



M-NCPPC EMPLOYEE BENEFIT GUIDE

MAKE THE BEST CHOICE!!!

JANUARY 1 – DECEMBER 31, 2021

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M-NCPPC Employee Benefit Guide

Make the Best Choice!- Your M-NCPPC Benefits

M-NCPPC is pleased to offer our employees access to a benefits program that provides you and your eligible dependents with valuable coverage and protection at competitive rates. This guide describes the benefits offered to active M-NCPPC employees. To learn more about the benefit options offered to eligible M-NCPPC retirees, refer to the 2021 M-NCPPC Retiree Benefit Guide.

This benefit guide is designed to provide you with an overview of your 2021 benefit options, including:

- Who is eligible
- How to enroll
- How the plans work
- Where to find more details about each plan

You will also find copies of required benefit notices at the end of this guide, which provide important legally required information about your plans.

Please review this information so you can make the best benefits choice for you and your family.

Your 2021 Benefit Options

If you are an eligible employee, you have the following benefit options for the 2021 plan year:

Benefit Plan	Your Options
Medical Plan	<ul style="list-style-type: none"> • UnitedHealthcare Choice Plus POS • UnitedHealthcare Select EPO • Kaiser Permanente HMO (includes prescription drug coverage)
Prescription Drug	<ul style="list-style-type: none"> • CVS Caremark (if you are enrolled in a UHC medical plan) • Kaiser Permanente (automatically included when you enroll in the HMO plan)
Dental Plan	<ul style="list-style-type: none"> • Delta Dental PPO • DeltaCare USA (Delta Dental HMO)
Vision Plan	<ul style="list-style-type: none"> • EyeMed – Low Plan • EyeMed – Moderate Plan • EyeMed – High Plan
Flexible Spending Accounts	<ul style="list-style-type: none"> • Healthcare Flexible Spending Account • Dependent Care Flexible Spending Account
Life and Accidental Death & Dismemberment Insurance	<ul style="list-style-type: none"> • Basic Life and AD&D: 2x base annual salary, up to \$200,000 • Supplemental Life: 1-5x base annual salary, up to \$750,000 • Dependent Life: <ul style="list-style-type: none"> o Option 1: \$10,000 spouse/\$5,000 child(ren) o Option 2: \$20,000 spouse/\$10,000 child(ren) o Option 3: \$30,000 spouse/\$15,000 child(ren)
Sick Leave Bank	<ul style="list-style-type: none"> • Make annual sick leave contribution
Long-Term Disability	<ul style="list-style-type: none"> • Basic Long-Term Disability • If eligible, Supplemental Long-Term Disability
Legal Services Plan	<ul style="list-style-type: none"> • Legal Resources

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Who is Eligible

You are eligible to participate in the plans described in this guide if you are an employee classified as one of the following employee types:

- Career FT/PT
- Appointed
- P/T Commissioners (not eligible for Sick Leave Bank)
- Merit Board (not eligible for Sick Leave Bank)

You may also choose to cover your eligible dependents, as applicable. Your eligible dependents include your:

- Legal spouse (as recognized under Maryland law)
- Natural, step, or adopted child under age 26
- Unmarried child, not in a domestic partnership or legal guardianship, age 26 or older who before turning age 26 became totally and permanently incapacitated due to mental or physical limitations; if they meet certain criteria
- Domestic partner (as certified by the Commission) and eligible child(ren)
- A child for whom you or your covered dependent spouse/partner has permanent (12 months or longer) legal guardianship before his/her 18th birthday who meets the above requirements (copy of court order required)

How to Enroll

When you first become eligible for benefits, you must enroll within 45 days of your date of hire or the date you become eligible for benefits. If you do not enroll within your 45-day enrollment window, you must wait until the next open enrollment period to enroll in coverage, unless you experience a qualifying life event.

After your initial enrollment period, you will have the opportunity to enroll in or change benefits each fall during open enrollment for benefits effective the following plan year.

In general, you have two ways to enroll – Employee Self Service (only available during annual open enrollment) or by paper.

Employee Self Service – only available during annual open enrollment

If you have access to Employee Self Service (ESS), which is only available during open enrollment, you will log in to our Lawson system to enroll. You will receive instructions on how to access the ESS via email prior to the start of the open enrollment period.

By Paper

If you do not have access to Employee Self Service (ESS), you must complete and return your enrollment form to the Health & Benefits Office by your enrollment deadline. Completed enrollment forms can be submitted as follows:

- Hand delivered or mailed (interoffice or U.S. mail) to the office at:
M-NCPPC Health & Benefits Office
6611 Kenilworth Avenue, Suite 404
Riverdale, MD 20737
*****During Open Enrollment use the secure drop box on the 1st Floor in the lobby.**
- Sent via email to benefits@mncppc.org
- Sent via fax to 301-454-1687

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Qualifying Life Events

In general, your benefit elections remain in effect for the entire plan year: January 1 to December 31. However, if you experience a qualifying life event, you may be permitted to enroll in or change your coverage before the end of the year.

