State Employee & Retiree Health & Welfare Benefits Program

Trouble Free OE

ABC Training-Satellites
Plan Year 2023

Together, we are working toward a *healthier community*

Maryland
DEPARTMENT OF BUDGET AND MANAGEMENT

Agenda

The Basics

Open Enrollment

Benefit Highlights

Wellness

EBD Reminders

Questions and Answers

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The Basics

The ABCs...

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ABC Knowledge: get with the Program

Resources:
dbm.maryland.gov/benefits
ABC Corner
Guide to Health Benefits
https://bas.dbm.state.md.us
https://mymdbenefits.com

Eligible Employees:

Full Time: 30 hours or more per week
Part Time: at the discretion of each agency

Eligible Dependents:

Spouse
Children
Legal Wards

Qualifying Events:
New Hire
Marriage
Birth/Adoption
Loss/Gain of Coverage
Divorce
Etc.

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ABC Knowledge: here's the plan

Ensure employee's understanding of:

- **Coverage effective date** – first of the month coinciding with or following the date of a qualifying event.
- **Coverage end date** – last day of the month in which the termination of employment or qualifying event takes place.
- **The 60 day window**- the amount of time given to employees to elect benefits and/or make changes to benefits once a qualifying event occurs. The 60 day window starts on the event date (day 1) and runs for 60 calendar days
  - -Retroactive **premiums**-billed on subsequent monthly Satellite invoices
  - -Retroactive **credits**-applied on subsequent monthly Satellite invoices

Assist employees:

- Completing forms
- Understanding documentation requirements
- Answering plan option questions (e.g.-networks, co-pays, co-insurance, etc)
- Communicating benefits information/updates/deadlines
- Printing and distributing Summary Statements

Consider all qualifying events to help the employee decide which event is the most beneficial.

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ABC Knowledge: sign me up…Resources!

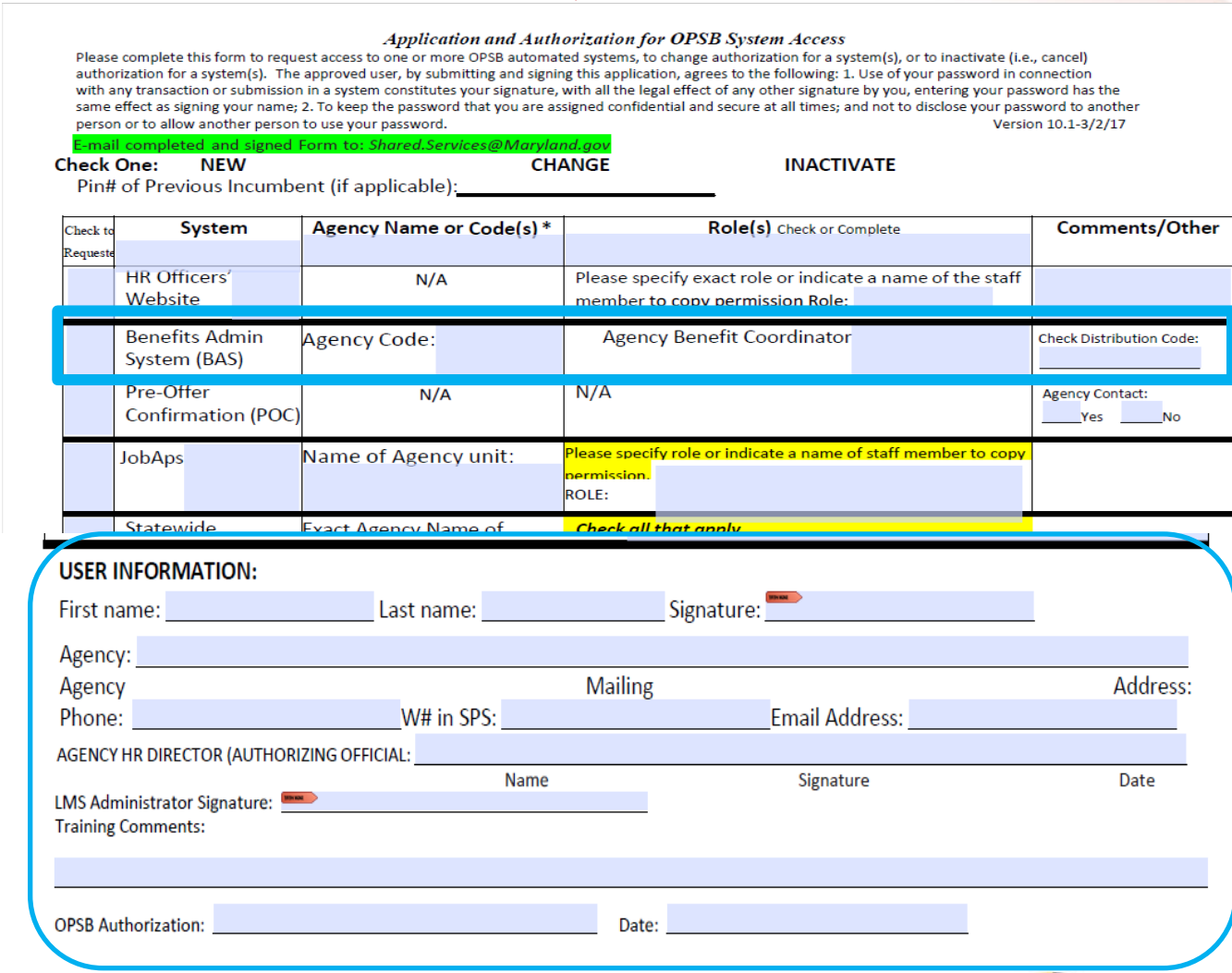
The BAS system houses your employees' health benefit elections along with covered dependent information including contact information.

Use the **Application and Authorization for OPSB System Access** whenever you need to:

1. Give a new ABC BAS access OR
2. Remove an ABC's BAS access

Complete the sections circled in blue and email completed forms to:

Shared.Services@maryland.gov



Application and Authorization for OPSB System Access

Please complete this form to request access to one or more OPSB automated systems, to change authorization for a system(s), or to inactivate (i.e., cancel) authorization for a system(s). The approved user, by submitting and signing this application, agrees to the following: 1. Use of your password in connection with any transaction or submission in a system constitutes your signature, with all the legal effect of any other signature by you, entering your password has the same effect as signing your name; 2. To keep the password that you are assigned confidential and secure at all times; and not to disclose your password to another person or to allow another person to use your password. Version 10.1-3/2/17

E-mail completed and signed Form to: *Shared.Services@Maryland.gov*

Check One: NEW CHANGE INACTIVATE

Pin# of Previous Incumbent (if applicable):_____

Check to Request	System	Agency Name or Code(s) *	Role(s) Check or Complete	Comments/Other
	HR Officers' Website	N/A	Please specify exact role or indicate a name of the staff member to copy permission Role:	
	Benefits Admin System (BAS)	Agency Code:	Agency Benefit Coordinator	Check Distribution Code:
	Pre-Offer Confirmation (POC)	N/A	N/A	Agency Contact: ____Yes ____No
	JobAps	Name of Agency unit:	Please specify role or indicate a name of staff member to copy permission. ROLE:	
	Statewide	Exact Agency Name of	*Check all that apply*	

USER INFORMATION:

First name: _____ Last name: _____ Signature: _____

Agency: _____

Agency Mailing Address:

Phone: _____ W# in SPS: _____ Email Address: _____

AGENCY HR DIRECTOR (AUTHORIZING OFFICIAL): _____

Name Signature Date

LMS Administrator Signature: _____

Training Comments:

OPSB Authorization: _____ Date: _____

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ABC Knowledge: ready, set...

Once your BAS access is approved you will receive an email notification with your Login ID and temporary password.

Requested for: New User
Item: User Access Request

Assigned to: Shared Services

Close notes: You have been approved as a user of the BAS application. The Benefits Application System enables users to view Health Benefits information for the employees at their agency. The location of this application is https://bas.dbm.state.md.usPlease save this link to your favorites so it can be easily accessed each time you need to use the application.

Login ID: new.user@dbm
Temporary password: ******

Please change your password after your first login.

To confirm your logon-id or obtain a temporary password contact the:
DoIT Service Desk
410-697-9700
service.desk@maryland.gov

Passwords must be at least 8 characters and contain at least one upper-case letter, one-lower case letter and at least one number. Special characters are allowed, but not necessary. Your password will expire every 90 days and is case sensitive.

Never share your password with anyone!

If you have any questions or problems, please contact the DoIT Service Desk. It is helpful if you identify yourself as a BAS customer.

We look forward to working with you!

Thank you.

