor cancers, coronary angioplasty, infectious disease with hospitalization.
- Skin cancer benefit is a flat $500.

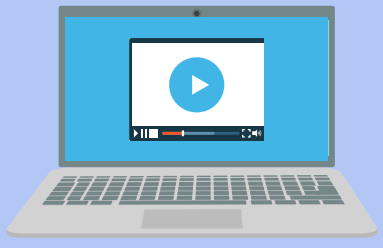
Benefit Example

After months of testing, Jean learned her liver was failing and that she would need a transplant.

Because she had enrolled in Critical Illness Insurance, she received a lump-sum payment as soon as the transplant need was documented—without having to be placed on a waiting list or complete surgery. The benefit helped Jean cover medical and household expenses while she focused on her health.

Out-of-Pocket Costs	$2,200
Transportation	$850
Lodging near Treatment Facility	$1,450
Special Diets and Household Help	$3,400
Spouse's Lost Wages	$5,000
Total Out-of-Pocket Expenses	$12,900
Critical Illness Benefit	$20,000
Remaining Benefit Amount	**$7,100**

LEARN MORE



Watch this short video on how Critical Illness Insurance benefits you and your family.

Flexible Spending Accounts (FSAs)

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

FSA Contributions

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

Healthcare Flexible Spending Account (HC FSA)

FSA funds may only be used to pay for "out-of-pocket" medical, dental, vision and prescription drug expenses at any time without federal tax liability or penalty. For the 2026 plan year, you may contribute up to $3,400 to your HC FSA.

Important Rules:

You may not change your FSA election during the plan year unless you experience a qualifying life event.

Rollover Provision—Participants in HC FSA plans with unused funds at next year end may carry over up to $680 into the plan year without changing the amount they can contribute.

You must submit all eligible expenses no later than 90 days after the end of the plan year. If your employment ends during the year, you will have 90 days from your date of termination in which to submit claims for reimbursement for claims incurred prior to your date of termination.

Dependent Care Flexible Spending Account(DC FSA)

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

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

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

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

- $7,500 if single, or married, filing jointly
- $3,750 if married, filing separately

FSA – Get Connected

Call 1-800-437-3539
Visit: https://fba.wealthcareportal.com

1. Click Register
2. Create your account
3. Employee ID = SSN
4. Employer ID = FBAQAPS

Life and AD&D Coverage

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

For all full-time employees, QACPS pays the premium cost of term life insurance coverage starting at $42,000 for the first year and increasing in increments of $2,000 until it reaches $50,000 the fifth year of employment and beyond. The coverage is effective the first of the month following employment unless hired on the first of the month.

	Eligible Employees
Benefit Schedule	Year 1 - $42,000
Benefit Schedule	Year 2 - $44,000
Benefit Schedule	Year 3 - $46,000
Benefit Schedule	Year 4 - $48,000
Benefit Schedule	Year 5 - $50,000
Maximum Benefit	$50,000
Minimum Benefit	$42,000
Guaranteed Issue	$50,000
AD&D Benefit	Matches Life Benefit
Age Reduction Schedule	To 75% at Age 70; to 50% at age 75
Employer Contribution	100%

Supplemental Term Life Insurance

Employees have the option to purchase supplemental life. This is a term life insurance that can be purchased in increments of $10,000 up to three times your salary not to exceed $200,000.

Employees can add or increase employee coverage during Open Enrollment by one increment ($10,000) without showing proof of good health (EOI), up to the plan maximum. Coverage for spouse is subject to proof of good health. Coverage for children is guaranteed issue with no requirement for proof of good health.

	Employee
Benefit Schedule	Increments of $10,000
Maximum Benefit	$200,000
Minimum Benefit	$10,000
New Hire Guaranteed Issue*	Full Benefit
Age Reduction Schedule	To 75% at Age 70; to 50% at age 75
Employer Contribution	0%

*Members may enroll for the first time or elect an increase up to one option ($10,000) without proof of good health during the Employer's designated Annual Enrollment Period.