Examples of qualifying life events include:


- Your marriage or divorce, annulment, or legal separation.
- A birth, adoption, or change in your child’s custody.
- A change in you or your spouse’s or child’s employment status.
- You or your dependent’s loss of healthcare coverage.

This list is not all inclusive. For a more detailed list, please refer to the Employee Benefits Handbook available on www.mncppc.org.

If you experience a qualifying life event, you must contact the Health & Benefits Office and submit necessary documentation to effect benefit changes within 45 days of the event. If you do not take action within the 45-day window, you will have to wait until the following open enrollment to make changes to your benefit elections.

Medical Plan

M-NCPPC offers you three medical plan options from which to choose.

Medical Plan Option	How it Works	Prescription Drug Coverage	Cost for Coverage
UnitedHealthcare Choice Plus POS	This plan covers eligible services when you use a provider or facility in the network or outside of the network – you choose where to receive care. You do not need referrals to see a specialist. However, in general, your out-of-pocket costs will be lower when you see a provider or facility in the network.	This plan does NOT include prescription drug coverage; you must elect prescription drug coverage separately.	
UnitedHealthcare Select EPO	This plan covers eligible services only when you use an in-network provider or facility (except in the case of an emergency). You do not need referrals to see a specialist.	This plan does NOT include prescription drug coverage; you must elect prescription drug coverage separately.	
Kaiser Permanente HMO	This plan covers eligible services only when you receive care at Kaiser facilities, through Kaiser doctors, and affiliated hospitals (except in the case of an emergency). You have the convenience of same day service for your office visit, lab tests, X-rays, and prescription fills at a Kaiser facility. You must elect a primary care physician when you enroll.	This plan includes prescription drug coverage at no additional cost.	

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How the Plans Compare

Below is a look at some of the key plan features of your three medical plan options. For more details about how each plan pays for specific services and care, refer to the Employee Benefits Handbook, available on www.mncppc.org.

Plan Feature	UHC Choice Plus POS		UHC Select EPO	Kaiser HMO
	In-network	Out-of-network	In-network only	In-network only
Annual Deductible	None	\$250 individual \$500 2-member \$600 family	None	None
Annual Out-of-Pocket Limit	\$600 individual \$1,200 2-member \$1,800 family Does not include copays; does include deductible		\$1,100 individual \$3,600 family Does not include copays	\$1,100 individual \$3,600 family Includes copays
Preventive Care	\$0 copay	Covered 80% after deductible	\$0 copay	\$0 copay
Office Visits	\$10 copay	Covered 80%	\$10 copay	\$10 copay
Emergency Room (medical emergency only)	\$50 copay, waived if admitted	\$50 copay, waived if admitted	\$50 copay, waived if admitted	\$50 copay, waived if admitted
Urgent Care Center	\$10 copay	Covered 80% after deductible	\$15 copay	\$15 copay
Virtual Visit	\$0 copay	Covered 80% after deductible	\$0 copay	\$0 copay
Inpatient Surgery	\$0 copay	Covered 80% after deductible, plus \$100 inpatient deductible	\$0 copay	\$0 copay
Outpatient Surgery	\$10 copay in office \$0 copay at facility	Covered 80% after deductible	\$0 copay in office \$25 copay at facility	\$25 copay
	\$\$\$ Highest Premium		\$\$ Lower Premium	\$ Lowest Premium and Includes Prescription Drug Coverage

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Choosing a Medical Plan

Choosing a medical plan can be an overwhelming task. To help you consider your options and make a choice that is best for you and your situation, see the decision tool below. It is designed to help you weigh your options.

Do you have an existing relationship with a doctor, but would be open to switching doctors?	
If you answered NO:	The UHC Choice Plus POS plan may be right for you. It offers you the greatest freedom to see any provider, by allowing you to receive benefits for care both with in-network and out-of-network providers. Therefore, if your current doctor is not in the UHC network, you can continue to receive services from that doctor. However, when you receive care from an out-of-network provider, you will pay more for care than if you see an in-network provider.
If you answered MAYBE:	The UHC Select EPO plan may be right for you. It only pays benefits for care received in-network. However, the UHC network includes a nationwide network of providers for you to choose from and many doctors in the area participate in the UHC network.
If you answered YES:	The Kaiser HMO may be right for you. It only provides benefits for care received from Kaiser doctors. This network is more limited than the UHC network as many Kaiser doctors do not participate in other plan networks. Prescription drug coverage is included at no additional cost.

Do you consider the premium you pay bi-weekly as a deal breaker; the lowest premium is best for your financial situation?	
If you answered YES:	The Kaiser Permanente plan may be the right choice for you, since not only is the premium the lowest, but this plan includes prescription drug coverage. If you select one of the UHC plans, you not only pay a higher premium, but will also pay additional for prescription drug coverage.
If you answered NO:	Take a closer look at the UHC plans, as well as the Kaiser HMO.