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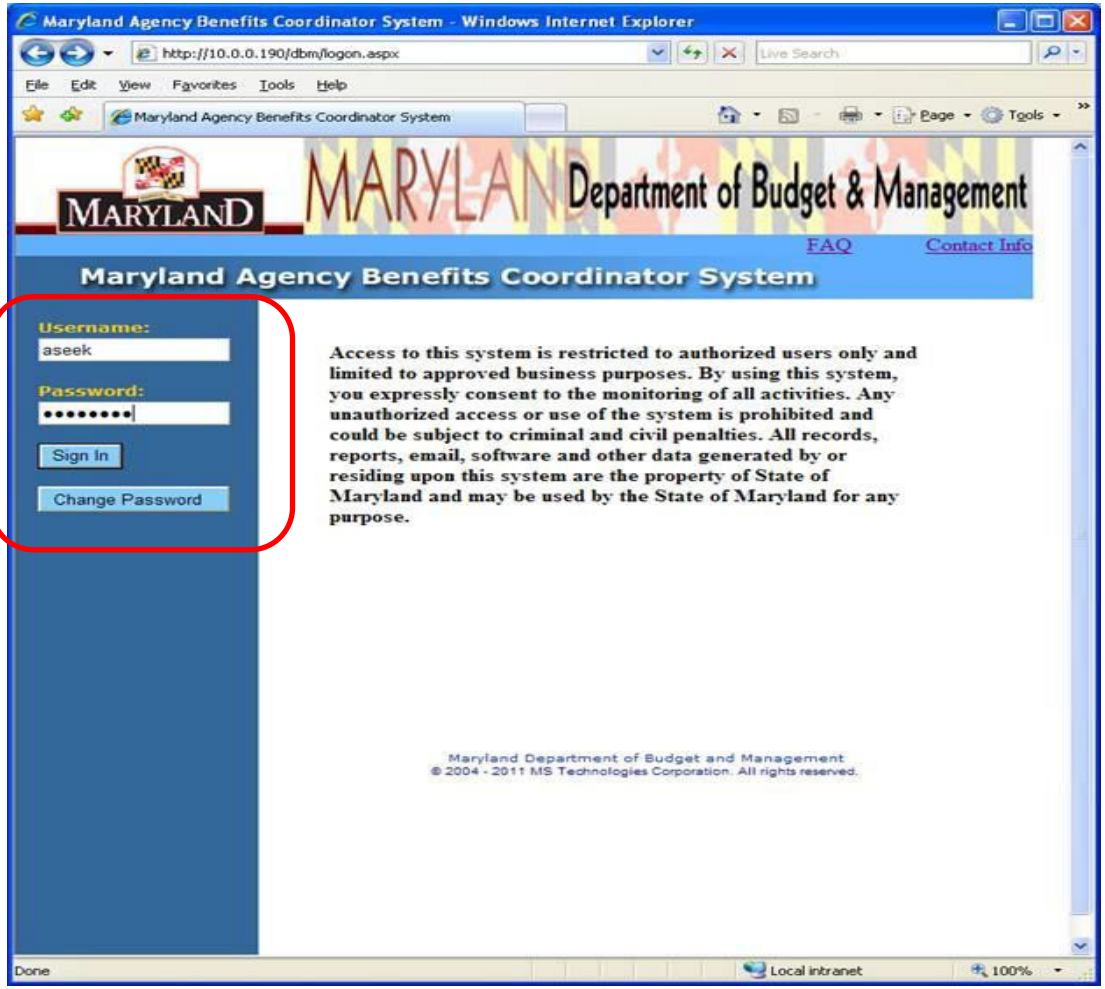
ABC Knowledge: GO…

Log into BAS with your LogIn ID (Username) and your temporary password

Change your password following your initial log-in, see instructions included with your email notification.



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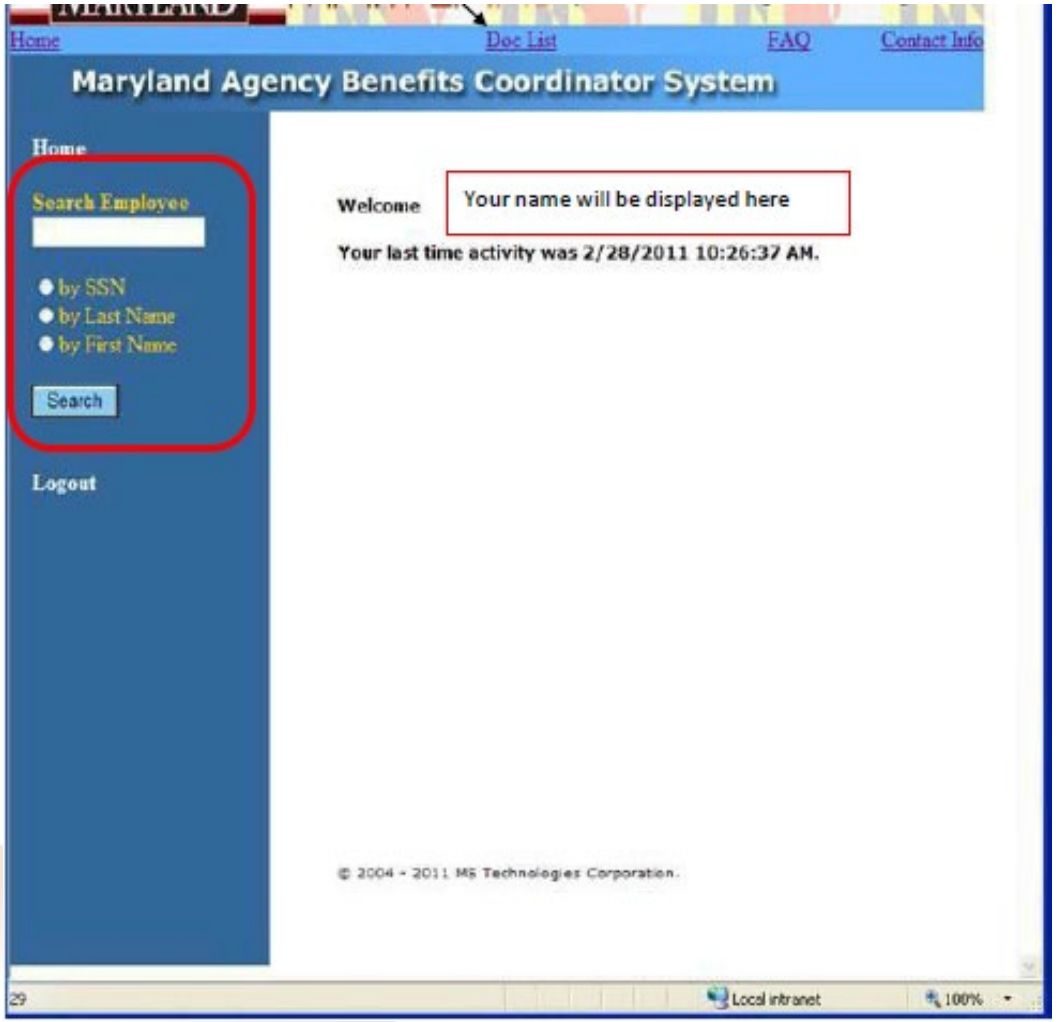
ABC Responsibilities: Search for an Employee

