2011- 2012 Open Enrollment
Frequently Asked Questions

1. What is Open Enrollment? **This is the time for you to think about your health benefits and to make changes to or enroll in one of the following State of Maryland Health Programs:**

   a. **Medical Benefits**
   b. **Prescription Drug Benefits**
   c. **Dental Benefits**
   d. **Flexible Spending Accounts**
   e. **Term Life Insurance**
   f. **Accidental Death & Dismemberment Insurance**
   g. **Long Term Care Insurance**

   This is the time to make elections you usually can't make any other time of the year, unless you experience a qualifying change in status. Open Enrollment is the time to exercise your right of choice. If you fail to consider your health plan choices, you could be without the healthcare services or supplies you need or with premiums you can't afford.

2. What are the dates for the Open Enrollment Period? **April 26, 2011 through May 26, 2011.**

3. Is there a Correction Period for Open Enrollment and what are the dates? **No. This year based on the new federal healthcare reform legislation, we must allow 30 days for Open Enrollment.**

4. What changes can I make during the Open Enrollment period? **You may make any changes to your health benefits.**

5. If I miss the Open Enrollment Period, when can I make changes to my health benefits? **You may make changes if you experience a qualifying event or change in status (i.e. loss of coverage, marriage, birth of a child, divorce, etc.). You have 60 days from the date of the qualifying change in status to submit an Enrollment Form making changes to your benefits. Any changes submitted after 60 days of the qualifying change in status cannot be accepted, and you will have to wait until the next Spring 2012 Open Enrollment period to make the desired changed and benefits are effective July 1, 2012.**

6. Why must I wait until the next Open Enrollment to enroll in benefits if I do not have a qualifying event? **The State Employee and Retiree Health Benefits Program is subject to federal and State laws and regulations. Complying with these provisions makes it possible for Employees to have pre-tax premium deductions in the Program, to have tax-free State subsidies for Active Employee and Retiree coverage, and to offer benefits like the FSA plans. State regulations and policies require treating Employees and State Retirees alike with respect to how benefits are administered and to follow certain administration rules. Section 125 of the Internal Revenue Code has strict regulations and guidelines for administering the Program.**

7. If I do not want to make any changes, do I have to do anything? **No. If you do not call the Interactive Voice Response System (IVR) your current health benefits will rollover for the new health benefit plan year of July 1, 2011 to June 30, 2012 with the exception of the Health Care Flexible Spending Account (HCFSA) or the Dependent Care Flexible Spending Account (DCFSA). If you are enrolled in a Health Care Flexible Spending**

Account (HCFSA) or a Dependent Care Flexible Spending Account (DCFSA) and would like to re-enroll for the benefit year July 1, 2011 to June 30, 2012, you MUST call the IVR to enroll.

MEDICAL PLAN

8. What medical plans are being offered? **Aetna POS, Aetna EPO, CareFirst Blue Cross Blue Shield PPO, CareFirst BlueCross BlueShield POS, CareFirst Blue Cross Blue Shield EPO, United Healthcare PPO, United Healthcare POS, United Healthcare EPO.**

9. What is a Preferred Provider Organization (PPO) plan?
The PPO Plans allow you to choose any doctor you want at the time of service – you do not have to choose a primary care physician or get referrals. Simply present your ID card to the provider.

10. What is an Exclusive Provider Organization (EPO) plan? **An EPO is a type of managed care plan. The EPO utilizes a network made up of providers from a specific network from which members must choose. EPO members are restricted to in-network providers only. Some carriers require the member to select a primary care physician and may require referrals.**

11. What is a Point-of-Service plan (POS)?
The POS plans are managed care plans. You may receive services in- or out-of-network, but you will pay more for out-of-network services. ***Referrals and primary care physicians are only required for CareFirst POS.***

PRESCRIPTION DRUG PLAN

12. What is the prescription drug plan being offered? **Catalyst Rx prescription drug plan.**

DENTAL PLAN

13. What dental plans are being offered? **United Concordia Dental PPO and United Concordia DHMO dental plans.**

VISION BENEFIT

14. Does the State of Maryland offer vision benefits? **Yes, if you are enrolled in a medical plan, you receive your vision benefit with your medical plan. Vision benefits are not available as a stand alone benefit.**

BEHAVIORAL HEALTH BENEFITS

15. Does the State offer Behavioral Health benefits? **Yes.**

    If you enroll in a State medical plan, you and your enrolled dependents will automatically receive behavioral health coverage. However, your behavioral health benefits vary depending on the medical plan in which you are enrolled.