Do you anticipate having a lot of out-of-pocket medical expenses in 2021? For example, do you know of any upcoming major medical events such as birth of a baby, surgeries, procedures, or tests that you or your dependents may need?	
If you answered YES:	The UHC Choice Plus POS plan may be right for you since it offers the lowest out-of-pocket maximum; which is the annual amount you will pay out of pocket before the plan begins to pay 100%.
If you answered NO:	The UHC Select EPO or Kaiser HMO may be right for you since they offer similar coverage for basic medical services for a lower premium.

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Make the Best Choice!

All three medical plans include programs and features in addition to basic medical coverage. Are you getting the most out of your benefits? Review each plan and make the best choice!

UnitedHealthcare

UHC offers plan members access to a program called Rally on myuhc.com to help track and improve your health. This online, interactive experience is designed to make it easy to understand your healthy behaviors and take any needed steps to live a healthier life. You can earn Rally points and redeem them for discounts on popular name-brand items.

UHC also offers programs to help you get and stay healthy, such as:

- Health coaching
- Urgent care at Minute Clinics
- Healthcare Advocate services
- Smoking cessation
- And more!

Visit www.myuhc.com for more information and to start earning those Rally points.

Kaiser Permanente

Kaiser offers plan members access to the following added benefits and services:

- Wellness Coaching
- Online Mobile Tools
- Vision Essentials
- Cosmetic Dermatology (fee for service)
- Urgent Care at Minute Clinics (outside the Kaiser service area)
- Healthy Resources Guide
- Transgender Services (adult and child)
- Choose Healthy (discounts for fitness centers, chiropractic care, acupuncture, and massage therapy)

Visit www.my.kp.org/mncppc to learn more.

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Prescription Drug Plan

The prescription drug plan option available to you depends on which medical plan option you enroll in:

- UHC medical plan participants: you may choose to separately enroll in prescription drug coverage through CVS Caremark
- Kaiser medical plan participants: when you enroll in Kaiser HMO, you automatically receive prescription drug coverage through Kaiser

Both prescription drug plans provide coverage for generic drugs, preferred brand name drugs, and non-preferred brand name drugs, as outlined below. In addition, the CVS Caremark plan provides coverage for lifestyle drugs.

Drug Type	CVS Caremark		Kaiser Prescription Plan	
	Participating Retail Pharmacy (up to 34-day supply)	CVS Mail Order or CVS Pharmacy (up to 90-day supply)	Pharmacy/ Network Pharmacy (up to 30-day supply)	Mail Order Pharmacy/ Network Pharmacy (up to 90-day supply)
Tier 1 – Generic Drugs	\$8 copay	\$16 copay	\$7/\$10 copay	\$14/\$20 copay
Tier 2 – Preferred Brand Name Drugs	\$16 copay	\$32 copay	\$15/\$20 copay	\$30/\$40 copay
Tier 3 – Non-Preferred Brand Name Drugs	\$25 copay	\$40 copay	\$30/\$35 copay	\$60/\$70 copay
Tier 4 – Lifestyle Drugs	50% copay	50% copay	N/A	N/A

For more specific details about the prescription drug plans, refer to the Employee Benefits Handbook, available on www.mncppc.org.

Make the Best Choice!

Both prescription drug plans provide you with programs and features you may not be aware of. Look at each plan to ensure that you make the best choice!

CVS Caremark

Go to www.caremark.com to find information about:

- Online access to track your prescription spending throughout the year at www.caremark.com
- Mobile app for access to your prescriptions and refills, on the go
- Mail order service for long term medications
- Drug cost tool to help you find the lowest cost around for your prescription

Kaiser Permanente

Go to www.my.kp.org/mncppc to find information about:

- Online access to access your prescriptions and order refills
- Mobile app for access to your prescriptions and refills, on the go
- Mail order service for long term medications

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Dental Plan

You have two dental plan options from which to choose:

- Delta Dental PPO plan – you can receive care from any dentist, but your out of pocket costs will be lowest when you see a provider in the Delta Dental PPO network, slightly higher when you see a provider in the Delta Dental Premier network, and the highest when you see a non-Delta Dental provider
- DeltaCare USA HMO – the plan will only pay benefits when you see a provider in the DeltaCare network

Plan Feature/ Services	DeltaCare USA HMO	Delta Dental PPO		
		Delta Dental PPO Network	Delta Dental Premier	Non-Delta Dental Provider
Annual Deductible	None	\$50/enrollee \$150/family		
Annual Maximum	No maximum	\$2,000		
Cleanings	You pay \$0	Estimated Dentist Fee: \$48 You pay 0%	Estimated Dentist Fee: \$66 You pay 0%	Estimated Dentist Fee: \$66+ You pay 0%
Fillings (2 surface silver)	You pay \$0	Estimated Dentist Fee: \$88 You pay 20%, or \$17.78	Estimated Dentist Fee: \$130 You pay 20%, or \$26	Estimated Dentist Fee: \$130+ You pay 20%+ Any Balance After Delta Pays, or \$26+*
Crown (titanium)	You pay \$380	Estimated Dentist Fee: \$728 You pay 40%, or \$291.20	Estimated Dentist Fee: \$825 You pay 40%, or \$330	Estimated Dentist Fee: \$825+ You pay 40%+ Any Balance After Delta Dental Pays, or \$330+*
Orthodontics (children, up to age 19)	You pay \$1,900	Estimated Dentist Fee: \$4,098 You pay \$2,098 (Plan pays \$2,000 lifetime maximum)	Estimated Dentist Fee: \$5,000 You pay \$3,000 (Plan pays \$2,000 lifetime maximum)	Estimated Dentist Fee: \$5,000+ You pay \$3,000+ Any Balance After Delta Dental Pays, or \$3,000+* (Plan pays \$2,000 lifetime maximum)
Teeth Whitening	You pay \$125/arch	Estimated Dentist Fee: \$280 You pay 100%, Whitening is not covered	Estimated Dentist Fee: \$400 You pay 100%, Whitening is not covered	Estimated Dentist Fee: \$400+ You pay 100%, Whitening is not covered
Implants	Not covered	Estimated Dentist Fee: \$1,127.00 You pay 40%, or \$450.80	Estimated Dentist Fee: \$1,600.00 You pay 40%, or \$640.00	Estimated Dentist Fee: \$1,600+ You pay 40%+ Any Balance After Delta Dental Pays, or \$640.00+*