Search for an employee's benefit information by SSN, Last Name, OR First Name



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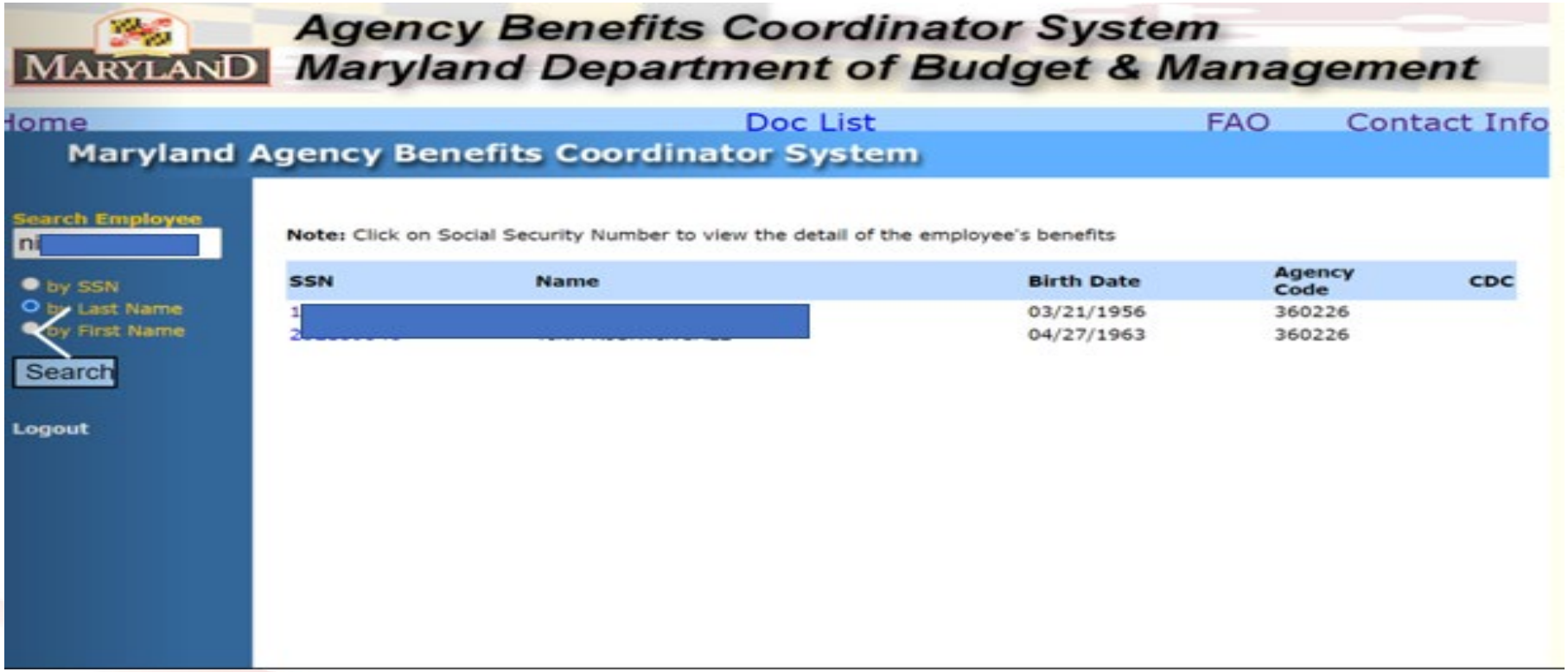
ABC Responsibilities: Search for an Employee



In this example, the search was based on last name yielding two results. Click on the SSN beside the name of the employee you want to review.

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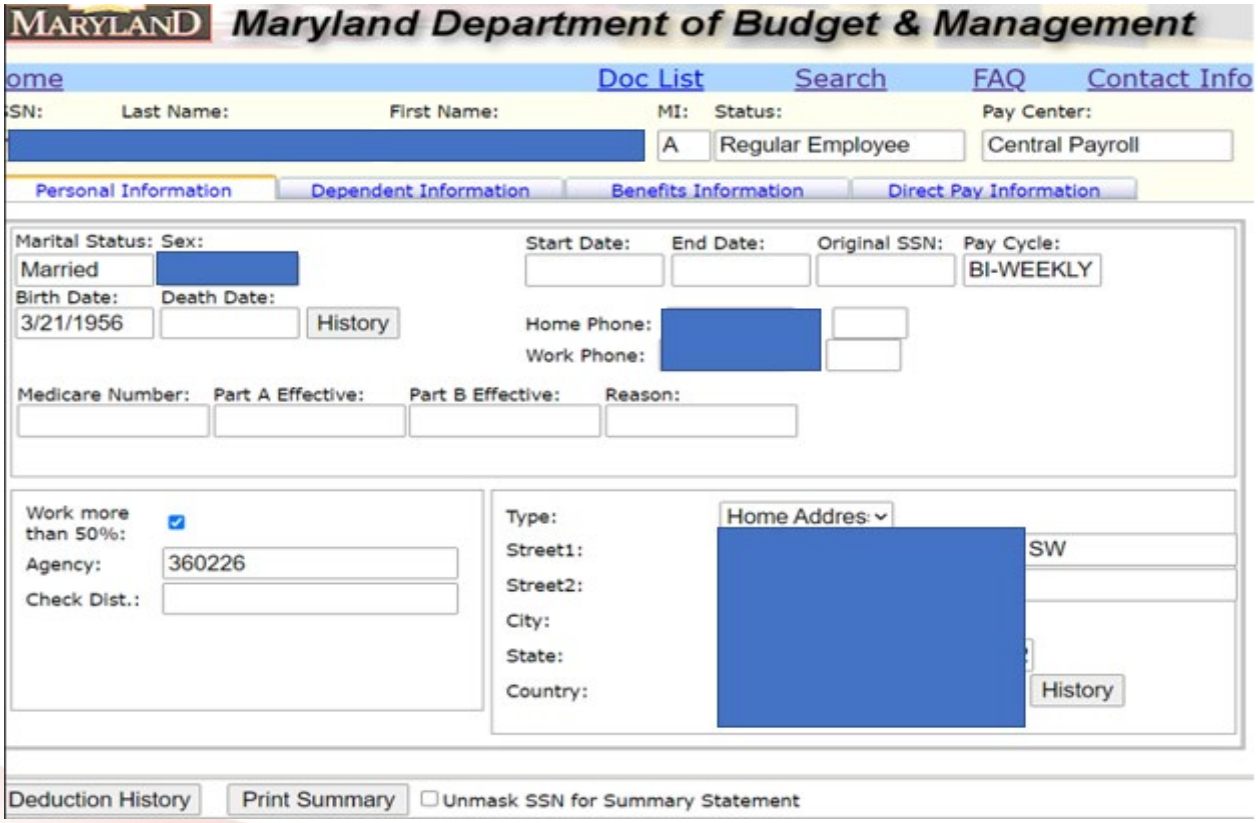
ABC Responsibilities: Search for an Employee



This screen displays Personal Information

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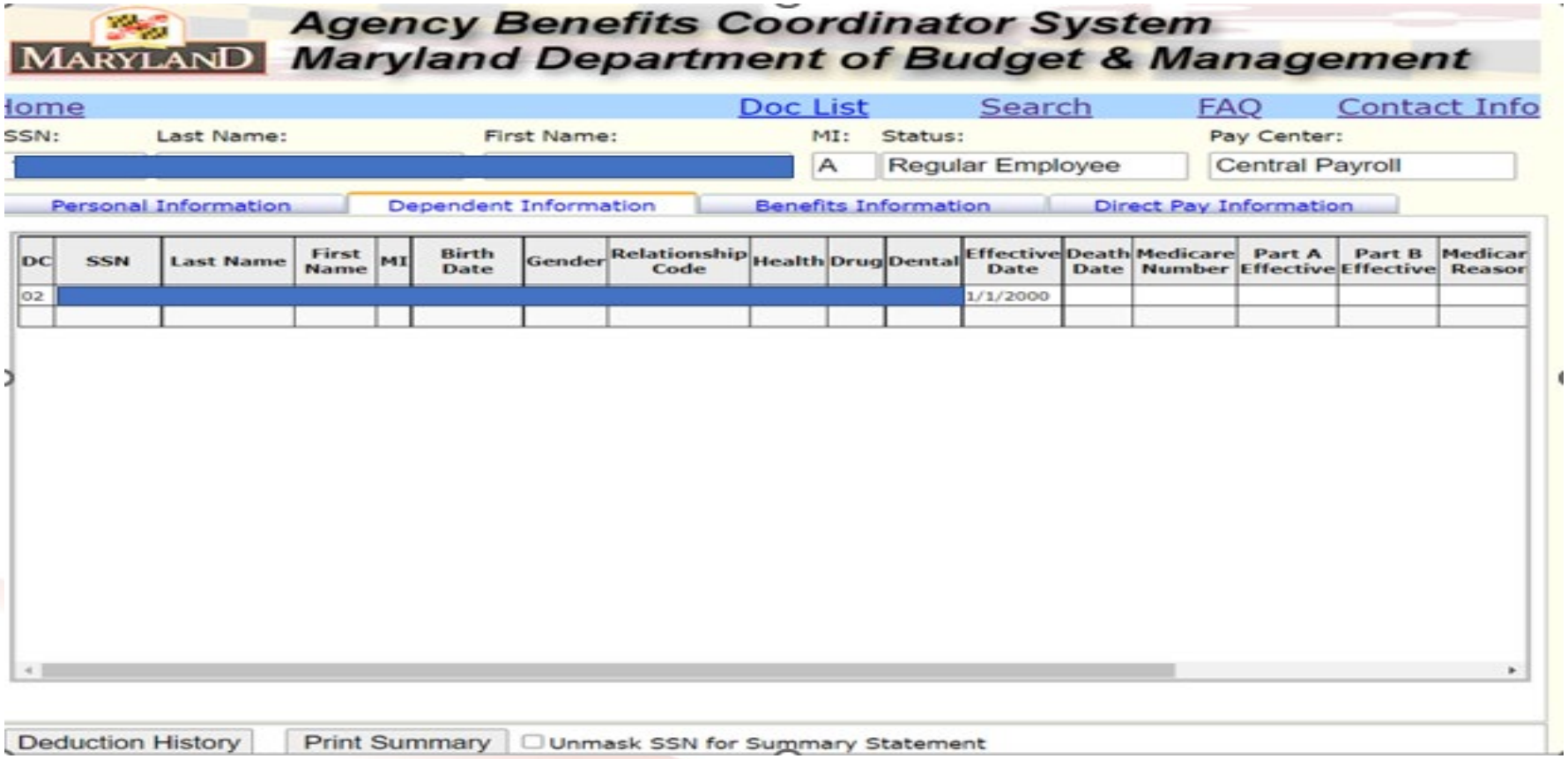
ABC Responsibilities: Search for an Employee