EPO PLANS

Your EPO plan must authorize all of your behavioral health services to be eligible for coverage. In addition, out-of-network services are not covered under any of the EPO plans. Contact your EPO plan for more details.

PPO AND POS PLANS

Your behavioral health benefits are provided by APS Healthcare Bethesda, Inc. The following types of services are covered under this plan:

Inpatient facility and professional services; Partial hospitalization;

Intensive Outpatient Program; and Outpatient facility and professional services. To get the most from your benefits, you should contact APS before receiving any services.

FLEXIBLE SPENDING ACCOUNTS

16. What is an FSA? **A Flexible Spending Account allows you to set aside money from each pay with deductions, on a pretax basis, to pay for a wide variety of common health care and dependent day care expenses for you and your eligible dependents. Even with an insurance plan, health care expenses can add up. From deductibles and copays to items not covered by insurance, the rising cost of health care can put a strain on your budget. Families paying for dependent day care, whether for children or for elders, know how expensive that can be as well. FSAs provide tax savings to help you offset the rising cost of health care and dependent day care expenses. You may want to discuss your personal situation with a tax advisor before deciding if an FSA may work for you. The State FSAs are administered by ConnectYourCare. FSA coverage is available only for your tax dependents.**

17. Is ConnectYourCare still the Flexible Spending Account (FSA) Vendor? **Yes.**

18. What Flexible Spending Accounts will the State of Maryland offer with ConnectYourCare? **The State will offer a Dependent Care Flexible Spending Account and a Health Care Flexible Spending Account.**

19. How much may I contribute to the Health Care Flexible Spending Account with ConnectYourCare? **You may contribute between $120 and $3,000 a year to reimburse yourself for eligible health care expenses not reimbursed by any medical, dental, or prescription plan you or your eligible dependents may have.**

20. How much may I contribute to my Dependent Care Flexible Spending Account with ConnectYourCare? **You may contribute between $120 and $5,000 a year, or up to $2,500 a year if married and filing separately to reimburse yourself for eligible dependent day care expenses incurred so you and your souse, if married, can work, look for work, or your spouse can attend school full-time.**

21. What are some of the features that ConnectYourCare offers? **Payment cards, sometimes referred to as Debit cards, for the health care spending account, online claims submission-no more faxing or mailing (unless you want to), encrypted Bar coded claims forms-no need to put your social security number all over the forms.**

22. What impact has the Patient Protection and Affordable Care Act (PPACA) had on the FSAs? **See changes below.**

a. **What has changed:**
   Expenses for Over-the-Counter (OTC) drugs or medicines (other than insulin) incurred on or after January 1, 2011 will only be considered medical care for IRS purposes if they are prescribed.
b. **What remains same:**
   OTC medical supplies and equipment, contact lens solutions, bandages, crutches, durable medical equipment or diagnostic devices, such as blood sugar test kits continue to be eligible for purchase without a prescription.
c. **What it means for you:**
   You must submit a copy of your actual prescription for OTC drugs and medicines along with your itemized receipt unless the receipt contains a prescription number.

23. How can I use my account funds for prescribed OTC medicines & drugs?
    The IRS guidance provides for two methods:

    a. Use another form of payment for purchase, then submit the items for manual reimbursement using your online account or paper form. With this method, you will need to submit either a) a receipt showing the date with amount of purchase and a copy of the prescription or b) a receipt that includes the prescription number, patient name, date and amount.

    b. If you have a healthcare payment card, you may use it at certain merchants that support IRS Notices 2010-59 and 2011-05 regulatory requirements by presenting the prescription to the pharmacist and having the pharmacist dispense the OTC drug or medicine in accordance with applicable law and regulations by which an Rx Number is generated and processed. ConnectYourCare has been working closely with industry groups to define which merchants will be able to accept cards for OTC medications and drugs. Please visit www.connectyourcare.com/otc for updated information.