An Accelerated Benefit is included. Terminally ill members may withdraw up to 90% of their Life benefit to a maximum of $500,000 (when Basic Life and any Additional Life are combined), if their life expectancy is 12 months or less.

New Chubb LifeTime Benefit Term

The Chubb LifeTime Benefits program combines life insurance and long-term care protection to support your financial security—both today and in the future. Your coverage can be used to help pay for long-term care expenses if needed, providing added flexibility and peace of mind. Coverage is available for you, your spouse, and your children.

Eligibility

- Employees: Ages 19–70
- Spouse: Ages 19–60
- Children: Coverage available through optional rider only

During this open enrollment only, employees can enroll in guaranteed issue coverage for up to $125,000 - no health questions to qualify.

Spouse coverage is available for up to $25,000 with only one health question.

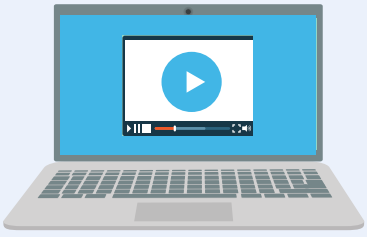
A $50,000 policy provides

- $50,000 in life insurance benefits, or
- $2,000 a month for up to 50 months in long-term care benefits with Extension of Benefits provision
- $25,000 in restored life insurance benefits after all long-term care is used

Lifetime protection with built-in benefits

- **Accelerated Death Benefit (Terminal Illness) -** Access up to 50% of the death benefit (max $100,000) if diagnosed as terminally ill available after coverage has been in force for 30 days
- **Long-Term Care (LTC) Benefit -** Receive monthly payments equal to 4% of the death benefit Paid for up to 25 months. Premiums are waived while LTC benefits are being paid. Covers services such as:
  - Home health care
  - Assisted living
  - Adult day care
  - Nursing home care

- **Extension of Benefits-** If the full death benefit is used for LTC, benefits may continue. Extends the same monthly LTC benefit for up to an additional 25 months. Effectively doubles the LTC benefit duration
- **Restoration of Death Benefit-** Restores 50% of the original death benefit (up to $50,000) after LTC is used, ensuring a remaining life insurance benefit is available
- **Optional Benefit Child Term Rider** up to $25,000 with option to convert to individual coverage at age 26 for up to 5 times the benefit amount.



Watch this short video to see how Chubb's policy is built for today, tomorrow, and a lifetime.

Please schedule an appointment with a DSS or send an email to service@boltonusa.com if you have additional questions on the New Chubb Insurance plan or need assistance enrolling.

Disability Insurance

QACPS recognizes an injury or illness could strike at any time and leave you unable to work. To protect you and your family financially in the event of an injury or illness, QACPS offers Voluntary Disability coverage through The Standard Insurance Company.

Benefit Amount

This coverage pays a benefit in the event that you cannot work because of injury or illness. This benefit replaces a portion of your monthly income, providing funds directly to you. It is designed to begin after you have been disabled for a specified waiting period, known as the benefit waiting period. The monthly benefit is 60% of your insured pre-disability earnings, reduced by deductible income from other sources, and not to exceed a maximum monthly benefit of $5,000. All late applications (applying 31 days after becoming eligible), requests for coverage increases, and reinstatements are subject to medical underwriting approval.

Benefit Waiting Period

You have the option to elect an LTD plan with either a 14- or 30-day benefit waiting period. This is the period from which you first become disabled to the date you are eligible to begin receiving disability benefits.

Note: for employees currently enrolled in the 60- or 90-day benefit waiting period plans, you may remain in your current selection.

Benefit Duration

There are two LTD benefit durations you may select: “To Age 65” or “5 Year Benefit.” The benefit duration over which you receive disability payments is based on the plan you select and your age when disability begins.