* If you see a non-Delta Dental provider, the provider can charge more than the fee estimated by Delta Dental. You will be balance billed. That means you pay the difference between the Delta Dental allowance and the provider's billed amount. Estimated Dentist Fees are for illustration only, since fees can vary by geographic location.

The description above is a brief summary of some plan features and how the benefits are covered under the dental plans. For more details about what is covered and your share of the costs for services, refer to the Employee Benefits Handbook, available on www.mncppc.org.

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Choosing a Dental Plan

Choosing a dental plan can be confusing. To help you consider your options and make a choice that is best for you and your family, see the decision tool below. It is designed to help you weigh your options.

Do you have an existing relationship with a dentist, but would be open to switching providers?	
If you answered NO:	The Delta Dental PPO plan may be right for you. It offers you the greatest freedom to see any dentist, by allowing you to receive benefits for care both with in-network and out-of-network dentists. Therefore, if your current dentist is not in the Delta Dental network, you can continue to receive services from that dentist. However, when you receive care from an out-of-network dentist, you will pay more for care than if you see a network dentist.
If you answered YES:	The DeltaCare HMO may be right for you. It only provides benefits for care received from DeltaCare dentists, but you pay less in premiums and copayments.

Do you anticipate having a lot of dental needs in 2021 outside of your regular cleanings? For example, will your dependent children need braces or do you anticipate needing a crown or root canal?	
If you answered YES:	Carefully review the plan coverage details above and available in the Employee Benefits Handbook to see which plan would pay higher benefits for the services you will need. Also remember, that the Delta Care USA plan has no annual maximum, while the Delta Dental PPO plan will only pay out \$2,000 each year no matter how many procedures you have. <i>If you anticipate getting an implant next year, it will only be covered under the Delta Dental PPO plan</i>
If you answered NO:	Then consider whether you would prefer to pay higher premiums for the freedom to see any dentist in the Delta Dental PPO network or if you would prefer to pay lower premiums, but be restricted to receiving care from network dentists only in the DeltaCare HMO.

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Vision Plan

You have three vision plan options from which to choose. All three plans are provided through EyeMed and vary in how the plan pays for benefits and how often you can receive certain services. When receiving vision care, you can use a provider in or out of the EyeMed network. EyeMed is a national network of 78,000 vision care providers, including independent providers and major retail chains such as LensCrafters, Target Optical, Pearle Vision, America's Best.

Here's how the plans compare:

Plan Feature	Low Plan	Moderate Plan	High Plan
Frequency of Vision Care Services			
Exam	Every plan year	Every plan year	Every plan year
Frame	Every other plan year	Every other plan year	Every plan year
Lenses	Every other plan year	Every plan year	Every plan year
Contact Lenses	Every other plan year	Every plan year	Every plan year
In-Network Provider Member Cost for Lens Enhancements			
Standard Anti-Reflective Coating	Up to \$45 copay	Up to \$45 copay	\$0 copay
Standard Progressive	\$55 copay	\$55 copay	\$0 copay
Standard Tint (Solid/ Gradient)	Up to \$15 copay	Up to \$15 copay	\$0 copay
Standard Photochromic/ Transition	\$75 copay	\$75 copay	\$0 copay

Out-of-Network Providers

If you use an out-of-network provider, you will need to pay at time of service and submit a claim for reimbursement. Your out-of-pocket cost will be more than with an in-network provider.

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Make the Best Choice!

The EyeMed vision plans offer more than just coverage for your basic vision needs. Take a closer look at other discounts and services available:

- You can receive these additional discounts when you see an EyeMed Access Network provider:
 - o 40% off unlimited additional eyeglasses after initial benefit is exhausted
 - o 20% discount on remaining frame balance (once allowance has been applied) and 15% discount on any balance over the conventional contact lens allowance
 - o 15% savings off retail price of LASIK – or 5% off promotional pricing
 - o 15% off any balance over the conventional contact lens allowance or 20% off any non-covered item
 - o 20% off any non-covered item
- Your EyeMed vision coverage includes a discount for hearing exams and hearing-related services and supplies through Amplifon. Call 1-844-526-5432 to find a hearing care provider near you.
- If you have a vision emergency while traveling abroad, you can get 24/7 international support through International Travel Solution. This may also provide temporary, adjustable eyewear delivered the next day.