This screen displays Dependent Information

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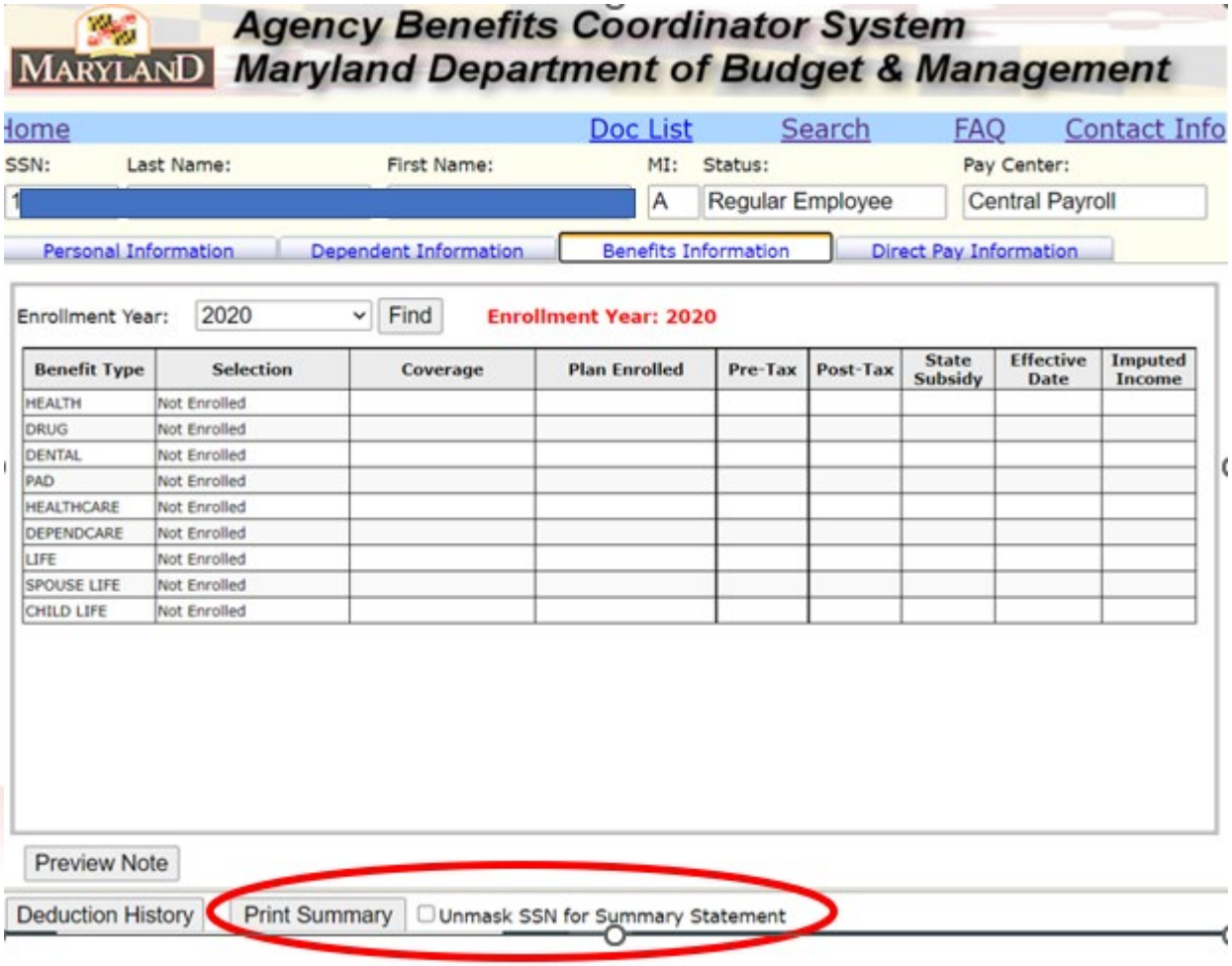
ABC Responsibilities: Search for an Employee



This screen displays Benefits Information including Benefit Type, Coverage Level, Plan, Premium Amounts. All screens allow you to Print Summaries with masked/unmasked SSNs.

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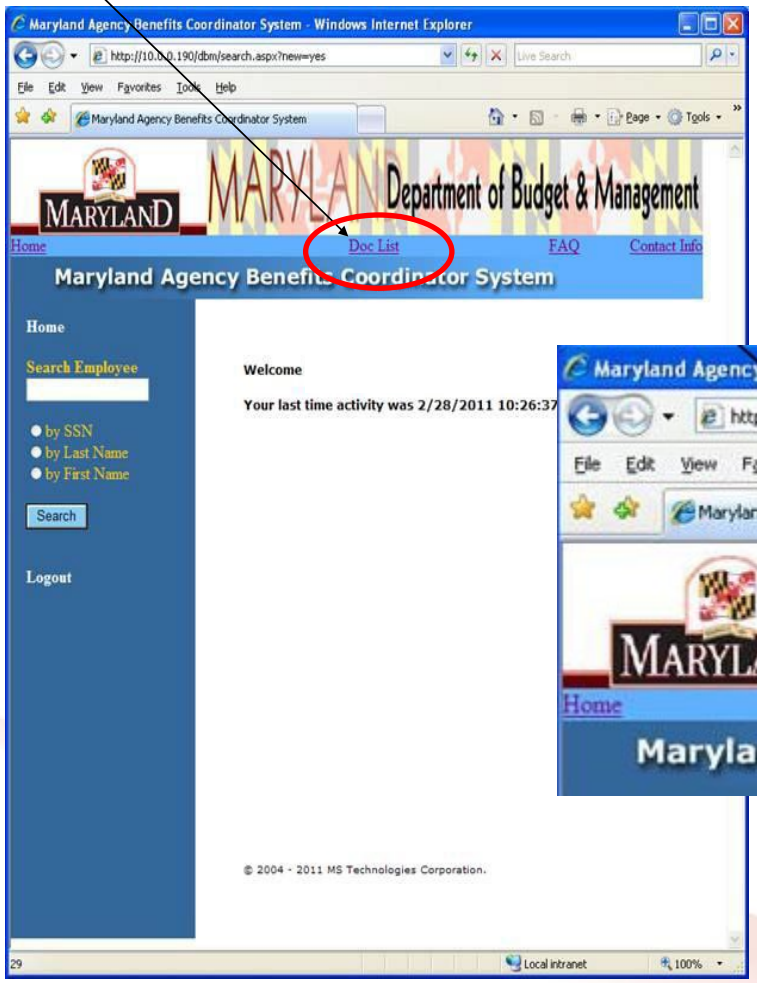
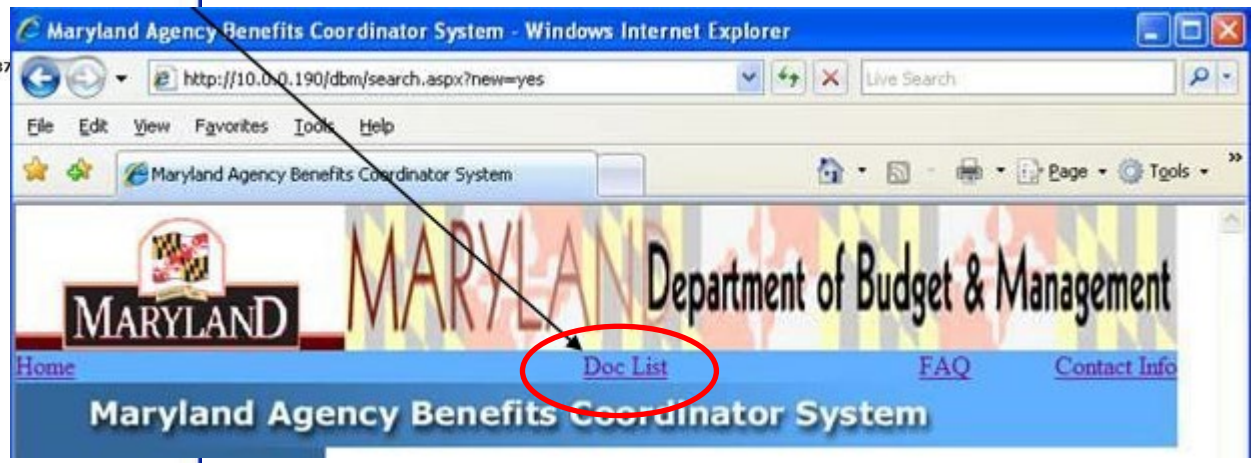
ABC Responsibilities: Printing Summary Statements