Long-Term Disability Plan Selected - Maximum Benefit Duration determined by your age when disability begins

5 Year Benefit

Age	Duration
≥ 61	To age 65 or 5 years, whichever is shorter
62	3 years 6 months
63	3 years
64	2 years 6 months
65	2 years
66	1 year 9 months
67	1 year 6 months
68	1 year 3 months
69+	1 year

To Age 65

Age	Duration
≥ 59	To age 65
60 through 64	5 years
65 through 68	To age 70
69+	1 year

Identity Management Services

Identity theft has reached near-record highs in 2024 effecting an estimated 2.6 million Americans with financial losses exceeding $12.5 billion.* Everyday things like online shopping, banking and even browsing can expose your personal information and make you more vulnerable to cybercriminals. Think about protecting your identity, personal information, and connected devices from the threats that you face in digitally connected homes, workplaces, and when using public Wi-Fi.

Norton LifeLock can make you safer in today's connected world with comprehensive identity theft protection and a whole lot more:

- 24/7 Live Member Support
- Credit Monitoring and Alerts
- Device Security including AntiVirus
- Social Media Monitoring
- Norton Secure VPN
- Discounted Rates

You Pay Per Paycheck:

Individual	Family
$3.69	$7.38

To view a list of the Identity Management Services, see the bswift Library.

*https://www.ftc.gov/system/files/ftc_gov/images/csn-scammy-snapshot-2024.png

Additional Benefits

Worker's Compensation
All employees are covered by Worker's Compensation under the Employee's Worker's compensation Guidelines for injuries occurring while performing normal work duties.

CareFirst Options Discount Program
Your CareFirst ID card entitles you to discounts on alternative therapies and health and wellness programs such as chiropractic, acupuncture, massage, yoga, Pilates, tai chi, qi gong, guided imagery, nutritional counseling, and fitness centers. Additionally, the program offers discounts on Weight Watchers® Online, Jenny Craig®, mail order contacts, laser vision correction, hearing aids, and eldercare referrals.

Since this program is in addition to your medical plan, rather than a benefit, there are no claim forms, referrals, or paperwork to complete. We see this as a way for our members to tap into health and wellness practitioners at discounted rates. To find out more, visit www.CareFirst.com/options. Additional discounts are also available through BlueCross BlueShield at www.blue-365.com.

Holiday Savings Club
All employees are eligible to participate in the Holiday Savings Club. This allows you to save any whole dollar amount per pay in an account for the holidays. The year starts with the first pay in November and checks are disbursed the following October. This is a great way to save for your holiday shopping.

Annual Leave
All eligible 12-month employees accrue annual leave (vacation) on a monthly basis of 1.25 days per month from July 1 through June 30 of each fiscal year. Employees can carry over 20 annual leave days from one fiscal year to the next.

Personal Leave
All full-time benefited employees are allotted personal leave to be used to take care of matters that cannot be handled outside of regular duty hours. Certificated employees and support employees receive four (4) days. Unused personal leave converts to sick leave at the beginning of the following fiscal year.

Sick Leave
A sick leave allowance of 12 days for 12-month employees and 10 days for 10-month employees is credited at the beginning of each fiscal year. Up to ten (10) days of sick leave can be used for family illness as stated in appropriate negotiated agreements. Employees can accumulate an unlimited number of sick days.

Jury Duty
Employees called for jury duty may be absent without loss of pay subject to verification of actual days served. (Verification to be provided by Clerk of the Court).

Family Medical Leave of Absence (FMLA)
All full-time employees who have been employed for one (1) year and have worked twelve hundred fifty hours (1,250) during the past 12 months are eligible for Family Medical leave under the Federal

Family and Medical Leave
Act. This allows an employee who meets the specific criteria to take up to 12 weeks off to care for an ill family member or for themselves.

Retirement Plans

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

Maryland State Retirement System

All employees working 500 hours or more in a school year must enroll in the Maryland State Retirement and Pension System. Currently, employees contribute 7% of their annual salary. Benefits include a death benefit that provides payment of 100% of annual salary to one's designated beneficiary, plus disability and service retirement. For more details on the plan, visit the Maryland Retirement website at www.sra.state.md.us.