Choosing a Vision Plan

Choosing a vision plan can be confusing. To help you consider your options and make the best choice for you and your family, see the decision tool below. It is designed to help you weigh your options.

Do you or your dependents need new glasses and/or contacts each year?	
If you answered NO:	The Low Plan or Moderate Plan may be right for you. The Low plan provides coverage for frames, lenses, and contact lenses every other year for a lower premium. The Moderate Plan provides coverage for frames every other year and lenses and contact lenses every year for a moderate premium.
If you answered YES:	The High Plan may be right for you. It provides coverage for frames, lenses, and contact lenses every year, but is the highest premium plan.

Do you or your dependents need lens enhancements: standard anti-reflective coating, standard progressive, tint (solid/gradient), or photochromic/transition?	
If you answered NO:	The Low Plan or Moderate Plan may be right for you. Lens enhancements are covered, but you must pay a copay.
If you answered YES:	The High Plan may be right for you. Standard Option lens enhancements are covered in full.

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Flexible Spending Accounts

M-NCPPC offers you two tax-free accounts to help you save money on everyday expenses:

- Healthcare Flexible Spending Account (FSA) – use funds in this account to pay for eligible medical, dental, and vision expenses for you and your eligible dependents.
 - **Over-the-Counter items no longer require a written prescription from a treating physician (i.e. allergy, heartburn, pain relief medications) to be considered an eligible expense for the Healthcare FSA.**
 - **Feminine care products (i.e., tampons, liners, shields, panties, pads, cups, etc.) are now eligible for reimbursement under the Healthcare FSA.**
- Dependent Care Flexible Spending Account (FSA) – use funds in this account to pay for eligible dependent day care expenses for your dependent children up to age 13 or for your elderly dependent(s)

How the Plans Work

You decide each year how much to contribute to each FSA, up to IRS limits. Unlike many other benefits, you must re-enroll for FSA participation each fall during open enrollment.

Each paycheck, your contribution amount is deducted before taxes and put into your FSA. When you have an eligible expense, you use the tax-free money to reimburse yourself.

You will receive a debit card linked to your FSAs that you can use at your doctor’s office, pharmacy, day care center, etc. to pay for expenses directly from your FSA. You can also pay upfront and then file a claim for reimbursement from your account later.

- Healthcare FSA – you will receive a debit card linked to your FSA that you can use at your doctor’s office, pharmacy, and hospital.
- Dependent Care FSA – you will receive a debit card linked to your FSA that you can use for your day care provider.

Flexible Spending Account Limits and Eligible Expenses

Type of FSA	Contribution 2020 Limits	Eligible Expenses
Healthcare FSA	\$2,700 per year	Copays, deductibles, coinsurance, orthodontia, contact lenses and solutions, laser eye surgery, hearing aids, chiropractor visits, and other healthcare that may not be fully covered by insurance Important Note: You cannot use your Health Care FSA to purchase over-the-counter medications (such as allergy medicines, etc.), unless you have a prescription from your healthcare provider
Dependent Care FSA	\$2,500 per year, if married and filing separate income tax returns \$5,000 per year, if single or married and filing joint income tax returns	Licensed day care, in-home care, elder care, day camp, and nursery school (if expenses are for a dependent child, the child must be under age 13)

This is a partial list of eligible expenses. For a more complete list, visit Benefit Strategies at www.benstrat.com.

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Tax Savings Example

The advantage of FSAs is the money you save on taxes when you use your contributions for eligible expenses. Below is an example of how much someone could save by contributing \$2,700 to a Healthcare FSA and \$3,000 to a Dependent Care FSA.

	Without FSA	With FSA
Gross Annual Salary	\$45,000	\$45,000
Healthcare FSA Contribution	\$0	\$2,700
Dependent Care FSA Contribution	\$0	\$3,000
Total FSA Contributions	\$0	\$5,700
Tax Savings on Total FSA Contributions	\$0	\$1,405.05
• State (5% x \$5,700)		\$285.00
• Federal (12% x \$5,700)		\$684.00
• Social Security (7.65% x \$5,700)		\$436.05

In the example above, you could save over \$1,400 for the year in taxes! Your situation may vary and will depend on your own personal situation.

Plan Carefully: Use It or Lose It

Because of the tax advantages these accounts provide, IRS regulations require that unused money left in your FSAs at the end of the plan year must be forfeited. For the M-NCPPC plans, you have until March 15 of the following year to incur claims and until March 31 to file claims for reimbursement. See the chart below for 2021 dates.