On the top of the toolbar, click on the Doc List link



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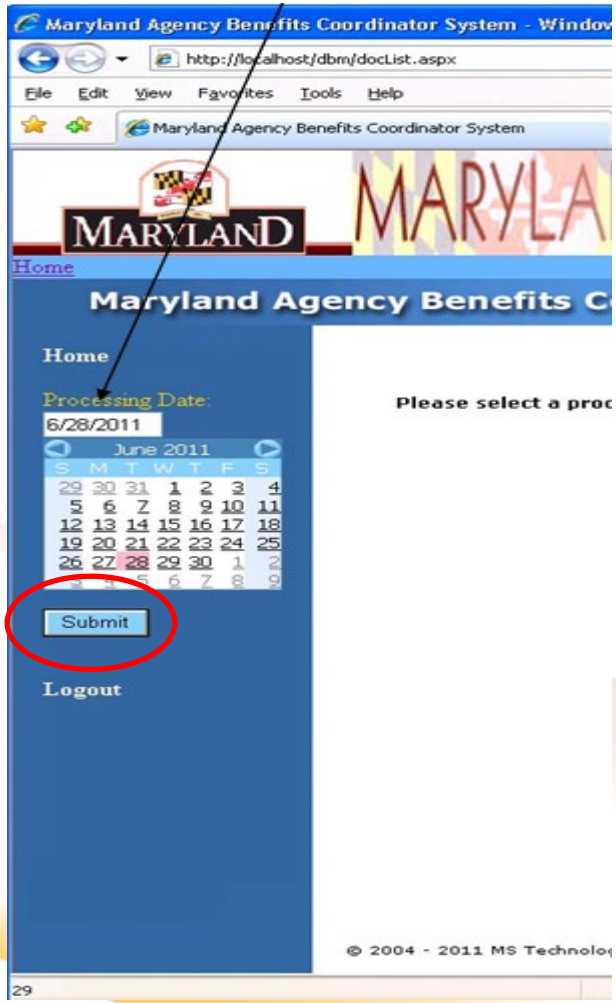
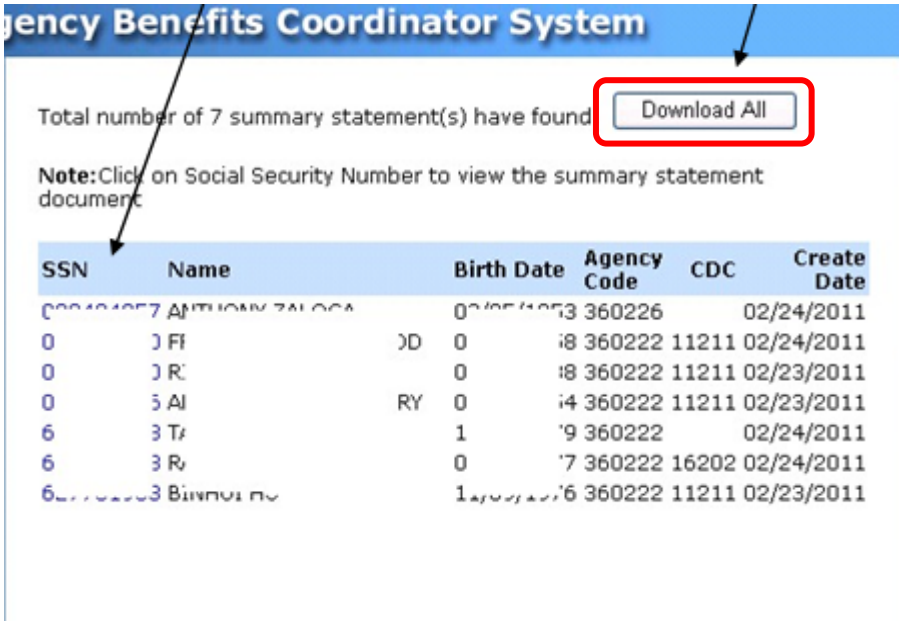
ABC Responsibilities: Printing Summary Statements cont.

Enter the processing date and click on the "Submit" button.





Click on the "Download All" button to download all of your agency's summary statements processed on the selected date or click on a specific employee's SSN to download an individual summary statement.

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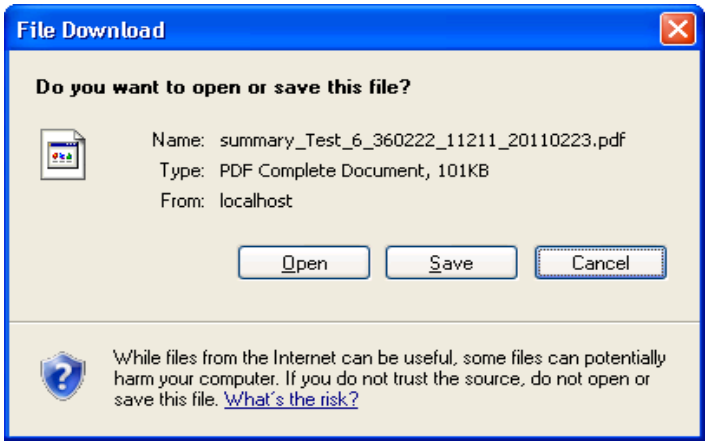
ABC Responsibilities: Printing Summary Statements cont.

After clicking on the "Download All" button, you can either **open** the file to view and/or print the summary statements listed. You can also **save** a copy for future reference.

Summary Statements are produced/available following any changes made to the employee's record. Changes could include: new hire, addition of dependent, change in name, change in address, Open Enrollment changes, etc.

As the ABC, you are responsible for distributing Summary Statements.



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ABC Responsibilities: the enrollment form

Save Print Clear

STATE OF MARYLAND

SATELLITE EMPLOYEES
HEALTH BENEFITS ENROLLMENT AND CHANGE FORM FOR JANUARY 2022-DECEMBER 2022

PERSONAL DATA *PLEASE PRINT CLEARLY*

Name: _____ (LAST) _____ (FIRST) _____ (MI)

Address: _____ Apt/Condo: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_ _ _) _ _ _ - _ _ _ _

Work Phone: (_ _ _) _ _ _ - _ _ _ _

Cell Phone: (_ _ _) _ _ _ - _ _ _ _

Personal E-mail: _____

Work E-mail: _____

Social Security Number: _ _ _ / _ _ / _ _ _ _

Date of Birth: _ _ / _ _ / _ _ _ _ (MM /DD/ YYYY)

Sex: ○ Male ○ Female

Legal Marital Status: ○ Single ○ Married ○ Divorced ○ Limited Divorce/Legally Separated ○ Widowed

TO BE COMPLETED BY AGENCY BENEFITS COORDINATOR

Work full-time or 50% or more of the normal week: Pay Center ○ Satellite: _____

Work _____ hrs. per week FTE% _____ (# hrs/40)

Agency Code: _____

Confirm personal information is complete

Confirm ALL Agency Credentials are completed

Status and Enrollment Change: **TYPES**

- ❑ New Employee
- ❑ Open Enrollment
- ❑ Employee Ineligible
- ❑ Cancel all Coverage in all Plans/Reason
- ❑ Change in Family Status
- ❑ Remove dependent

STATUS & ENROLLMENT/CHANGE ACTION REQUESTED

○ New Employee Entry on Duty Date: _____

Waiting Period: ○ Yes ○ No

Duration: ○ 30 ○ 60

○ Open Enrollment - Effective January 1st

○ Employee ineligible (e.g., change to part-time less than 50%)

○ Cancel all Coverage in all Plans/Reason: _____

Change in Family Status (See Benefits Guide for documentation requirements)
Note: Request must be made within 60 days of the date of the qualifying event.