403(b) Tax Sheltered Annuity

QACPS offers a 403(b) retirement plan designed for employees of public schools that allows participants to set aside additional money for retirement. Participation is voluntary.

Personal pre-tax and/or post-tax contributions are added to your account conveniently through payroll deductions up to annual IRS limits. You decide how much to contribute and how to invest your contributions. The QACPS 403(b) plan offers investment choices with our approved vendors listed on the Contacts page.

403(b) Eligibility

You are eligible to participate in the QACPS 403(b) plan at any time. You can increase, decrease, or discontinue personal contributions at any time. Contributions are 100% vested.

457(b) Retirement Plan

The 457(b) retirement plan is available to public school employees and can serve as a supplement to a traditional pension plan or other retirement plans such as the 403(b) plan. You determine the pre-tax amount you want to contribute (up to the IRS maximum) and how it is to be invested.

How a 457(b) Works

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

Roth IRA

A Roth IRA is an individual retirement account that offers tax-free growth and tax-free withdrawals in retirement. Roth IRA rules dictate that as long as you have owned your account for five years and you are age 59½ or older, you can withdraw your money when you want to and you won't owe any federal taxes.

Employee Assistance Program

We recognize you may experience issues that affect the quality of life at home or at work. The Employee Assistance Program (EAP) is available to you and your household family members 24 hours a day, seven days a week by calling 800-327-2251. All calls are completely confidential and there is no cost to you for using the service.

The professionals at the EAP will help by assessing, advising, and recommending options to help you or your family members deal with problems. In addition to unlimited phone counseling, you're eligible for six free face-to-face counseling sessions per incident per year.

The EAP can help with many issues including:

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

Program Benefits Include:

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

For information about the EAP services, contact Business Health Services, 800-327-2251, or see your Human Resources Representative.

Visit us online at www.bhsonline.com for program information, wellness resources and health tips. Employees accessing the website will need to enter the Organization ID ESMEC to log on.

Questions? Your Benefits Contacts

Benefit Plan	Contact	Phone	Website or Email
bswift Online Enrollment	Bolton	844-850-3380	service@boltonusa.com
Medical	CareFirst	877-691-5856	www.carefirst.com
Prescription Claims Retail & Mail Order	Care First Pharmacy	800-241-3371	www.carefirst.com/rx
Dental	CareFirst	866-891-2802	carefirst.com
Vision	Davis Vision	800-783-5602	carefirst.com
Critical Illness (Symetra)	Bolton	844-850-3380	service@boltonusa.com
Accident & Hospital Indemnity (Prudential)	Bolton	844-850-3380	service@boltonusa.com
Basic & Supplemental Term Life Insurance	The Standard	800-378-4667	www.standard.com
Unum Whole Life Insurance with Long Term Care	Bolton	844-850-3380	service@boltonusa.com
Chubb Lifetime Benefit Term with Long Term Care	Bolton	844-850-3380	service@boltonusa.com
Disability Insurance	The Standard	800-378-4667	www.standard.com
Identity Management Services	Norton LifeLock	800-607-9174	www.nortonlifelock.com
Flexible Spending Account	Flexible Benefits Administrators	800-437-3539	fba.welthcareportal.com
403(b), Roth IRAs	AXA Equitable	301-938-7942	derek.boyle@equitable.com
403(b), Roth IRAs	VOYA	410-507-5273	robin.gibbons@voyafa.com
403(b), Roth IRAs	MetLife	800-638-5433	http://www.metlife.com
403(b), Roth IRAs	Security Benefit	410-829-2206	rsullivan@cfiemail.com
403(b), Roth IRAs	Corebridge	410-410-859-2164, Cell: 410-991-5022	logan.grossman@corebridge financial.com
403(b), Roth IRAs	Corebridge	410-859-2164, Cell: 410-200-1551	adam.grace@corebridge financial.com
MD State Employees Credit Union	Customer Service	800-879-7328	www.secumd.org
Maryland Retirement System		410-625-5555	www.sra.state.md.us