24. What are some suggestions and a few tips to make it even easier to use my Healthcare FSA payment card?

    a. Save Your Documentation - The IRS requires each expense be validated to make sure it is for an eligible item, like a physical, instead of an ineligible item, like cosmetic surgery. Many times, we can validate the expense automatically, but sometimes we have to request itemized receipts from you. **Be sure to always ask for and save your itemized receipts, even if you pay with your payment card!**
    b. **Submit Documentation When Requested** - When documentation is required, it is a quick and easy process to submit it. Review these FAQs for more information.
    c. **How do I know if documentation is needed?** There will be a notice in your online account, and we will also send you three notices within a 45 day period. The first notice will be sent via email if we have your email address on file or postal mail if we don't. The next two notices will be sent via postal mail.
    d. **How do I submit documentation?** You may choose the way that's easiest for you to submit the documentation. Either log into your online account and use the document upload feature, or submit via fax or postal mail.
    e. **What is required on the documentation?** The IRS requires that the following information be provided: patient name, service provider name and address, date of service, detailed description of the service, and the amount charged. Non-itemized

statements, cash register receipts, credit card receipts and canceled checks alone are not sufficient.

f. **How long do I have to submit documentation?** You have 45 days from the date of the first letter to submit documentation.
g. **What if I do not have the documentation?** You may repay your account for the amount of the claim.
h. **What if I do not submit my documentation?** If your documentation or repayment is not received, your payment card will be suspended, future claims reimbursements may be decreased by the amount owed, deductions in the amount of the unsubstantiated expenses may be made against your salary, and there may be negative tax consequences at the end of the year.
i. **Enjoy Automatic Substantiation for Many Payment Card Charges** - We automatically substantiate (approve the expense without documentation) certain payment card charges, eliminating the need to submit any documentation at all! Automatically substantiated payment card charges include: Charges that exactly match the dollar amount, or up to five times the dollar amount, of State of Maryland's standard copayment dollar amount for medical, dental, vision and prescription plans. For example, since the standard vision copayment is $15, a card charge at a vision provider of $15, $30, $45, $60, or $75 would be automatically approved. Recurring charges that were previously approved will be approved the next time. For example, let's say you use your card to pay for a $25 allergy treatment at Dr. Smith, submit documentation, and the claim is approved. The next time you use your card for a $25 allergy treatment at Dr. Smith, it will be automatically approved with no need to submit documentation!

TERM LIFE INSURANCE BENEFIT

25. Does the State offer Life Insurance coverage? Yes.

    a. ***Coverage for Yourself***
    You may choose coverage in $10,000 increments up to a maximum of $300,000. You may choose up to $50,000 guaranteed coverage without completing a medical history statement. If you select coverage greater than $50,000 for yourself, you must complete and submit a Statement of Health form to be reviewed by MetLife.
    b. ***Coverage for Your Dependents.*** You may choose to purchase coverage for your dependents who are eligible for health benefits with the State in $5,000 increments up to half of your coverage amount (up to a maximum of $150,000). You may choose up to $25,000 guaranteed coverage for eligible dependents without a medical history statement. If you select coverage greater than $25,000 for a dependent, a medical history statement for that dependent must be completed and reviewed by MetLife.

ACCIDENTAL DEATH AND DISMEMBERMENT PLAN

26. Does the State offer an Accidental Death and Dismemberment Plan? **Yes. The Accidental Death and Dismemberment (AD&D) Plan is available to all Active Employees and their dependents who are eligible for health benefits with the State. The AD&D Plan is offered through Metropolitan Life Insurance Company (MetLife). The plan provides benefits in the event of an accidental death or dismemberment. No medical review is required for enrollment in the plan. This plan will cover you for accidents that occur at work as well as accidents off the job. You can choose individual or family coverage in an amount equal to:**

$100,000

$200,000

$300,000

If you choose family coverage, your dependents are covered for a percentage of your benefit amount.