○ **Add dependent** because of:

○ Marriage Date: _____

○ Birth/Adoption/Appointed Permanent Legal Guardian Date: _____

○ Other Reason: _____

○ **Remove dependent** because of:

○ Divorce/Limited Divorce/Legal Separation Date: _____

○ Death Date: _____ *(Attach copy of Death Certificate)*

○ Dependent no longer eligible Date: _____

Reason: _____

○ Other Change: _____

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ABC Responsibilities:

Dependent Information

DEPENDENT INFORMATION *PLEASE PRINT*

Dependent means your eligible: (a) spouse, or (b) dependent child(ren) (including biological child, adopted child, stepchild, grandchild, step grandchild, other child relative, legal ward). See Benefits Guide for a complete listing of eligible dependents and the dependent documentation requirements.

Please provide your dependent information below. **PLEASE PRINT. THIS FORM MUST BE FILLED OUT COMPLETELY (INCLUDING SOCIAL SECURITY NUMBER AND DATE OF BIRTH) TO ENSURE YOUR DEPENDENTS ARE ENROLLED IN THE PLANS YOU SELECT.** Please use this section for additions (A), deletions (D) or changes (C) to your existing dependent information for Open Enrollment or a qualifying event.

A D C	LAST NAME	FIRST NAME, MI	SEX	DATE OF BIRTH MM/DD/YYYY	RELATIONSHIP	SOCIAL SECURITY NO.	(✓) COVER THIS DEPENDENT FOR: MEDICAL	DRUG	DENTAL
▼							☐	☐	☐
▼							☐	☐	☐
▼							☐	☐	☐
▼							☐	☐	☐

Status options:
A: Add
D: Delete
C: Change

Include all dependent information: (Last name, First name, gender, DOB, Relationship with primary, and SSN

Please confirm ALL dependent documents received with request, if not already on file for primary.

Confirm benefit elections for dependent match benefit elections page

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ABC Responsibilities:

Benefit Elections…

Medical Benefits

CHOOSE ONE OPTION:
- ☐ New Enrollment
- ☐ Change in plan
- ☐ Addition or removal of dependent
- ☐ No, I do not want to enroll in this benefit
- ☐ Cancel current coverage

CHOOSE ONE COVERAGE LEVEL:
- ☐ Employee Only
- ☐ Employee & One Child
- ☐ Employee & Spouse
- ☐ Employee & Family
- ☐ End Stage Renal (ESRD)

(Complete Medicare Information below)

CHOOSE ONE MEDICAL PLAN:
- ☐ CareFirst BC/BS EPO
- ☐ CareFirst BC/BS PPO
- ☐ Kaiser IHM*
- ☐ UnitedHealthcare EPO
- ☐ UnitedHealthcare PPO

**Employees and/or dependents with Medicare due to End Stage Renal Disease (ESRD) are not eligible to enroll in the Kaiser medical plan.*

If you or a dependent have Medicare, write in name, Medicare number, and effective date of Medicare coverage.

NAMES OF INDIVIDUALS WITH MEDICARE	MEDICARE NUMBER (with suffix)	PART A (Hospital Claims) Effective Date MM/DD/YYYY	PART B (Medical Claims) Effective Date MM/DD/YYYY	PART D (Prescription Drug) Effective Date MM/DD/YYYY	MEDICARE DUE TO ( ): Age 65	Disabled	ESRD
Employee					☐	☐	☐
Spouse					☐	☐	☐
Child					☐	☐	☐
Child					☐	☐	☐

Complete all required fields for Medical:
- Enrollment type
- Coverage Level
- Plan Type

***Medicare Information as needed**

Prescription Drug Coverage

CHOOSE ONE OPTION:
- ☐ New enrollment
- ☐ Addition or removal of dependent
- ☐ No, I do not want to enroll in this benefit
- ☐ Cancel current coverage

CHOOSE ONE COVERAGE LEVEL:
- ☐ Employee Only
- ☐ Employee & One Child
- ☐ Employee & Spouse
- ☐ Employee & Family

Dental Coverage

CHOOSE ONE OPTION:
- ☐ New enrollment
- ☐ Change in plan
- ☐ Addition or removal of dependent
- ☐ No, I do not want to enroll in this benefit
- ☐ Cancel current coverage

CHOOSE ONE COVERAGE LEVEL:
- ☐ Employee Only
- ☐ Employee & One Child
- ☐ Employee & Spouse
- ☐ Employee & Family

CHOOSE ONE DENTAL PLAN:
- ☐ United Concordia DPPO
- ☐ Delta Dental DHMO

For the DHMO Plan: You must select a primary Dentist office once enrolled. Call plan or see plan website for detail.

Accidental Death and Dismemberment Benefits

CHOOSE ONE OPTION:
- ☐ New enrollment
- ☐ Change of benefit amount
- ☐ Addition or removal of dependent
- ☐ No, I do not want to enroll in this benefit
- ☐ Cancel current coverage

CHOOSE ONE COVERAGE LEVEL:
- ☐ Employee Only coverage
- ☐ Family coverage

CHOOSE ONE BENEFIT AMOUNT
- ☐ $100,000
- ☐ $200,000
- ☐ $300,000

Flexible Spending Accounts *(Available to CEIWC, MAIF, MES, MTA & UMUC)*

YOU MUST COMPLETE THIS SECTION IF YOU WANT TO PARTICIPATE IN A FLEXIBLE SPENDING ACCOUNT FROM JANUARY 2022-DECEMBER 20

HEALTHCARE

CHOOSE ONE OPTION:
- ☐ Enroll in Healthcare Spending Account
- ☐ Change in Healthcare Spending Account
- ☐ No, I do not want to enroll in this benefit
- ☐ Cancel Healthcare Spending Account

$ ☐,☐☐☐.☐☐

Write in Annual Election Amount

DAY CARE

CHOOSE ONE OPTION:
- ☐ Enroll in Dependent Day Care Spending Account
- ☐ Change in Dependent Day Care Spending Account
- ☐ No, I do not want to enroll in this benefit
- ☐ Cancel Dependent Day Care Spending Account

$ ☐,☐☐☐.☐☐

Write in Annual Election Amount

If you will be retiring before January 1, 2023, only expenses incurred prior to retirement can be considered for reimbursement.

See Benefits Guide for Minimum/Maximum deduction amounts. The per pay amount will be determined based on the number of pay periods left in the plan year when you are eligible for enrollment.

Complete all required fields:
- Prescription
- Dental
- Accidental Death & Dismemberment
- FSA(dep/health)-see enrollment form for details

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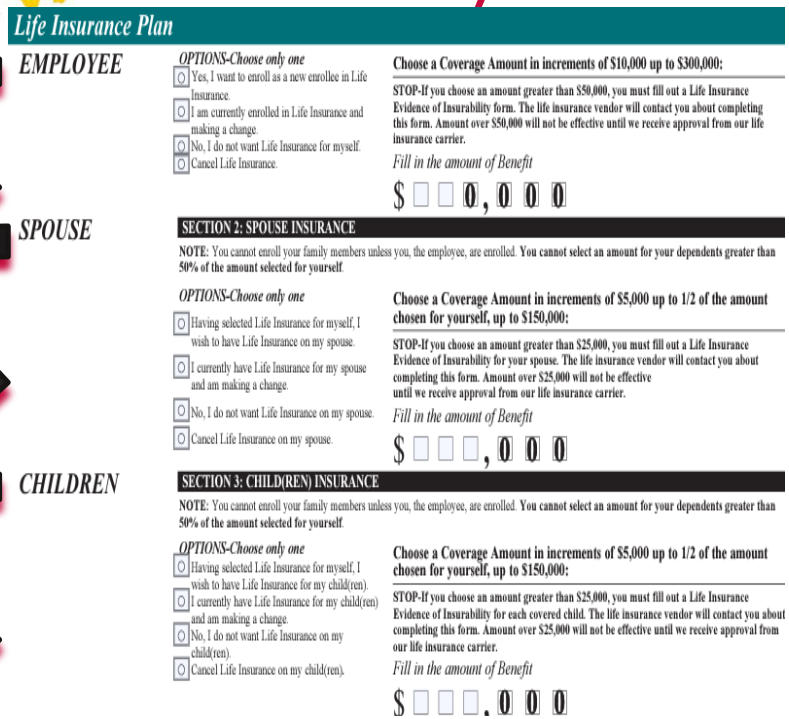
ABC Responsibilities:



Life Insurance Plan

EMPLOYEE

OPTIONS-Choose only one

- Yes, I want to enroll as a new enrollee in Life Insurance.
- I am currently enrolled in Life Insurance and making a change.
- No, I do not want Life Insurance for myself.
- Cancel Life Insurance.

Choose a Coverage Amount in increments of $10,000 up to $300,000;

STOP-If you choose an amount greater than $50,000, you must fill out a Life Insurance Evidence of Insurability form. The life insurance vendor will contact you about completing this form. Amount over $50,000 will not be effective until we receive approval from our life insurance carrier.