Central Office Address: 115 Vincit St., Centreville, MD 21617; Phone Number: 410-758-2403
Office Hours: Monday-Friday 8:00am-4:00pm

Questions? Your Benefits Contacts

Benefit Plan	Contact	Phone	Website or Email
Employee Assistance Program	Business Health Services	800-327-2251	bhsonline.com
Payroll	Kimberly Adams	410-758-2403 ext. 119/153	kimberly.adams@qacps.org
Benefits	Theresa Steinhice	410-758-2403 ext. 227	theresa.steinhice@qacps.org
Employee Services	Dawn Custer	410-758-2403 ext. 118	dawn.custer@qacps.org
Certification & Professional Development	Sarah Hause	410-758-2403 ext. 196	sarah.hause@qacps.org

Annual Notices

Medicare Part D-Creditable Coverage

Important Notice about Your Prescription Drug Coverage and Medicare

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

Two Important Things You Need to Know About Your Current Coverage and Medicare's Prescription Drug Coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. QACPS has determined that the prescription drug coverage offered by the QACPS Health Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

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

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

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

Annual Notices

*Cont'd from **page 39***

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

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

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

For further information contact Human Resources Department at 410-758-2403. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through QACPS changes. You also may request a copy of this notice at any time.

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

For more information about Medicare prescription drug coverage:

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

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

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

HIPAA Notice of Availability of Privacy Practices

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

HIPAA Notice of Special Enrollment

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

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

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

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

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

Waiver of Coverage

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

Women's Health and Cancer Rights Act (WHCRA)

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

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

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

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law took effect in 2014, there was a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace? The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October for coverage starting as early as January 1.

Can I Save Money on my Health Insurance Premiums in the Marketplace? You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace? Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution — as well as your employee contribution to employer-offered coverage — is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information? For more information about your coverage offered by your employer, please check your summary plan description or contact HR. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area/

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. Please refer to the bswift Benefit Library for this document

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

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

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

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

Coordination of Benefits (COB)

All QAC medical and dental plans contain a "non-duplication of benefits," or Coordination of Benefits (COB), clause. Under the COB provision, in order to determine which plan pays benefits first (the "primary" plan), the general rules below apply:

- The plan under which the person is covered as an employee is primary.
  - CHAMPUS and Medicare are normally secondary.
- Qualified children are covered first under the plan of the parent whose birthday (month and day) falls earlier in the year (insurance companies call this "the Birthday Rule").
- If the parents are divorced or separated, the plan of the parent with custody pays first; the plan of the custodial parent's spouse pays second; the plan of the parent who does not have custody pays third.
- The plan that covers an active employee and qualified children pays first; the plan that covers a laid-off or retired employee and dependents pays second.
- Contact your health plan's Member Services department to confirm your plan's specific COB rules.

Model Wellness Program Disclosure

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact HR at 410-758-4406 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status