Plan Year	January 1, 2021 – March 31, 2022
Dates to Incur Eligible Expenses	January 1, 2021 – March 15, 2022
Deadline to File Claims	March 31, 2022

IRS Rules: Making Contribution Changes During the Year

- Within 45 days of a Qualified Life Event (marriage, newborn, adoption, etc.), you can change your contribution to the Healthcare FSA and Dependent Care FSA.
- You can also, change your contribution to the Dependent Care FSA during the year if you experience a significant change in cost of coverage for dependent care. For example, if your daycare closes and you stay home to care for your child, you can decrease or stop your contribution. If you have to hire a new nanny or babysitter and the cost of care increases, you can increase your contribution (as long as the provider is not a relative). You can also make contributions changes due to school closure; affecting the cost of back-up or before/after-school care.

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Life and Accidental Death & Dismemberment Insurance

M-NCPPC gives you access to Life and Accidental Death & Dismemberment (AD&D) insurance to help provide financial protection for you and your loved ones in the event of death or injury. You have the following coverage options:

- Basic Life and AD&D: 2 times your base annual salary, up to \$200,000
- Supplemental Life: 1, 2, 3, 4, or 5 times your base annual salary, up to \$750,000
- Dependent Life:
 - o Option 1: \$10,000 spouse/\$5,000 child(ren)
 - o Option 2: \$20,000 spouse/\$10,000 child(ren)
 - o Option 3: \$30,000 spouse/\$15,000 child(ren)

In the event of your death, your designated beneficiaries will receive the benefit payment. In the event of your dismemberment, your spouse's death, or your child's death, you will receive the benefit payment.

Enrolling for Coverage

If you are newly eligible for this coverage, you have 45 days to enroll in coverage without needing to provide evidence of insurability (EOI). If you enroll in or change coverage outside of this initial enrollment window, you must provide EOI and be approved before your coverage takes effect. You may make changes to your life and AD&D insurance coverage throughout the plan year.

Designating Your Beneficiary

To ensure benefits are paid the way you would want them paid in the event of your death, make sure your beneficiary designations are up to date. If you have access to ESS you can view your current basic life insurance beneficiaries and make changes at that site. If you do not have access to ESS and want to update the beneficiaries that you have designated for your basic life insurance, visit www.mncppc.org to obtain a Designation of Beneficiary Form and return it to the Health & Benefits Office once completed.

*Remember, the beneficiaries designated for the basic life insurance will also be used for the supplemental life insurance. Also, you are the beneficiary for proceeds from the spousal life or dependent child life insurance plan.

Make the Best Choice!

In addition to providing you and your dependents with financial security should the unthinkable happen, Securian Financial also provides additional benefits if you are a plan participant:

- Legal, financial, and grief resources
- Travel assistance
- Legacy planning resources
- Beneficiary financial counseling

Visit www.LifeBenefits.com/MNCPPC for more information.

If you need help, Benefit Scout, a decision-making tool is available 24/7 to answer your questions and recommend different life insurance coverage scenarios to fit your unique needs. You can also reach a benefit counselor via chatline or by phone for a one-on-one consultation. Visit Benefit Scout at LifeBenefits.com/MNCPPC.

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Sick Leave Bank

Sick Leave Bank is a short-term, income-replacement disability plan designed to provide you with income if you are unable to work and have exhausted all of your leave before you become eligible for Long-Term Disability coverage. It can also be used for short-term conditions, such as pregnancy.

How it Works

You have two chances to enroll in the Sick Leave Bank. You can enroll within 45 days after you satisfactorily complete your initial probationary period or during open enrollment.

If you wish to participate, you must contribute the required number of sick hours to become a member. Typically, it is 8 hours* (full-time employees) or 4 hours* (part-time employees) of your sick leave. Should you become unable to work for more than 14 days, you can apply for benefits from the Sick Leave Bank. If approved, you will receive 80% of your pre-disability income for up to 518 work hours (259 hours for part-time employees) while you remain unable to work.

If you continue to be disabled and are unable to work for 120 days, you may apply for benefits under the Long-Term Disability plan.

* May change based on the balance of hours in the bank.

Long-Term Disability

As an eligible employee, you are automatically enrolled in basic Long-Term Disability (LTD) coverage. This coverage provides you with income replacement should you become disabled and unable to work.

If you become disabled for more than 120 days, your LTD coverage pays 66-2/3% of your basic monthly earnings, up to a maximum benefit of \$6,000 per month. (Note: Park Police may have different benefits; refer to your collective bargaining agreement for details).

Supplemental Long-Term Disability Coverage

If you earn more than \$108,000 annually, you may enroll in supplemental LTD coverage. Supplemental LTD coverage provides you with 66-2/3% of your base salary between \$108,000 to \$216,000. Any benefit you receive from Supplemental LTD coverage is in addition to the coverage you would receive from Basic LTD. The maximum benefit for the supplemental coverage is \$6,000 per month.

If you are eligible for Supplemental LTD, you may enroll in coverage when you first become eligible and during open enrollment each fall. If you enroll more than 45 days after your initial eligibility period, you must provide evidence of insurability.

Make the Best Choice!

Your Long-Term Disability coverage through MetLife includes an added Will Preparation Service – at no cost to you! As a covered Member, you can easily create a will, a living will, or power of attorney through MetLife's on-line will preparation services provided by Smart-Legal Forms. Visit www.willscenter.com and Register as a new user to get started.