Fill in the amount of Benefit

$ 0,000

SPOUSE

SECTION 2: SPOUSE INSURANCE

NOTE: You cannot enroll your family members unless you, the employee, are enrolled. You cannot select an amount for your dependents greater than 50% of the amount selected for yourself.

OPTIONS-Choose only one

- Having selected Life Insurance for myself, I wish to have Life Insurance on my spouse.
- I currently have Life Insurance for my spouse and am making a change.
- No, I do not want Life Insurance on my spouse.
- Cancel Life Insurance on my spouse.

Choose a Coverage Amount in increments of $5,000 up to 1/2 of the amount chosen for yourself, up to $150,000;

STOP-If you choose an amount greater than $25,000, you must fill out a Life Insurance Evidence of Insurability for your spouse. The life insurance vendor will contact you about completing this form. Amount over $25,000 will not be effective until we receive approval from our life insurance carrier.

Fill in the amount of Benefit

$ 0,000

CHILDREN

SECTION 3: CHILD(REN) INSURANCE

NOTE: You cannot enroll your family members unless you, the employee, are enrolled. You cannot select an amount for your dependents greater than 50% of the amount selected for yourself.

OPTIONS-Choose only one

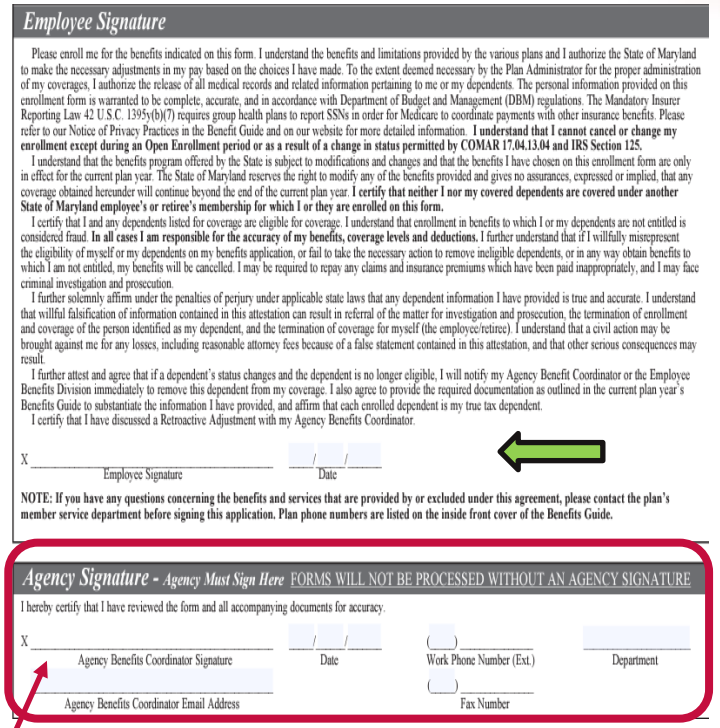
- Having selected Life Insurance for myself, I wish to have Life Insurance for my child(ren).
- I currently have Life Insurance for my child(ren) and am making a change.
- No, I do not want Life Insurance on my child(ren).
- Cancel Life Insurance on my child(ren).

Choose a Coverage Amount in increments of $5,000 up to 1/2 of the amount chosen for yourself, up to $150,000;

STOP-If you choose an amount greater than $25,000, you must fill out a Life Insurance Evidence of Insurability for each covered child. The life insurance vendor will contact you about completing this form. Amount over $25,000 will not be effective until we receive approval from our life insurance carrier.

Fill in the amount of Benefit

$ 0,000



Employee Signature

Please enroll me for the benefits indicated on this form. I understand the benefits and limitations provided by the various plans and I authorize the State of Maryland to make the necessary adjustments in my pay based on the choices I have made. To the extent deemed necessary by the Plan Administrator for the proper administration of my coverages, I authorize the release of all medical records and related information pertaining to me or my dependents. The personal information provided on this enrollment form is warranted to be complete, accurate, and in accordance with Department of Budget and Management (DBM) regulations. The Mandatory Insurer Reporting Law 42 U.S.C. 1395y(b)(7) requires group health plans to report SSNs in order for Medicare to coordinate payments with other insurance benefits. Please refer to our Notice of Privacy Practices in the Benefit Guide and on our website for more detailed information. **I understand that I cannot cancel or change my enrollment except during an Open Enrollment period or as a result of a change in status permitted by COMAR 17.04.13.04 and IRS Section 125.**

I understand that the benefits program offered by the State is subject to modifications and changes and that the benefits I have chosen on this enrollment form are only in effect for the current plan year. The State of Maryland reserves the right to modify any of the benefits provided and gives no assurances, expressed or implied, that any coverage obtained hereunder will continue beyond the end of the current plan year. **I certify that neither I nor my covered dependents are covered under another State of Maryland employee's or retiree's membership for which I or they are enrolled on this form.**

I certify that I and any dependents listed for coverage are eligible for coverage. I understand that enrollment in benefits to which I or my dependents are not entitled is considered fraud. **In all cases I am responsible for the accuracy of my benefits, coverage levels and deductions.** I further understand that if I willfully misrepresent the eligibility of myself or my dependents on my benefits application, or fail to take the necessary action to remove ineligible dependents, or in any way obtain benefits to which I am not entitled, my benefits will be cancelled. I may be required to repay any claims and insurance premiums which have been paid inappropriately, and I may face criminal investigation and prosecution.

I further solemnly affirm under the penalties of perjury under applicable state laws that any dependent information I have provided is true and accurate. I understand that willful falsification of information contained in this attestation can result in referral of the matter for investigation and prosecution, the termination of enrollment and coverage of the person identified as my dependent, and the termination of coverage for myself (the employee/retiree). I understand that a civil action may be brought against me for any losses, including reasonable attorney fees because of a false statement contained in this attestation, and that other serious consequences may result.

I further attest and agree that if a dependent's status changes and the dependent is no longer eligible, I will notify my Agency Benefit Coordinator or the Employee Benefits Division immediately to remove this dependent from my coverage. I also agree to provide the required documentation as outlined in the current plan year's Benefits Guide to substantiate the information I have provided, and affirm that each enrolled dependent is my true tax dependent.

I certify that I have discussed a Retroactive Adjustment with my Agency Benefits Coordinator.

X _____ Employee Signature ___/___/___ Date

NOTE: If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact the plan's member service department before signing this application. Plan phone numbers are listed on the inside front cover of the Benefits Guide.

Agency Signature - *Agency Must Sign Here* FORMS WILL NOT BE PROCESSED WITHOUT AN AGENCY SIGNATURE

I hereby certify that I have reviewed the form and all accompanying documents for accuracy.

X _____ Agency Benefits Coordinator Signature ___/___/___ Date (___) _____ Work Phone Number (Ext.) _____ Department

_____ Agency Benefits Coordinator Email Address (___) _____ Fax Number

Check and confirm life insurance selections and amounts.

★ ***Did you know?***

In order for dependents to enroll in life insurance, primary must also enroll as well

Confirm signature is completed by requestor

Confirm Agency Information is completed

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ABC Responsibilities: finally…

Your signature on a form indicates:

- You have reviewed the form as fully complete and accurate
- You have confirmed all supporting documentation is complete and accurate

Timeliness:

- Ensure all forms are sent timely, know the time frames for the following:
- Enrollment forms, Notice of Termination forms*& Personal Information Change forms

  *due to the impact on Satellite invoicing and access to benefits-**prompt** notification should be given. Delays may cause denial of credits on subsequent invoices.

Method of Delivery:

- Ensure forms are sent using the appropriate email address, fax number, or mailing address
- Email delivery method is preferrable for response and tracking purposes
- satellite.ebd@maryland.gov ; fax: 410-333-5191; mailing address: 301 W. Preston Street, Room 510, Baltimore, MD 21201

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DEPARTMENT OF BUDGET AND MANAGEMENT

ABC Responsibilities

Terminations and Invoicing:

Submit your Notices timely/Review Invoice:

- Review the invoice monthly with special attention given to **terminated employees**
- Termination requests received more than 60 days following the date of termination are not eligible for retroactive credits
- Monthly Invoices must be paid in full…adjustments to the invoicing will be made on subsequent invoices by EBD once notified of the discrepancies, errors and/or omissions

- All invoices are password protected: redsky

NOTIFICATION OF TERMINATION OF EMPLOYEE BENEFITS
SATELLITE AGENCIES

Complete and email this form to the Employee Benefits in a timely manner following termination resignation or death to terminate coverage.