LONG TERM CARE INSURANCE

27. What is Long Term Care Insurance? **Long Term Care (LTC) is the help or supervision provided for someone with severe cognitive impairment or the inability to perform the Activities of Daily Living, including bathing, dressing, eating, toileting, transferring, and continence. Services may be provided at home or in a facility – and care may be provided by a professional or informal caregiver, such as a friend or family member. The Long Term Care (LTC) Insurance plan is offered through The Prudential Insurance Company of America (Prudential LTC).**

28. Can I use the Interactive Voice Response System (IVR) to enroll in the Prudential Long Term Care Plan? **No. You must contact them directly at 1.800.732.0416 or visit their website at www.prudential.com/gltc**

HEALTH BENEFITS RATES

29. Will the employee/retiree rates increase this benefit year? **Yes. Rates will be available for Open Enrollment.**

SAME SEX DOMESTIC PARTNER AND SAME SEX SPOUSE

30. May I enroll my opposite sex domestic partner on my State of Maryland Health Benefits for July1, 2011? **No, the State only covers same sex domestic partners.**

31. What is the reason that I cannot enroll my opposite sex domestic partner on my State of Maryland Health Benefits? **Persons of the opposite sex may marry in the State of Maryland.**

32. If my same sex domestic partner and I have a civil union in another state, what documentation should I supply to enroll my same sex domestic partner on my Maryland Health Benefits for July1, 2011? **An Active, Retiree and/or Direct Pay Enrollment Form, an official copy of your civil union certificate and an Affidavit for Spousal Eligibility and Tax Status Form.**

33. If a domestic partner receives a monthly retirement allowance as the beneficiary of a deceased retiree, can he/she enroll in health benefits with State subsidy? **No. Current Maryland law limits who may enroll as a survivor of a deceased employee or deceased retiree. *See* State Pers. & Pen. §§2-507, 2-508 and 2-509. If a domestic partner loses health benefits coverage as the result of the death of an employee or retiree, the State's voluntary extension of continuation of coverage rights for up to three years (similar to COBRA) is the only coverage that is available.**

Pursuant to Section 2-507, 2-508 and 2-509 of the State Personnel and Pensions Article, Maryland Annotated Code, only the following individuals who are in receipt of a State retirement allowance or a State ORP periodic distribution of benefits or a certain kind of State death benefit may participate (i.e. enroll indefinitely) in the Program: a surviving spouse of an employee or retiree, a surviving dependent/minor child of an employee or retiree, and in some very limited cases, a surviving dependent parent of a deceased State employee who was killed while a State employee.

34. Are the health benefits rates for same sex domestic partners included in the benefits guide? **No, the post-tax and imputed income calculations are available on the DBM website.**

35. Are my same sex domestic partner's/spouse's child(ren) eligible to enroll in the Program? **Yes, as long as they meet the eligibility criteria. See pages 15-17 of the *Benefits Guide* for eligibility requirements and documentation.**

<u>DEPENDENT ELIGIBILITY</u>

36. Can I add my father/mother on my State of Maryland Health Benefits? **No, parents are not eligible dependents under the Program.**

37. Can I add my sister/brother on my State of Maryland Health Benefits? **Yes, however, only if they meet the State of Maryland Health Benefits tax eligibility criteria. See page 16 of the *Benefits Guide* for eligibility requirements and documentation.**

38. When a retiree passes away can his/her spouse keep health benefits? **Spouses that continue to receive a monthly beneficiary retirement allowance are eligible to submit a Retiree Enrollment Form for health benefits.**

<u>DIRECT PAY/COUPON/PAYMENT</u>

39. If I pay by coupon, when must I pay by? **Payments must be <u>postmarked</u> by the end of the month for which you are paying. Payments deadlines are strictly enforced.**

40. Do you offer payment plans? **No.**