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Legal Services Plan

You have access to **one prepaid legal plan option**: Legal Resources . Ask yourself if you will need legal services during the upcoming year: adoption, marriage/divorce, buying or selling a home, eviction/foreclosure or landlord/tenant issues. Review a few of the features of the plan below so you can make the best choice to fit your needs!

Plan Feature	Legal Resources
Who is Covered	You, your spouse, and your dependent children up to age 19 or up to age 23, if a full-time student
Family Coverage Offered	Your parents can get 25% discount off legal needs
Covered Services	<ul style="list-style-type: none">• Legal Consultation• Will Preparation• Traffic Violations• Purchase and Sale of Your Home• Criminal Law• Family Law – Uncontested Divorce Uncontested Domestic Adoption, Uncontested Name Change• Identity Theft Assistance
Cost of Services Not Covered Under the Plan	25% discount
Attorney Assignment	You must select one participating firm for all your legal needs
Monthly Premium	\$17.00/month

Important:

- If you enroll in the prepaid legal plan, you must remain enrolled for 12 months before you can cancel coverage
- You cannot use your coverage under these plans for any M-NCPPC related lawsuits

Make the Best Choice!

Legal Resources also provides additional services:

- Identity Theft Assistance including prevention, education and identity recovery assistance.
- Consumer Relations and Credit Protection Assistance for warranty disputes, billing disputes, and collection agency harassment.
- For more information on these services call 1-800-728-5768.

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Your Costs for Coverage

Below are your bi-weekly rates for medical, dental, and vision coverage for 2021.

Plan	Fraternal Order of Police Bi-weekly Rate			MCGEO and Non-Union Bi-Weekly Rates			Contract Employees Bi-Weekly Rates		
	Single	Two Member	Family	Single	Two Member	Family	Single	Two Member	Family
UHC Choice Plus POS	\$75.95	\$151.89	\$227.84	\$66.04	\$132.08	\$198.12	--	--	--
UHC Medicare Complement	\$29.34	\$58.68	\$88.03	25.51	\$51.03	\$76.54	--	--	--
UHC Select EPO	\$62.42	\$124.84	\$187.25	\$54.28	\$108.55	\$162.83	\$94.98	\$189.97	\$284.95
UHC Select EPO Medicare Eligible	\$43.55	\$87.11	\$130.66	\$37.87	\$75.74	\$113.62	--	--	--
Caremark Prescription (for UHC plans only)	\$24.20	\$48.41	\$72.61	\$15.78	\$31.57	\$47.35	\$36.83	\$73.66	\$110.49
Kaiser HMO with Prescription	\$55.70	\$111.41	\$167.10	\$36.33	\$72.66	\$108.98	\$84.76	\$169.53	\$254.29
Kaiser HMO Medicare Complement	\$32.44	\$64.89	\$97.33	\$21.16	\$42.32	\$63.48	--	--	--
Delta Dental PPO	\$3.42	\$6.86	\$12.69	\$2.98	\$5.97	\$11.04	--	--	--
Delta Dental HMO	\$1.92	\$3.73	\$5.40	\$1.67	\$3.24	\$4.69	--	--	--
EyeMed Vision Plan* – Low	\$0.29	\$0.59	\$0.88	\$0.29	\$0.59	\$0.88	--	--	--
EyeMed Vision Plan* – Moderate	\$1.36	\$2.72	\$4.09	\$1.36	\$2.72	\$4.09	--	--	--
EyeMed Vision Plan* – High	\$3.23	\$6.45	\$9.69	\$3.23	\$6.45	\$9.69	--	--	--

* M-NCPPC caps employer contribution to the vision plan at 80% of the cost for the Low Vision Plan. You pay the remainder.

Legal Service Plans Rates

Plan	Employee Bi-Weekly Rate
Legal Resources	\$8.50

Employee Rate for Supplemental Long-Term Disability

Plan	Employee Monthly Rate (per \$100 monthly benefit)
Supplemental LTD (annual salary must exceed \$108,000)	\$1.14

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For More Information

If you have questions about the benefits described in this guide, you can contact the Health & Benefits Office at 301-454-1694. For other questions, contact the benefit providers as listed below.