- Coverage terminates on the last day of the month coincident with or following termination
- Premium is due and payable for members that are not terminated in a timely manner
- Email: Satellite.ebd@Maryland.gov

TO: Employee Benefits Division – Participant Services

FROM: _____ Phone: _____
Agency Appointing Authority/Designee

The following employee is no longer employed and should be removed from our Benefit Plans

Name: _____ SSN: _____

Agency Code: _____ DOB: _____

Last Day on Payroll: _____ Date of Termination: _____

Reason

- ☐ Terminated
- ☐ Resignation
- ☐ Deceased – Date _____

_____ _____
Print Name / Appointing Authority/Designee Email

_____ _____
Signature / Appointing Authority/Designee Date

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ABC Responsibilities: and the bill…

Monthly Invoicing:

Invoices Generate: 22nd
Invoices Emailed: 23rd OR NBD

Review invoice for discrepancies, omissions OR errors

Reply to the invoice email no later than **14** business days from receipt noting any errors.

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ABC Responsibilities: and the bill…

SSPS

Maryland Department of Budget & Management
Remittance Slip for Satellite Payment
For the Period of Coverage Month Ending
August-22

Agency Code	900001	ATTORNEY GRIEVANCE COMMISSION	
Due Date	09/15/22	Amount	$38,087.76
Total for	August-22		
Contact Name		Phone number	

Premium Amount	37,340.94
Prior Period Adjustment	-
Administrative Fee	746.82
Surcharge	-
OPEB	-
Late Fee	-
Total Amount Enclosed	$38,087.76

		# Bi-weekly Deduction - Active	# Monthly Deduction - Retiree	Premium	41710 APS	DBM USE Only
PPO BCBS	41420	9	-	10,520.00		
PPO UHC	41490	5	0	4,403.76		
POS BCBS	41580	-	-	-		
POS UHC	41530	0	0	-		
POS Aetna	41650	-	-	-		
EPO BCBS	41470	8	0	6,671.20		
EPO UHC	41640	1	0	1,242.28		
EPO Aetna	41660	-	-	-		
IHM Kaiser	41560	3	-	2,835.80		
Drug	45410	26	-	9,992.32		
DPPO Concordia	48411	20	-	1,400.54		
DHMO Concordia	48411	-	-	-		
DHMO Delta	48412	4		66.64		

Remittance Summary by Plan | Detail Listing | POS UHC | EPO UHC | PPO UHC | EPO BCBS | PPO BCBS | POS BCBS

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ABC Responsibilities-P.S...ACA

The ACA report is crucial for a:

- Submit the ACA Report on time, schedule was provided, there are no excuses for being tardy
- Address, SSN, Agency Code are always required, it should never be left blank
- If an employee is terminated, put the termination date in **Column N**
- Errors may be sent to agencies, and those errors need to be addressed quickly
- The August- December files are important for IRS regulations, Open Enrollment and 2023 benefits eligibility.

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Open Enrollment

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Open Enrollment

October 11 - November 4, 2022

- Important Dates:
  - October 11: Open Enrollment begins
  - November 4: Open Enrollment closes at **5** pm
  - November 10: Open Enrollment forms must be sent to EBD (email, fax, regular mail)
  - **Do not hold your forms, send them as they are submitted to you.**
  - Dependent Verification Review (DVR) …ongoing

- 100% Virtual Campaign
  - **On-Demand Open Enrollment Materials & Videos at mymdbenefits.com**
  - All materials available online as of October 8th

- Current Benefit Summaries and 2023 Satellite Enrollment forms mailed to members.

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Dependent Verification Review (DVR)

- If an employee adds a qualified dependent during Open Enrollment, they **MUST** include the required documentation **when submitting** the Open Enrollment Form. **This is part of your review process** before signing and submitting.
- If the required dependent(s) documentation is not submitted to you by 11/4/22 **at 5:00pm** the newly added dependent(s) listed **will not be processed.**
  - **They will not have coverage effective January 1, 2023**
- Please reference page 39 of your 2023 Benefit Guide to determine what official documentation is required for each dependent

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Open Enrollment-Special Notes:

- The BAS Open Enrollment will default to the current employee elections including dependents. Exception: **FSAs, must be re-enrolled each year**.
- Open Enrollment allows employees to change plans, add or remove eligible dependents and/or waive coverage.
- FSA elections are mandatory re-enrollment each year, no rollover. (eligible organizations only-see Satellite enrollment form)
- Health Care FSA maximum is updated to $2,850
- Review the Open Enrollment Forms for accuracy, supporting documentation, signature, date, etc.
- Ensure forms are legible; to avoid entry errors-Use the fillable form online at dbm.Maryland.gov/benefits!
- **No correction period, No exceptions!! No crying!**

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Agency Readiness Checklist:

- **Develop a communication plan for staying in touch with employees**
- **Remind employees that supporting documentation must be provided WITH the enrollment form – *we suggest distributing our Documentation flier in advance***
- Forward Open Enrollment Forms and supporting documentation as received. DO NOT hold all forms until the final day.
- Submit Open Enrollment Forms and supporting documents via email: Satellite.ebd@maryland.gov
- **Format Subject Line:** Agency code, OE, first initial.last name (950002 OE J.Hancock) **1 per email**

IMPORTANT: scan and email form w/ documentation as one packet – please do not send each page as a separate document/attachment.

Do not combine calendar years; i.e., 2022 new hires with 2023 open enrollment forms

Forms may also be faxed or sent via regular mail. Those sent via fax must follow the same naming protocol for ease of identification.

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Benefit Highlights

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Highlights 2023:

No more Waiting Periods effective January 1, 2023

1. All organizations will be required to mirror the State waiting period:
   a. First of the month coincident with or following the date of hire
   b. Example: A date of hire of July 5, 2022, results in an August 1, 2022, effective date

New!

2. All organizations will be required to offer the State's full suite of benefits*

New!

Given the breadth of services provided, it is necessary to increase the administration fee from 2% to 5% of monthly premium.

New!

*Excluding Flexible Spending Accounts ***(Eligible organizations only)***

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Highlights 2023

- 

Obtain an annual routine eye exam for an additional $5 reduction on your specialist copay when you participate in the Wellness Program.

- Flu shots and COVID vaccines are available at your local retail pharmacy using your CVS Rx card - $0 Copay

- Benefits are unchanged-same plans, same carriers

- FSA Maximum Deferral is $2,850
  - Expanded eligibility for Over-the-counter (OTC)
  - View our website or **mymdbenefits.com** for details

- 2023 Rx Formulary updates (updates to follow)
  - Member notification
  - Physician notification
  - No changes to the Retiree EGWP Program

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Wellness

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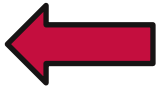
Wellness 2023

- Activities **do** reset for 2023
- Wellness program managed by your medical carrier
- Activities for $0 PCP Copay
  - Select or Confirm PCP (Primary Care Physician)
  - Complete HRA (Health Risk Assessment)
  - Kaiser members: Sign online HIPAA release
- Activities for a discount of $5 Specialist Copay (total $10)
  - Obtain an annual eye exam  

  - Complete any age/gender preventative screenings

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Wellness 2023

Wellness program managed by your medical carrier and includes motivating digital resources you can access anytime anywhere! Examples include:

- Health Surveys (annual and on demand) and Personalized Health timelines to include recommendations, content and services available to you
- Health Profile for maintaining all your health data in one place
- Trackers: Connect your wearable devices or enter your own data to monitor sleep, step, nutrition and more
- Challenges providing extra motivation for achieving your goals
- Wellness Coaching at no cost – 1:1, can be telephonic or online
- Diabetes Prevention Programs for members who meet pre-diabetes criteria. Programs contain success kits (wireless scale, wearable fitness trackers, exercise equipment) and 1:1 coaching + weekly cohort meetings

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Financial Wellness: Upwise

upwise

MetLife

- Upwise from MetLife is a no-cost confidential financial wellness app available to all State of Maryland Employees
- Participation does not depend on benefits eligibility and no election is required for participation
- Designed to help build financial progress through good money habits

Download the app: App Store or Google Play

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EBD Reminders

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Reminders

- **Benefit Guide**
  - Available online for everyone at DBM.Maryland.gov/benefits
  - Read the Benefit Guide!
- **Contacting EBD**
  - Use satellite.ebd@maryland.gov (forms, monthly invoicing)
  - Use ebd.mail@maryland.gov for general questions
  - Please refrain from emailing or calling EBD staff directly

- **Open Enrollment closes to employees at 5pm on November 4th. Delivery of forms from the agencies accepted no later than November 10th (post mark, fax confirmation, email)**

Visit our microsite at: Mymdbenefits.com

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Questions?

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Thank You!