General Glossary of Terms

AD&D	Accidental Death & Dismemberment (AD&D) Insurance pays a benefit if you suffer certain types of injuries, such as the loss of a hand, foot, or eye as a result of an accident, or if you die as a result of an accident. AD&D coverage is automatically provided as part of your Basic Life Insurance.
Allowed Benefit	The fee an insurance company has negotiated with a provider to charge for covered services. Payment for covered services is based on this negotiated amount.
Annual Benefits Election Period	A period during the year when your employer allows you to elect new benefits or make changes to your current benefits. Also referred to as Open Enrollment.
Basic Life Insurance	The group term life insurance provided at no cost to full-time and part-time employees working at least 20 hours per week.
Beneficiary	A person(s) or an entity (such as an association or organization) that you name to receive your life and AD&D insurance benefits if you die while covered; or to receive your vested account balances in your Retirement and Savings Program if you should die.
Calendar Year	The period spanning from January 1 to December 31 of each year.
Coordination of Benefits (COB)	A provision of the insurance industry which limits benefits if you are covered under multiple insurance plans. Benefits are limited to 100% of covered expenses. The order in which insurance companies are paid is also designated by this provision.
Coinsurance	A fixed percentage of medical or dental costs that you are required to pay for covered services under your insurance policy. This applies if you use out-of-network providers, or if your plan specifies that it will pay a fixed percentage of covered services. Coinsurance is not the same as, and does not include, copay
Copayment (Copay)	The amount you pay when you use in-network providers or purchase prescription drugs.
Covered Expenses	Charges that are paid in part, or in full, by the plan
Deductible	The amount you must pay in covered health care expenses before the plan begins to pay a percentage of your costs.
Dependent	The definition of a “dependent” will vary according to each plan. Dependents under the medical, dental, vision, or health flexible spending plan are: 1) an employee’s lawful spouse; or 2) an employee’s child who a) has not yet reached age 26, b) in the case of a minor, is a member of the employee’s household unless the employee has been court or administratively ordered to provide insurance coverage. Dependent requirements are different for life insurance and the dependent flexible spending plan. Please contact Human Resources for details.
Dependent Care Expenses	Monthly expenses charged by a daycare provider (maximum of $5,000 per calendar year) who is not your spouse, or someone claimed by you as a dependent.
Flexible Spending Account (FSA)	Flexible spending account (FSA) allows you to set aside pre-tax dollars for unreimbursed medical, prescription, vision, and dental expenses, and dependent care costs.
Generic Drug	A drug that may be sold under more than one name, by more than one company.

General Glossary of Terms

Guaranteed Issue	A provision that allows you to purchase insurance coverage regardless of the health of you and/or your spouse.
In-Network Benefits	Benefits that are paid at a higher level when you use network participating providers.
LTD	Long-Term Disability Insurance. This type of insurance provides a percentage of your income if you become totally disabled.
Medical Evidence of Insurability	If you do not purchase life insurance, long-term disability insurance, or Whole Life with long term care insurance when it is first offered, or within 30 days of your date of eligibility, you must complete a health questionnaire in order to be approved for the plan, thus providing evidence that you are insurable. The insurance company will review your health information and determine whether or not they will provide coverage to you. The insurance company may take several months to determine whether or not they will provide you with coverage.
Non-Preferred Provider	A provider who does not have any agreement with your insurance plan to accept copays or reduced fees for services rendered.
Open Enrollment	See “Annual Benefits Election.”
Out-of-Network Benefits	Benefits that are paid at a lower level when you use out-of-network providers.
Plan Year	The period spanning from the beginning of the benefit plan year to the end of the benefit plan year. Currently for QAC this is from September 1 to August 31 of the following year.
Preferred Provider	A provider who has contracted with your insurance company to be paid directly for covered services, and who will accept the allowed benefit as a payment in full. Also referred to as a participating provider, or an in-network provider.
Prescription Drugs	Allergy serums, biologicals, prescription drugs, and injectable insulin that are approved by your Insurance company, or that by law must be dispensed with a prescription.
Primary Care Physician (PCP)	In an HMO plan, you must choose a network doctor from a directory of providers, as your Primary Care Physician (PCP). You visit this doctor every time you need health care. In an HMO, your PCP must give you a written referral to see a specialist, or to receive treatment in an emergency room or hospital. If you do not get a referral, the services will not be paid by your insurance company.
Provider	A person or facility who provides medical or dental services to you or your dependents. This can include doctors, hospitals, labs, and other ancillary services, and health care providers.
Qualifying Event	An occurrence that entitles a person to select or change benefits outside of a defined “Open Enrollment” period. Events could include but are not limited to termination of employment, death of a covered person, marriage, divorce, birth, adoption, Medicare eligibility, a dependent child’s loss of dependent status, or commencement of or return from an unpaid leave of absence (see page 7 for more details).
STD	Short-Term Disability Insurance (STD) helps protect your income by replacing a percentage of your income if you become sick or disabled

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