Benefits Provider	Phone Number	Website
Medical		
UnitedHealthcare Choice Plus POS and Select EPO	1-800-603-4190 (M-F, 8 a.m. to 8 p.m.)	www.myuhc.com
Kaiser Permanente HMO	1-800-777-7902 (M-F, 8:30 a.m. to 5:30 p.m.)	www.my.kp.org/mncppc
Prescription Drug		
CVS Caremark (UnitedHealthcare Plans only)	1-800-421-5501, 1-800-231-4403 (TTD), 1-800-213-0879 (Rx request) (Monday-Friday, 6:30 a.m. to 9:00 p.m.)	www.caremark.com www.rxrequest.com (online refills)
Dental		
Delta Dental (PPO and HMO)	1-800-422-4234 (HMO), 1-800-932-0783 (PPO) (Monday-Friday, 8:00 a.m. to 9:00 p.m.)	www.deltadentalins.com
Vision		
EyeMed Vision	1-866-800-5457 (Monday-Friday, 7:30 a.m. to 11:00 p.m.; Saturday-Sunday, 11:00 a.m. to 8:00 p.m.)	www.eyemed.com
Flexible Spending Accounts		
Benefit Strategies	1-888-401-FLEX (Monday-Thursday, 8:00 a.m. to 6:00 p.m.; Friday 8:00 a.m. to 5:00 p.m.)	www.benstrat.com
Life and AD&D Insurance		
Securian Financial	1-866-293-6047 (Monday-Friday, 6:00 a.m. to 5:00 p.m.)	www.LifeBenefits.com
Legal Service Plan		
Legal Resources	1-800-728-5768 (Monday-Friday, 8:30 a.m. to 5:30 p.m.)	www.legalresources.com

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Required Benefit Notices

Health Insurance Portability and Accountability Act (HIPAA)

An Important Notice About Your Privacy

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health plans protect the confidentiality of your private health information. The Plan uses health information about you and your covered dependents only for the purposes of providing treatment, paying claims, and related functions. To protect the privacy of health information, access to your health information is limited to such purposes. In addition, effective April 14, 2003, the Plan complies with the applicable health information privacy requirements of federal regulations issued by the Department of Health and Human Services. The Plan's privacy policies are described in more detail in the Plan's privacy notice. You may contact the Commission's Health & Benefits Office if you would like to receive a copy of the HIPAA notice.

HIPAA 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 in the following circumstances:

- If you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards you or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage);
- If you or your dependents lose Medicaid or Children's Health Insurance Program ("CHIP") coverage as a result of a loss of eligibility for such coverage. However, you must request enrollment within 60 days after the loss of such coverage; or
- If you or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP. However, you must request enrollment within 60 days after you or your dependents become eligible for such assistance.

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.

To request special enrollment or obtain more information, contact the Health & Benefits Office at 301-454-1694

COBRA - Continuing Coverage for Health Benefits

Under certain circumstances, you and your enrolled dependents have the right to continue coverage under the medical and dental plans, as well as the health care flex account, beyond the time that coverage would have ordinarily ended. You may elect continuation of coverage for yourself and your dependents if you lose coverage under the plan due to one of the following qualifying events:

- Termination (for reasons other than gross conduct)
- Reduction in employment hours
- Retirement
- You become entitled to Medicare

In addition, continuation of coverage may be available to your eligible dependents if:

- You die
- You and your spouse divorce or separate
- A covered child ceases to be an eligible dependent
- You become entitled to Medicare

To apply for COBRA coverage, you or a dependent must contact the Health & Benefits Office at 301-454-1694 within 60 days of a qualifying life event. You and/or your dependents must pay the You and/or your dependents must pay the 102% of the group monthly premium (full cost plus 2% for administration fees). See the chart on the next page.

Under the law, COBRA must be offered to eligible individuals at group rates. These rates are subject to change annually, based on plan experience.

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Your Costs for COBRA

Below are your monthly rates for medical, dental, prescription and vision coverage for 2021.

Plan			
	Single Monthly	Two Member Monthly	Family Monthly
UHC Choice Plus POS	\$729.75	\$1,459.50	\$2,189.25
UHC Medicare Complement	\$281.94	\$563.88	\$845.81
UHC Select EPO	\$599.76	\$1,199.52	\$1,799.28
UHC Select EPO Medicare Eligible	\$418.49	\$836.97	\$1,255.46
Caremark Prescription (for UHC plans only)	\$232.56	\$465.12	\$697.68
Kaiser HMO	\$535.22	\$1,070.45	\$1,605.66
Kaiser HMO Medicare Complement	\$311.75	\$623.51	\$935.26
Delta Dental PPO	\$32.91	\$65.96	\$121.98
Delta Dental HMO	\$18.41	\$35.80	\$51.87
EyeMed Vision Plan* – Low	\$3.22	\$6.49	\$9.71
EyeMed Vision Plan* – Moderate	\$5.59	\$11.20	\$16.80
EyeMed Vision Plan* – High	\$9.72	\$19.45	\$29.18

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Newborns and Mothers Health Protection Act

Group health plans and health insurance issuers offering group insurance coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth, for the mother of newborn child, to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable).

In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

Women's Health and Cancer Rights Act of 1998

This law requires group health plans that provide coverage for medically necessary mastectomies to also provide coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to provide a symmetrical appearance; and
- Prosthesis and the treatment of physical complications during all stages of the mastectomy.

The Commission's plans cover mastectomies and the benefits required by this act. If you would like more information on WHCRA benefits, call the Health & Benefits Office at 301-454-1694.

Children's Health Insurance Program Reauthorization Act (CHIPRA)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov. If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office, or call 877-KIDSNOW (877.543.7669); or visit www.insurekidsnow.gov to find out how to apply.

If you qualify, ask your state if it has a program that might help you pay the premiums for an employer sponsored plan. If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. For more information, contact the Health & Benefits Office at 301-454-1694.

